Luminis Health Doctors Community Medical Center
Certificate of Need Application to Establish a 16-Bed
Adult Inpatient Psychiatric Unit

Applicant's Responses to Completeness Questions Dated April 29, 2021

Part 1 Introduction

1. In the Brief Project Description (p. 4), the application states that 80 % of the service population is diverse. Provide a demographic description of the population to be served by this project.

Applicant Response:

According to the 2019 Community Health Needs Assessment (CHNA), Prince George's County is more diverse than Maryland and the United States.

Prince George's County by Race and Ethnicity
2017

Race and Ethnicity	Percent of Total Population
Black, Non-Hispanic	62.0%
Hispanic	18.5%
White, Non-Hispanic	12.6%
Asian, Non-Hispanic	4.3%
Other, Non-Hispanic	2.6%

Source: Prince George's County CHNA, p3-4 attached as Exhibit 28.

2. In the Brief Project Description (p. 5), the application states that there is a comprehensive care facility (CCF) on campus. Is this the CCF that previously occupied the second floor where the psychiatric unit is to be built? Will the facility refer any patients to this CCF post discharge?

Applicant Response:

In 2015 the Magnolia Gardens CCF was relocated from the building in the CON to the north east portion of the LHDCMC campus and renamed the Doctors Community Rehabilitation and Patient Care Center. That facility is now located at 6710 Mallery Drive and operated by Genesis Healthcare. There are no plans to establish a referral relationship between the new LHDCMC inpatient psychiatric unit and the Doctors Community Rehabilitation and Patient Care Center.

Background

3. Provide an inventory of adult psych beds currently in Prince George's County and the Southern Planning Region, both before and after project completion. Include changes in bed numbers after the completion of the new Prince George's Regional Medical Center.

Applicant Response:

The information presented below is excerpted from the most recent report on licensed bed capacity published by the Maryland Health Care Commission (MHCC) and made available on the MHCC website. This report is dated Fiscal Year 2020 and is based on licensed bed capacity as of July 1, 2019.

FY2020 Licensed Acute Psychiatric Beds and Projection
Planning Region: Southern Maryland

County/Hospital	FY 2020	Project Completion
Prince George's County		
UM Capital Region Medical Center[1]	32	28
MedStar Southern Maryland Hospital Center	28	28
LHDCMC: New Psychiatry Unit		16
Calvert County		
CalvertHealth Medical Center	8	8
St. Mary's County		
MedStar St. Mary's Hospital	12	12
Charles County		
No Inpatient Psychiatric Programs		
Total Acute Psych Ben Capacity, Southern Maryland	**80**	**92**

Source: "Fiscal Year 2020: Licensed Acute Care Beds by Hospital and Service," Maryland Health Care Commission. Available at: https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Licensed_Acute_Care_Beds_by_Hospital_and_Service_%20Maryland_FY2020.pdf

Note 1: Based on CON application for new Capital Region Medical Center facility which was approved for 28 licensed acute psychiatric beds, a 4-bed reduction

On project completion, there will be a total of 92 acute psychiatric beds operating in Southern Maryland. Even with the additional 16 beds at LHDCMC, the Southern Maryland Planning Region will continue to have the lowest population-to-bed ratio for acute psychiatric care across all of Maryland's Planning Regions, assuming no significant change in population.

Part II Proposed Project and Its Impact

4. The proposed project (p. 10) calls for a warm hand-off to continuing care and a relationship with a clinician across the continuum of care. Will there be follow up on patients post-release, and if so, for how long will patient's progress be followed?

Applicant Response:

With a shared medical record and continuum-of-care services under the same roof, discharge follow-up within the Luminis Health system will be same day and day of scheduled outpatient appointment. Operationally, a missed patient appointment will instigate a report to the discharge service to coordinate follow-up with the patient.

If the hand-off is to a provider other than a Luminis Health provider, at a minimum it is expected once the hand-off has been completed, the LHDCMC staff will following up at one day, day of scheduled community appointment and at seven (7) days post discharge to gauge success and further referrals/recommendations as appropriate.

5. The application states (p.12) that the facility will treat adolescents under the partial hospitalization program, but not in the inpatient program. Provide the rationale for serving only adult patients at the new facility. Where will the adolescents treated in partial hospitalization be transferred to if inpatient care is needed?

Applicant Response:

LHDCMC intends to only offer inpatient services for adults in the unit at this time and will not serve any special populations, including adolescents. The needs analysis demonstrates that a 16-bed inpatient unit is required to adequately support adult psychiatric demand in the market. In addition, as is best practice, LHDCMC intends to offer an array of outpatient services across the care continuum, collocated at the facility, to best address the behavioral health needs of the entire community. Therefore, given the size and capacity limitations of the existing building, the extent of services already planned for the building, and the requirements that adolescent inpatient care would need to be separate from adult inpatient care, the building cannot support an inpatient adolescent unit.

While there is a need for adolescent behavioral health services in the region, Luminis Health believes its new partial hospitalization program (PHP) will significantly improve access to care for the adolescent population without the addition of inpatient services at this time. Inpatient hospital beds for adolescents are available at facilities with specialty adolescent services such as Sheppard Pratt and Psychiatric Institute of Washington. The development of the adolescent PHP and IOP will also provide a discharge location for those dispositioned out of a hospital back to their community. This delivery model will be closely evaluated in terms of clinical outcomes, patient satisfaction, relapse rates, and ongoing need to validate that community needs for adolescents are appropriately met by this program.

6. The application states (p. 13) that the new facility will work with community-based services as part of the continuum of behavioral health services. Provide a list of organizations that have agreed to accept referrals from the facility.

Applicant Response:

While the work of continuing the development of this network continues, initial supportive referral discussions have been held with: Sheppard Pratt Outpatient Services with a presence in that market, Arundel Lodge with a presence in that market, Affiliated Sante who provides Mobile Crisis Services in the county, Drs. Ganjoo-Sood and Behl who operate private outpatient practices in the market. That network will continue to expand.

Facility details

7. Apart from upgraded windows, describe any other specialized safety features that will be included in the building plan, especially as the facility will be accommodating involuntary admissions.

Applicant Response:

In keeping with its longstanding commitment to patient safety, LHDCMC's plan for implementing evidence based patient centric facility for inpatient psychiatric services that will maximize the safety of our patients as well as staff.

The interior design embodies safe, residential components, with improved aesthetics, ventilation, and noise control. In order to achieve the best possible outcomes for the patients, design of the built environment will be based upon credible research and experience focusing on a healthy healing environment

To best meet this need LHDCMC will be utilizing the following resources during the planning design and construction phases. Behavioral Health Design Guide, November 2020 Edition by Kimberly N. McMurray, James Hunt, and David M. Sine that is recognized by Facility Guidelines Institute as the fundamental requirements for designing behavioral health facilities.

Design features Maximizing Patient Safety

Safety is the utmost important criteria in a behavioral health care environment, particularly an inpatient unit with restricted access. Despite this, it does not benefit patients to be subjected to an "institutional" environment. Recent studies describe the benefit patients receive from a healing environment with thoughtful consideration given to home-like elements such as comfortable furniture, use of color, windows that provide natural light, natural ventilation and access to nature or "green" space, and artwork that highlights local scenery and activities. The inpatient psychiatric unit will be configured to promote interaction among staff and patients to facilitate the establishment of therapeutic relationships, trust and patient engagement. In addition to the healing elements of a trusting relationship, this will allow staff to observe such issues as patient agitation or a change in behavior, providing an opportunity for early intervention.

Patient Needs

Patient dignity, respect for individuality, and privacy will be maintained without compromising the operational realities of close observation, safety, and security. Patient to stress

from noise, lack of privacy, poor or inadequate lighting, ventilation and other causes, and the subsequent harmful effect on wellbeing, are well-known and documented.

A key architectural objective will be to reduce emphasis on the institutional aspects of care and to surround the patient with furniture, furnishings, and fixtures that are appropriate from a safety standpoint but are more residential in appearance.

Behavioral health facilities should be environments of healing that allow the building itself to be part of the therapeutic setting and process. The technical requirements to operate the building should be unobtrusive and integrated in a manner to support this concept.

Nursing Station

The Nursing Station will be open and promote staff-patient interaction to facilitate ongoing observation, interaction, and early intervention. Clinical and medical items needed by the staff that could present hazards to patients will be kept in a safe and secure location out of reach of patients.

Private Patient Rooms and Bathrooms

The inpatient unit with have all private patient rooms which will allow more patient assignment flexibility, enhances patient privacy, and reduces disruptions and incidents related to a shared patient bedroom. Single occupancy patient rooms have the benefit of being more private and having less noise, which may be agitating to some patients and can disturb sleep. The fixtures in the bathroom will be behavioral style anti-ligature type with security hardware. Taking into account lessons learned on a previous project, the bathroom door will be a soft door that is held in place magnetically. This will reduce a ligature point at the top of the door hinge.

Inpatient Entrance/Reception

Beyond its functional benefits, the inclusion of designated reception and waiting areas is an important aspect of patient-centered design and creates initial perceptions and expectancies of a welcoming environment embracing patient value.

A secure vestibule consisting of two interlocking doors at the entrance is required to prevent patient elopement. The design of this entry to the unit will be developed so that the image is welcoming to family and other visitors and the impact of the security provisions is minimized. Ideally, during the daytime, a receptionist will be adjacent to the entrance to the unit to welcome visitors in addition to performing administrative tasks.

Security Command Center

The security command center is the security hub for the facility and will be staffed 24/7/365. Within command center they able to observe the CCTV system, communicate with staff during emergent situations, and monitor the overall safety status of the facility. The command center will be located directly adjacent to the reception lobby and will have full view of the area.

Patient Assessment/Intake

Inpatient staff must provide assessment and ongoing reassessment of suicide and safety risk. Suicide prevention and precaution procedures must be followed to mitigate risk for patients on the unit who are at risk for suicide. Recovery-oriented model includes safety planning and suicide prevention care.

Risk Reduction

The following facility detailing, planning, and design concepts will be integrated into the project to reduce the following risks in behavioral health facilities:

Elopement Prevention

- Allowing one way in and out of congregate areas, as allowed by code
- Electronic door controls for emergency egress as allowed by code
- Simple circulation with no blind spots
- Casual observation (visibility from staff offices and work areas that are not directly responsible for observing patients)

Patient Behavioral Incidents

- Visibility
- Specify products for the facility that cannot be used as a weapon or used in an attempt of self-harm
- Design appropriate abuse resistance in areas where patients are alone for periods of time
- Equipment, carts, and other supplies will be adequately stored in locked rooms. Alcoves will not be used for storing or parking of equipment, carts and assistive devices in corridors and other unsecured areas

Reducing Patient/Staff Injuries:

- Appropriate accommodations for disabled and bariatric patients.
- Patient rooms and other areas where patient is alone have enough abuse resistance to allow time for an appropriate response team to arrive before a patient harms themselves or is able to exit the space

Reducing Patient and Staff Stress:

- Natural light in staff/patient areas
- Noise control
- Open layout, with no unnecessary barriers between staff and patient
- Space for both patients and staff is designed so neither feels trapped or vulnerable; overcrowding is avoided
- Exterior views
- Use of natural materials, a soothing color palette and residential character in the interior design of the facility
- Familiar and healing environments
- Patient and staff areas that allow for relaxation and controlling one’s social environment (e.g., quiet rooms, staff lounges, and secure outdoor space)

Part IV Consistency with General Review Criteria at COMAR 10.24.01.08G(3)

Need

8. The application (p. 29) points to the COVID pandemic as a rationale for more psych beds in PG county. As the facility will not open until 2023, explain why the pandemic will still be a driver of patient admissions.

Applicant Response:

While the dearth of inpatient psychiatric beds in the LHDCMC market justifies the need for the 16 bed unit even without consideration of the impact of the COVID pandemic, many experts are predicting long-term pandemic impacts that will prolong the need for more intensive behavioral health services over the coming years. The COVID pandemic worsened many social determinants of health including employment, income, housing, and access to food. These effects will likely last for many years and have long term impacts on behavioral health. (Exhibit 29).

Other natural disasters have demonstrated long-term impacts on behavioral health services. Five years after Hurricane Katrina, researchers found that thirty three percent of New Orleans residents still experience post-traumatic stress and thirty percent experienced psychological distress. (Exhibit 30).

The COVID pandemic has not only increased the prevalence of behavioral health problems, it has also increased conversations about behavioral health. Since the start of the COVID pandemic media stories have featured the impact on behavioral health, employers are discussing behavioral health with their employees, overall the community is having more conversations about behavioral health. The more conversations occur the likelihood stigma reduces around behavioral health. As stigma reduces more people will seek care for behavioral health. (Exhibit 31).

9. In calculating cost of care differentials (p. 45), the application states that Sheppard Pratt's charge per case is $1,432 per case higher than at psychiatric units at community hospitals. As previously stated in the application, (p. 28), Sheppard Pratt treats a patient population eligible for care at LHDCMC, as well as specialized populations that may require more costly care. Provide a comparison of costs for LHDCMC-eligible patients at Sheppard Pratt and the proposed facility.

Applicant Response:

Sheppard Pratt cares for a broad range of patients including adolescents and an adolescent neuro-psychiatric cases. As such, the overall average charge at Sheppard Pratt of $14,253 is not comparable to the proposed program at LHDCMC. However, once we limit the cases to those that would be treated at LHDCMC (or LHDCMC eligible), the average charge at Sheppard Pratt of $13,979 is $2,537 higher than the $11,281 estimated at LHDCMC as illustrated in the table below.

FY 2019 Average Charge
Patients Originating in Prince George's County

	Total Volume w/ Patient Origin = PG County			LHDCMC Eligible w/ Patient Origin = PG County		
	Cases	Total Charges	Average Charge	Cases	Total Charges	Average Charge
Sheppard Pratt	319	$4,546,717	$14,253	306	$4,277,615	$13,979
LHDCMC				710	$8,123,892	$11,442
LHDCMC over (under) Sheppard Pratt						($2,537)

10. Explain the projection (p. 45) that 95% of discharges will be from Prince George's County. Will the facility preferentially admit individuals residing in the county?

Applicant Response:

The LHDCMC unit will accept adult patients for whom an inpatient psychiatric admission is medically necessary (except for the specialized categories described in the application). It is anticipated the unit will serve a predominantly local population as they will utilize the LHDCMC Emergency Department instead of traveling longer distances to an alternative site. Therefore, if the need for an inpatient admission is proved, this population will naturally migrate to the local unit. There will be no preferential priority given to local residents.

11. Provide the assumptions that resulted in the projection that the proposed facility would garner a 19% market share in Prince George's County. (P.46)

Applicant Response:

The projected market share for LHDCMC was based on the projected volume shifts by region, by hospital. The aggregate projected volume shift results in a 19% market share projection. These assumptions are delineated in the table below.

The projected volume shifts represent:

- LHDCMC-eligible volume only, and includes residents of Prince George's County only.
- 10% of current discharges from Prince George's County hospitals are projected to shift to LHDCMC.
- 30-50% of current discharges from hospitals outside Prince George's County are expected to shift to LHDCMC once a hospital unit in closer proximity becomes an option for County residents.

Based on the total of these volume shifts, the projected market share for LHDCMC was calculated as 19% of Prince George's County adult psychiatric discharges. In addition, the 19% Prince George's County market share is consistent with LHDCMC's 18% market share based on

CY2019 adult medical/surgical volume in Prince George's County. Cardiac surgery and acute rehabilitation care were excluded since LHDCMC does not provide these services.

Projected Volume Shifts to LHDCMC Acute Psychiatric Unit, by Hospital
In CY2019 Volumes
(Original Application Table 12)

		Total # Psych Admits				DCMC-eligible Volume, Age 18+ after Market Adjustments				Impact on Existing Providers			
	CY 2019	CY2019 Actual			DCMC-eligible Volume, Age 18+	Prince George's County Residents			Montgomery County Cases	Impact Based on CY 2019 Volume			With Demographic Growth 2019-2023
Hospital	Licensed Beds	Cases	ADC	Occupancy Rate	Cases	# Discharges	Shift: % Discharges	Shift: # Discharges	Shift: # Discharges	Balance, Total # Psych Discharges	Total Psych ADC	Effect on Psych Occupancy %	Effect on Psych Occupancy %
Maryland Hospitals													
UM Capital Region Prince George's	32	1,665	25.2	78.9%	1,144	1,098	10%	110	-	1,509	22	68.9%	71.0%
MedStarSouthern MD	28	1,222	19.3	68.8%	594	576	10%	58	-	1,147	18	64.1%	66.1%
Shady Grove Adventist	117	3,157	84.1	71.9%	315	308	10%	31	-	3,120	83	71.1%	73.3%
Sheppard Pratt	414	7,830	297.8	71.9%	306	303	50%	151	-	7,675	293	70.8%	73.0%
White Oak Medical Center (formerly Wash Adv)	26	654	12.5	48.2%	222	216	10%	22	-	627	12	46.3%	47.7%
Suburban Hospital	24	1,451	16.5	68.8%	101	97	10%	10	-	1,437	16	68.2%	70.3%
Other Maryland Hospitals	684	28,884	519.6	76.0%	468	447	30%	134	-	28,729	516	75.4%	77.8%
Subtotal, Maryland Hospitals	**1,325**	**44,863**	**975.0**	**73.6%**	**3,150**	**3,046**	**0%**	**515**	**-**	**44,244**	**961**	**72.5%**	**74.7%**
Washington DC Hospitals													
United Medical Center		1,504	20.3		120	111	30%	33	-	1,462	20		
MedStar Wash Hosp Center	46	2,167	44.2	96.0%	152	146	30%	44	32	2,086	43	92.6%	95.5%
George Washington Univ	20	998	14.9	74.5%	63	58	30%	17	-	976	15	72.7%	74.9%
Sibley Hospital	21	683	14.5	68.8%	37	36	30%	11	-	671	14	67.4%	69.5%
Howard Univ Hosp	18	655	8.2	45.4%	27	24	30%	7	-	645	8	44.9%	46.3%
MedStar Georgetown Univ	-	585	11.9		35	34	30%	10	-	574	12		
Subtotal, Washington DC Hospitals	**105**	**6,592**	**113.9**		**434**	**410**	**0%**	**123**	**32**	**6,413**	**111**		
Total Existing Programs	**1,430**	**51,455**	**1,088.9**		**3,584**	**3,456**	**0%**	**638**	**32**	**51,327**	**1,084**		
Total Shift, Maryalnd & DC Hospitals								**670**					
DCMC Market Share, PG County								**18.5%**					

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

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

Cost Effective Alternatives

12. Explain why existing facilities and population health initiatives would not be a cost-effective way to provide services in Prince George's County.

Applicant Response:

The most cost-effective long term strategy for psychiatric care in Prince George's County is a multi-pronged approach that will provide adequate access to care in the lowest acuity, lowest cost environment. Inpatient care outside the County is the least cost-effective option, and existing services inside the County do not adequately meet demand, as evidenced by the fact that more than half of all psychiatric admissions for County residents occur outside of Prince George's County. Expanded access to care in the County can be achieved through offering sufficient inpatient care

closer to home and expanding outpatient services and population health initiatives to reduce the demand for inpatient care.

In addition to offering inpatient psychiatric beds in Prince George's County, Luminis Health is committed to providing a range of psychiatric services across the care continuum and leveraging population health strategies to target reducing the need for inpatient psychiatric services. Population health efforts include a range of lower acuity and community-based services designed to keep some individuals from requiring more acute, inpatient care, but it is not anticipated that these efforts will eliminate the need for adult inpatient psychiatric beds. Population health efforts combined with LHDCMC's proposed adult psychiatric beds will ensure beds are occupied only by patients requiring high acuity, inpatient care. It is our position that through a broad array of care expansion, including repatriating inpatient care close to home, we will reduce lengths of stay, reduce psychiatric admissions and readmissions, and achieve high quality, long term, and cost-effective outcomes in the lowest acuity setting.

Length of stay in out-of-county facilities tends to be longer than necessary because out-of-county programs are not as well-integrated with local, community-based resources in Prince George's County; oftentimes, new relationships with clinicians must also be established which can take time to arrange. Stated simply, the discharge planning process takes longer until post-acute services are in place.

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

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

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

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

In addition to improving outcomes, the new behavioral health program at LHDCMC is a cost-effective alternative because we will have comparable rates to the other providers in the Southern Planning Region (see response to completeness question 23 below) and LHDCMC cost is much lower than providers outside the Southern Planning region including Washington D.C. It is projected that the shift of cases to LHDCMC will generate $2.5 million in healthcare savings. See revised Table 14 below.

Table 14 – Revised

Psychiatric Unit: Projected Reduction in the Costs of Acute Psychiatric Services
FY2027

	FY 2027 - Payments					
	Cases	Average Payment	Total Payment	VCF	Payment @ VCF	
Doctors Community Health Projected Cases	710	$10,780	$7,653,519	50%	$3,826,759	
Incremental Revenue	710	10,780	7,653,519	50%	3,826,759	
Estimated Payment at 94.21% [2]					$3,652,259	[A]
Impact on Hospitals with Volume Reductions:						
Prince George's	(117)	10,612	(1,241,581)	50%	(620,790)	
Southern Maryland Hospital	(61)	11,899	(725,843)	50%	(362,921)	
Adventist Shady Grove	(33)	9,127	(301,206)	50%	(150,603)	
Sheppard-Enoch Pratt Hospital	(157)	12,874	(2,021,220)	100%	(2,021,220)	
Adventist White Oak	(23)	9,496	(218,404)	50%	(109,202)	
Suburban	(11)	6,300	(69,296)	50%	(34,648)	
MedStar Washington Hospital Center	(81)	11,360	(920,145)	100%	(920,145)	
United Medical Center	(35)	11,018	(385,639)	100%	(385,639)	
George Washington University	(18)	11,694	(210,484)	100%	(210,484)	
Other DC Hospitals[4]	(30)	12,768	(383,038)	100%	(383,038)	
Other Maryland Hospitals	(144)	13,239	(1,906,419)	50%	(953,209)	
Total Estimated Payment	(710)	11,807	(8,383,272)	73%	(6,151,899)	[B]
Net Savings on Total Health Care Spend ( ) = Savings					**($2,499,640)**	[A-B]

Notes:

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

[2] Payment discount calculated at 5.79% (94.21%), a blend of the 7.7% discount for Medicare/Medicaid (66.5% of Maryland cases) and a 2% discount for non-Medicaid/Medicare (33.5% of cases) for Maryland acute hospitals. Sheppard Pratt discount calculated at 11.5% based on MC pymts at 68.5%, Medicaid discount at 7.7%, and other payers at 2%.

[3] DC hospital payments estimated as a blend of payments for Medicaid, Medicare and other payer payments based on historical payer mix. The Medicare payment was derived from CY2019 CMS LDS claims for residents in PG County with the referenced primary diagnosis code. FY2021 DC Medicaid base payment times the DRG weights plus DRG add-ons was used to estimate Medicaid FFS and MCO pymts. For all other payers, average payment was derived from CY18 (inflated to FY21) Truven claims for patients at DC hospitals that were assigned MS-MDC 19 and had a primary

[4] Other (not Doctor's) hospital charges are based on CY2019 case mix data times inflation for 1.5 years for the past two year's of update factors (2.77%, 2.64%)

Impact on Existing Providers

13. In the staffing plan (p.55), the application states that staffing needs will be met "with the allure of a 'new' facility that is state of the art." Given this "allure," explain the impact of the new facility on the staffing levels of existing providers.

Applicant Response:

The use of the word "allure" is merely a reflection that providers are sometimes drawn to the aspects of a new facility. In reality, we expect to face the same challenges all health care and behavioral health care facilities are facing with a tighter job market. We would expect individuals who are employed by other providers outside of the immediate areas will be drawn to a new facility closer to their home. As another hospital in the county prepares to open a new facility with fewer

behavioral health beds then they currently operate, we would expect some of those displaced staff will migrate to our new services. It is hard to predict what the net impact of this churn will be to any one service provider.

Acute Care Standards

Information Regarding Charges

14. The update available on the website is dated January 2021. According to the standard, these pages should be updated quarterly. The updated April 2021 charges should be posted before May 1st.

Applicant Response:

This CON application was submitted prior to May 1st. The charges were updated on Monday May 3, 2021.

Charity Care

15. Provide the following information concerning your charity care policies and procedures:

REQUIRED PROVISION	GUIDANCE FOR APPLICANTS
Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. **(a) The policy shall provide:**	**Provide exact quote from the policy that covers this provision, and provide the section citation…in addition, provide the responses indicated in each cell below.**
(i) Determination of Probable Eligibility. **Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.**	Policy must guarantee a determination of probable eligibility within two business days of request for charity/reduced fee care or application for Medicaid Quote the specific language from the policy that describes the determination *of probable eligibility* (and give a citation to the location within the policy). Provide copies of any application and/or other forms involved in the process for making a determination of probable eligibility within two business days. Describe your procedure for making a final determination, including defining any documentation required.

	Note that requiring a completed application with documentation does not comply with this standard, which is intended to ensure that a procedure is in place to inform a potential charity/reduced fee care recipient of his/her probable eligibility within two business days of initial inquiry or application for Medicaid based on a simple and expeditious process. *A two-step process that allows for a probable determination to be communicated within two days based on an abridged set of information, followed by a final determination based on a completed application with the required documentation is permissible. But the policy must include the more easily navigated determination of probable eligibility.*
REQUIRED PROVISION	**GUIDANCE FOR APPLICANTS**
(ii) Minimum Required Notice of Charity Care Policy. **1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format understandable by the target population on an annual basis;**	Quote the specific language from the policy that describes the method of implementing and provide a sample for each communications vehicle(s). Provide examples of the public information tools.
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	Provide copies of postings.
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	Quote from policy with section citation
(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all	If level of charity care is in bottom quartile, provide rationale/explanation for this variance.

hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.	

Applicant Response:

Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. **(a) The policy shall provide:**	**Provide exact quote from the policy that covers this provision, and provide the section citation…in addition, provide the responses indicated in each cell below.**
(ii) Determination of Probable Eligibility. **Within two business days following a patient's request for charity care services, application for medical assistance, or both, the hospital must make a determination of probable eligibility.**	**Policy must guarantee a determination of probable eligibility within two business days of request for charity/reduced fee care or application for Medicaid** **Quote the specific language from the policy that describes the determination *of probable eligibility* (and give a citation to the location within the policy).** **Applicant Response:** LHDCMC maintains a written policy titled *Patient Financial Services — Hospital Financial Assistance* (Exhibit 17). On page 2 under Policies and Procedures the first full bullet states: • The following two-step process shall be followed when a patient or a patient's representative requests or applies for financial assistance, Medical Assistance, or both: o Step One: Determination of Probable Eligibility. Within two business days following the initial request for financial assistance, application for Medical Assistance, or both, Luminis Health shall: (1) make a determination of probable eligibility, and (2) communicate the determination to the patient and/or the patient's representative. In order

	to make the determination of probable eligibility, the patient or his/her representative will be required to provide information about family size, insurance, assets and income, and the determination of probable eligibility will be based solely on the information provided by the patient or patient's representative. No application form, verification or documentation of eligibility will be requested or required for the determination of probable eligibility. o Step Two: Final Determination of Eligibility. Following a determination of probable eligibility, Luminis Health will make a final determination of eligibility for Financial Assistance, which (except as otherwise provided in this Policy) will be based on a completed Uniform Financial Assistance Application and supporting documentation of eligibility. **Provide copies of any application and/or other forms involved in the process for making a determination of probable eligibility within two business days.** **Applicant Response:** A copy of the application is attached as Exhibit 32. **Describe your procedure for making a final determination, including defining any documentation required.** **Applicant Response:** Luminis Health's procedure for making a final determination is outlined as well as the documentation required in Exhibit 33.
REQUIRED PROVISION	**GUIDANCE FOR APPLICANTS**
(ii) Minimum Required Notice of Charity Care Policy. **1. Public notice of information regarding the hospital's charity care policy shall be distributed through methods designed to best reach the target population and in a format**	**Quote the specific language from the policy that describes the method of implementing and provide a sample for each communications vehicle(s).** **Applicant Response:** On page 6 of the Financial Assistance Policy (Exhibit 17) the final section reads:

understandable by the target population on an annual basis;	Hospital Financial Assistance Communications: • The Financial Assistance Signage is conspicuously displayed in English & Spanish in each hospital's Emergency Department, Cashiering & Financial Counseling office. Patients desiring to discuss financial assistance in another language may call the contact numbers in this policy and interpretive services will be provided. • The Financial Assistance Policy as well as a printable Uniform Financial Assistance Application is posted on the hospitals' websites. • Financial Assistance information is included in each patient guide located in the inpatient rooms. • Registration staff and Financial Coordinators are trained on how to refer patients for financial assistance. • The Uniform Financial Assistance Application is available at all registration points in each hospital, including the Emergency Department. • A brochure "Patient Information Sheet" is available at every patient access point in each hospital and is posted on the Luminis Health website. This brochure includes information regarding financial assistance/contact points and is available in English/Spanish. • Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet. • Information is available through the patient access/registration staff to provide to the uninsured or any individual concerned about paying their hospital bill directing them to the hospital's Financial Counseling office for assistance.

	Provide examples of the public information tools. **Applicant Response:** The Patient Information Sheet (Exhibit 34) and Patient Handbook (Exhibit 35) are attached.
2. Notices regarding the hospital's charity care policy shall be posted in the admissions office, business office, and emergency department areas within the hospital.	**Provide copies of postings.** **Applicant Response:** Please see Exhibit 36 entitled Financial Assistance Signage at LHDCMC as of 05012021.pptx
3. Individual notice regarding the hospital's charity care policy shall be provided at the time of preadmission or admission to each person who seeks services in the hospital.	**Quote from policy with section citation.** **Applicant Response:** On page 6 of the Financial Assistance Policy (Exhibit 17) under Hospital Financial Assistance Communications, the seventh bullet states: • Individual notice regarding the Financial Assistance Policy shall be provided at the time of admission or preadmission to each person who seeks services in the hospital. It is mandatory that all inpatients receive the "Patient Information Sheet" brochure as part of the admission packet.
(b) A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Service Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.	**If level of charity care is in bottom quartile, provide rationale/explanation for this variance.** **Applicant Response:** • This standard is not applicable. Please refer to Exhibit 37 (LHDCMC Charity Care Comparison FY19) which shows that when comparing regulated charity care write-offs to total operating expenses, LHDCMC is in the top quartile. The source is the HSCRC Annual Filing RE schedule and this is most recent data publicly available. Please also refer to Exhibit 19, demonstrating that LHDCMC's level of charity care as a percentage of total operating expenses is in the top quartile of all hospitals. • Luminis Health's Policy is to provide 100% free care up to 300% of the Federal Poverty Guideline which exceeds the Maryland mandated minimum of 200%.

	• FY20 is an atypical year for Financial Assistance due to COVID relief programs. LHDCMC has collected over $900,000 from the Health Resources and Services Administration (HRSA) to cover the cost of COVID treatment for patients without insurance.

16. Provide a copy of the "patient guide" (containing financial assistance information) that is in each inpatient room. (P.63)

Applicant Response:

The Patient Information Sheet (Exhibit 34) and Patient Handbook (Exhibit 35) are attached.

Quality

17. The current quality ratings for the applicant show worse than average scores for (1) staff flu vaccination rates; (2) How quickly patients received help from staff; and (3) How often the area around patient's rooms was kept quiet at night. Provide a performance improvement plan for these measures.

Applicant Response:

Since LHDCMC filed the CON Application, the quality ratings have been updated. Below are the identified improvement plans based on the updated ratings:

(1) Staff flu vaccination rates

Action Plan for Increasing LHDCMC Staff Influenza Rate

LHDCMC has been implementing mandatory employee/staff influenza vaccination for the past eight years. Employment is terminated if an employee does not receive the influenza vaccine by the determined deadline, and staff/volunteers/contractors are not allowed to conduct services onsite until their influenza vaccination requirement has been completed. Many factors may have influenced the vaccination rates:

- ◦Employees may be out on medical leave during this time.
- ◦Employees may have delayed receiving their vaccine until cleared for a medical condition by their provider.

Action Plan to Increase Compliance/Reporting of Staff Influenza Rates:

1. Improve education of employees/staff of the importance of receiving the influenza vaccination for the health and safety of patients, other staff, and family
2. Make egg-free vaccine available to those with egg allergies
3. Improve tracking of employee/staff influenza vaccination data
    a. Purchase of two scanning devices that will enable uploading of employee influenza vaccination data into employee health record (HRP)

b. Utilization of new employee health record system which will allow for easier reporting

4. Improve communication with employees/staff
    a. Send early communication via email, department flyers, MSO flyer
    b. Send frequent reminders to those who have not yet received the vaccine

5. Incentivize departments who complete vaccination of employees/staff within a certain period of time
6. Develop easy mechanism for submitting outside influenza documentation
    a. Provide EHO (employee health office) email address where employees can send their flu shot document
    b. Provide resource/information for submission sent via email and on EHO website

(2) <u>How quickly patients received help from staff</u>

- Dedicated Director of Patient Experience, started at LHDCMC on Feb. 1st, 2021.
- Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%).
- Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds.
- Daily 8 Communication Toolkit (began OCT 2020) integrated within Luminis RISE values (FEB 2021) – education is ongoing.
- Daily inpatient hospital medicine patient satisfaction surveys (initiated in April 2019 and held for COVID since mid-2020) to be tentatively resumed in person for April 2021.
- Increasing rounding (leader/patient/staff) across LHDCMC.
- Patient Experience Steering Committee beginning April 2021.
- Standardizing transparency of data and patient comments.
- Standardizing DCMC Patient Experience Strategy.
- Developing a Reward/Recognition banner program.

(3) <u>How often the area around patients' rooms was kept quiet at night</u>

- Dedicated Director of Patient Experience, started at LHDCMC on Feb. 1st, 2021.
- Initiation of Plan of Care Rounds: Nurse-Physician Dyad Bedside Rounding (November 2020) with 85% goal of completion daily (currently at 78%).
- Opened back up to visitors in March 2021 which allows inclusion of family members in Plan of Care Rounds.
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- Increasing rounding (leader/patient/staff) across LHDCMC.
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- Standardizing transparency of data and patient comments.
- Standardizing LHDCMC Patient Experience Strategy.
- Developing a Reward/Recognition banner program.

Psychiatric Standards

AP2A

18. The application states that the facility will have physician coverage 24 hours a day/7 days a week, yet the staffing plan (Table H) calls for just 2 new physicians. How will the facility provide the round the clock physician coverage with the low level of staffing?

Applicant Response:

Similar to other inpatient psychiatric hospitals, the two full-time psychiatrists will provide Monday-Friday rounding (on all patients) as well as leading treatment teams, admissions and discharges. In addition, those two and an array of additional full and part-time psychiatrists and psychiatric nurse practitioners who will serve on medical staff will be in an on-call rotation to provide the off hours and weekend 24/7 coverage of the inpatient unit. Weekends will include daily rounding on all inpatients on the unit as well as admissions and discharges, similar to Monday-Friday. The same array of providers will rotate to cover off-hour calls for medication and other issues which will be done virtually in most cases via computer, telephone, video and on-site if necessary. It is our intention to partner with providers currently in the community as well as create an environment to encourage future behavioral health services to grow within the community. LHDCMC is replicating the physician coverage model of the McNew Family Medical Center, a 16-bed psychiatric specialty hospital in operation for a year.

AP2B

19. Does the facility plan to receive a designation by the Maryland Department of Health to provide evaluations of individuals brought in on emergency petition? If so, when does the facility plan to receive this designation?

Applicant Response:

The Emergency Department at LHDCMC does not turn away an Emergency Petition patients. LHDCMC is currently establishing an on-site Consult-Liaison team in the Emergency Department. It is our intention to apply to MDH to be a designated site for accepting emergency petitions as soon as we are staffed and able to do so. LHDCMC is working to hire and train staff in order to provide appropriate evaluations for those on emergency petition.

AP2C

20. The application states that the current emergency department does not include a seclusion room. How does the hospital currently deal with patients requiring de-escalation in the absence of a seclusion room?

Applicant Response:

Much like other hospital emergency departments that do not have a dedicated “seclusion room”, LHDCMC has two dedicated ED rooms that are restraint capable and a number of other

medicine-focused rooms that can be made psych-ready with minor disruption. All ED staff, medical and behavioral, will be trained in all facets of trauma informed care, de-escalation, win-win negotiation and safe interventions to lessen the need for high acuity interventions like restraints. It is anticipated those skills will lead to safer, more person-centered interventions with the need for higher acuity interventions only rarely.

AP3A

21. Please affirm that the facility will provide each of the services in the standard including chemotherapy, individual therapy, group therapy, family therapy, social services, and adjunct therapies. (P.67)

Applicant Response:

As an adult psychiatric inpatient hospital, LHDCMC will provide chemotherapy, individual and group therapy, and family therapy were appropriate and adjunct therapies such as art and music when available and appropriate to the population being served.

AP6

22. The standard requires separate quality assurance programs for specialized populations that will be served. Provide quality assurance programs for individuals with a secondary diagnosis of substance use and for geriatric patients.

Applicant Response:

The Quality Assurance Programs for the co-occurring substance use and geriatric populations are attached as Exhibit 38.

AP11

23. While a chart is including comparing inpatient charges for the new facility compared to state averages, the standard requires that the costs must be compared to those in the local planning region. Provide a chart showing a comparison of the proposed facility charges as compared to charges in the local planning region.

Applicant Response:

The average charge for LHDCMC eligible patients at each facility located on the Southern Maryland Planning Region ranges between $5,761 and $12,137 with a $11,161 weighted average for the region. The estimated average charge at LHDCMC is $11,442 or about 2.5% higher than the current regional average.

Average Charge for LHDCMC Eligible Cases at Southern Maryland Planning Region Hospitals
In CY2019 Dollars

	Cases	Total Charges	Average Charge	Over (under) LHDCMC Avg Charge
LHDCMC	710	$8,123,820	$11,442	
Southern Maryland Region				
UM Capital Region Medical Center	1,144	$12,383,055	$10,824	($618)
MedStar Southern Maryland Hospital Center	594	$7,209,609	$12,137	$695
CalvertHealth Medical Center	26	$252,329	$9,705	($1,737)
MedStar Southern St. Mary's Hospital	29	$167,056	$5,761	($5,681)
Current average of region	**1,793**	**20,012,049**	**$11,161**	**($281)**

AP13

24. Confirm that discharge planning includes the possibility of referrals to long term psychiatric care.

Applicant Response:

Yes, we will make available to patients, based on their individual situation and needs, referrals to services such as Psychiatric Rehabilitation Programs (PRPs), Residential Rehabilitation Programs (PRPs), Residential Treatment Centers (RTCs), Residential Crisis Services (RCSs) and Assertive Community Treatment teams (ACT), as appropriate.

Tables

25. Table F. The Psychiatric beds proposed in the project appear on the line for Obstetric services. Provide a corrected Table F.

Applicant Response:

An updated Table F has been attached as Exhibit 39. The psychiatric beds have been moved to the line for psychiatric services. The table also noted that LHDCMC had pediatric discharges. This was a mistake and those discharges have been removed.

26. Table G/H – Provide a breakdown/description of "other" revenues (line 1f) and expenses (line 2j)

Applicant Response:

Other operating revenue (line 1f) is composed of contribution revenue, net assets released from restrictions for operating purposes and the CARES Act funding (2020) recognized.

Other operating expenses (line 2j) is composed of maintenance contracts, marketing, employees (includes employee travel, seminars, dues, and education), facility fees, and insurance.