Luminis Health℠

J. Kent McNew Family Medical Center
175 Harry S. Truman Parkway
Annapolis, Md. 21401
luminishealth.org

January 15, 2021

Eileen Fleck
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
Eileen.Fleck@maryland.gov

Dear Ms. Fleck:

On behalf of Luminis Health, Inc. (and its subsidiary hospitals Luminis Health Anne Arundel Medical Center and Luminis Health Doctors Community Medical Center), please accept these comments regarding the draft State Health Plan (SHP) for Facilities and Services: Acute Psychiatric Hospital Services-COMAR 10.24.07, dated December 17, 2020.

We would like to commend the Maryland Health Care Commission (MHCC) on its process and thorough review of this SHP chapter. We have been anticipating this update and are pleased to see the attention and thoughtfulness that has been given to it at this important time.

Page 18 – .06 Methodology for Utilization for Acute Psychiatric Hospital Beds

A. Geographic Area

Comment: While we fully support a rational, common sense, planning approach to addressing a regional collection of Maryland's counties, we think there are some areas that can be improved in the draft document. We do not see obvious advantages or rationale for making Montgomery County a solo region when that county is very much aligned with Prince George's County and might better be representative of a "Baltimore/Washington" region in terms of their service areas and overlap with Washington DC. While we agree Cecil County more effectively is attached to Harford County and the northern Baltimore area, we believe the middle/upper eastern shore counties of Kent, Queen Anne's and Talbot serve as their own region (or in combination with the Lower Eastern Shore) and are much more comparable than being added to more metro counties of Baltimore and Anne Arundel.

Page 5 – Timely Admission to Acute Psychiatric Services

Comment: The final paragraph could be improved upon for consistency and clarity. While we think any and all inpatient psychiatric facilities/units in Maryland should accept "involuntary" patients (more costly to treat and an additional level of infrastructure are not borne out in fact), we understand the challenges presented with retro-fitting such a requirement. That being said, we agree that any CON application for a new unit(s) or alteration of an existing unit(s), should require acceptance of involuntary patients as grounds for CON approval.

Page 14 – (3) Patient Rooms

Comment: We wholeheartedly agree that any CON application for a new unit(s) or alteration of an existing unit(s) should be single-occupancy and we cannot envision a circumstance where, within new or altered space, semi-private rooms make sense. All evidence points to single-occupancy rooms greatly decreasing the need for seclusion and restraint and patient-to-patient and patient-to-staff altercations. In addition, we expect

single-occupancy rooms and the inherent privacy in more and more medical hospital rooms and should not settle for anything less in a psychiatric hospital room.

Page 5 – Timely Discharge Following Treatment

Comment: We fully agree there is a lack of affordable community-based care for behavioral health that can both avoid or limit admission to an acute inpatient hospital and/or serve as a discharge location for the admitted patient. In Maryland's "Total Cost of Care" environment, providing appropriate financial resources to support community-based, less restrictive services is paramount to the success of the entire system and, frankly, it's the right thing to do for the individuals we serve. Maryland's Medical Assistance program, Behavioral Health Administration, Governor's Office and Legislative Branch MUST support additional funding to incent development of these necessary services.

Page 4/5 – Timely Admission to Acute Psychiatric Services

Comment: "The CAG suggested that programs should have some baseline ability to respond to high intensity needs, similar to the expectations for medical surgical units, rather than relying on higher staffing ratios." It would be appropriate to cite examples of how that can be accomplished: (i.e. single patient rooms, appropriate and timely medications for the disorder, med-psych specialty units, increased training of psychiatric nursing staff in medical/surgical skills, geriatrics, dementia, substance use, etc.). The aforementioned suggestions could serve the anticipated increased complexity of hospitalized patients along with increased training with security and a program of crisis prevention to prevent or decrease the need for seclusion and restraints.

Additional

Comment: While not a recommendation highlighted in the draft document, we believe Maryland's General Assembly needs to address "Assisted Outpatient Treatment" or involuntary outpatient commitment which would provide tools beyond the hospital setting, to court order services in a community, least restrictive setting. This is already working well in 47 states. This will require additional financial and human resources, and a culture change similar to "alternative site" legislation, but would create a new environment where patients receive appropriate services outside of the acute hospital setting.

Thank you very much for your efforts toward updating of this document and consideration of these comments.

Sincerely,

Rod Kornrumpf
Vice President, Behavioral Health Services
Luminis Health
rkornrumpf@aahs.org