Enclosure B

Summary of Public Informational Hearing Regarding Conversion of University of Maryland Harford Memorial Hospital to a Freestanding Medical Facility

PUBLIC INFORMATION HEARING

August 30, 2017, 6:00 p.m.

Level Fire Hall

3633 Level Village Road

Havre de Grace, Maryland 21078

P R O C E E D I N G S

MR. SHELDON: Good evening, Ladies and Gentlemen. I want to thank you all for coming this evening. Thank you for coming to Level Fire Hall.

Before we get started, I wanted to thank the men and ladies of the Level Fire Hall for the wonderful job they did in not only providing beverages and food for us, but also for hosting us this evening.

I'm want to put a quick pitch in for the Level Fire Hall. They do a wonderful job with their Sunday morning brunches that they have a few times year and also a spaghetti dinner that they host with one of the Boy Scout Troops and a wonderful Thanksgiving dinner for our County Executive Barry Glassman.

In tonight's public information meeting we wanted to share with you about our plans for what we refer to as Vision 2020, which is our

plan to transform healthcare near Harford County.

I thought I'd start off with a picture and share with you a little bit about myself. As you can see here on the screen, my wife of 37 years, we celebrated our 37th wedding anniversary last week. We have four adult children. Three of those children live here in Harford County, and four grandchildren.

What's interesting about this group, in the 30 years we've lived here in the county, we've lived just a couple miles from here. We lived on Glendale Road to the west for about ten years, and for the last 20 years, we've lived over on Craigs Corner Road next to Susquehanna State Park.

Our four children have attended Harford Community College and two graduated from there. One of our daughters graduated Havre de Grace High School. We spent a lot of time at Stancil Field with little league and football. One of our daughters also spent a lot of time at the

Opera House. She performed with Annie, Footllose, Guys and Dolls, Beauty and the Beast. So we got to see some of those theater production.

So longstanding representatives and colleagues here in Harford county. Level Fire Hall responded to our house a number of times taking two of our children to different hospitals. Our son, between the between the age of 18 and 24 months, had several trips to the emergency room, 70 stitches in his head and face. So Level Fire Hall responded to all of those as well.

I wanted to share with you that this is very, very much our home. Two of our children were born at Harford Memorial Hospital. I've had treatment there and my children and my grandchildren had treatment there. We recognize from a patient-family-community standpoint the role that health care plays not only for all of you and Harford County.

This is the reason I get up every morning. The reason I go to work every day is to take care of all of you. We recognize the responsibility that we have, and it is a very near and dear one that we take very, very seriously.

I have with me a couple of colleagues that I wanted to introduce. First of all, Kathy Kraft. Kathy Craft is a colleague of mine at University of Maryland, and she's going to serve as facilitator for this evening.

What we plan on doing is actually I'll go through my presentation. We'll take a break about halfway through. But you should have index cards in front of you that if you have a question that you'd like to raise, what we'll do is when we take a couple-minute break, grab those questions from you, and we will proceed with our presentation, and Kathy and some of my colleagues will help put them in prioritization.

And secondly, I wanted to introduce

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Dr. Fermin Barrueto, who is the Chief Medical Officer of University of Maryland Upper Chesapeake Hospital, helping with the presentation, and also Sharon Lipford, Executive Director for Healthy Harford. Then we'll have a number of colleges and a number of our board of directors that I'd like to recognize, Don Mathis, Larry Sanders, folks also on our board of directors.

Let me jump into this, and I want to thank you for coming. To give you an idea, we had gone through this over the last almost three years. My colleagues and I have actually been in front of about 80 different audiences, not only those organizations at the state level, but we've been in front of the Harford County Council, our delegations for the state. We've been to Economic Development, Chamber of Commerce and your neighbors and friends. Literally almost 80 different groups and individuals over last three years.

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What we're talking about is actually how we can reinvent health care. As I mentioned, I've been here in the State of Maryland and working for Upper Chesapeake for 30 years. In that 30 years I think we have seen more change in how health care is being delivered in the last three years then we probably have in the prior 27 years combined.

So this is a period of dramatic change in health care. How do we reinvent health care for all of you? Our focus has been on hospital care, that hospital care is what takes place within the four walls of the hospital. Today we have a focus that's much broader, health care for our community and health care for you as our prospective patient, both inside and outside of the four walls of our facility. On average, we have about 300,000 patient encounters for patients that come to our two hospitals, emergency rooms, see our physicians, come to us for surgery.

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Historically, almost all of that took place within the four walls of the hospital. What we have seen happening in the last three or four years is that we're really doing a significant amount of community outreach in a very different way. How many of you remember Marcus Welby, M.D.? A number of you don't. But as I think back on this, I'm not sure if he made house calls or not, but what we'll share with you tonight is a program that we implemented a year and half ago where we're literally making house calls to our patients, changing how we deliver care.

For us it's about the right care at the right time in the right setting. That's an example of how we see health care changing.

Historically, almost all health care was delivered either at a physician's office or at the hospital. I think what we're seeing today is the hospital might not necessarily be the right place to have that care delivered. There may be

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a different setting that's more appropriate depending on the circumstance for that particular patient.

As we're seeing this health care transformation in front of our very eyes, what we're sharing is something that's very, very proactive. What we're proposing to do is actually the first time this approach has been taken with what we're proposing here in the State of Maryland.

So we recognize that we're trying to be proactive instead of reactive. I think when you look around the country, whether it's in the traditional business or when you look around health care, those organizations that have tended to be proactive instead of reactive have tended to be more successful over time, and I think that's really what I'm going to share with you this evening.

Really what we're looking at is how do we improve the quality of life for those

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individuals, for our patients here in Harford County and Cecil County. And again, quality of life, we're defining that not only from a clinical, but also from a social standpoint and financial standpoint. How do we do that in a way that's focused on wellness, prevention, disease management, partnerships and transforming care.

As you listen to some of my colleagues talk, I think you'll hear about some of those elements around transforming care, partnerships, and wellness intervention. It's very, very new in what we're doing now and than what we used to do historically.

We talk about wellness initiatives. A lot of the focus is around patients who have traditionally chronic disease, whether it's diabetes or morbid obesity. I think when you look around the country, I think we see this whole trend of obesity taking place here in the United States, congestive heart failure or lung disease, and also around behavioral health.

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We recognize that there's a different way to interface with that patient population that over time gives them better clinical outcomes and hopefully a better quality of life.

When we talk about outreach, we've introduced a program where we're literally making house calls to our most vulnerable, sickest patients. Instead of waiting for them to come to the hospital for care, we're going out and meeting them in their own homes and places of residence, helping to intervene with them before they get into distress.

We also see a lot of work we do around disease management. For a number of years we've had a program at Upper Chesapeake called Health Link where we offer almost 150 programs during the course of year for patients that may need help with chronic disease management or self-management.

When we print our publications, the phones go off the hook with folks calling and

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responding to these particular programs that we're offering.

And then another example around wellness initiatives is using technology in a very, very different way. How many you have Skyped or FaceTimed a child or a grandchild? So a number of you have. We're using that same type of technology with our long-term care facilities here in the county. So literally we have two-way interactive video capabilities at five or six nursing homes and soon to be six. Patients in the nursing home that need to be evaluated can visually be observed by an emergency room physician at one of our two hospitals with interactive video. And then that physician can decide whether or not that patient actually needs to be transferred to the hospital for further workup.

What we have found since we implemented this about 18 months ago, we've seen a 35 percent reduction in the number of patients that are

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coming to the hospital from the nursing home, eliminating two ambulance transfers to the hospital and back, eliminating the time they need to spend in the emergency room and then be hospitalized.

So again another example of how we're using technology to change the face of health care here in the county.

It is also about part of something greater -- being a part of something greater. About three and half years ago, we formally affiliated with University of Maryland Medical System. That organization has 14 hospitals in the State of Maryland but has a number of employed physicians, has outpatient services, has an insurance program.

From our perspective, the colors that you he see up here on the screen are not colors of the Pittsburgh Steelers, but they're the colors of the University of Maryland Medical System.

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So folks have asked what's driving our actions at this particular time. And again, we'll put this in the context of right care, right place, right time. And if you were to talk to most physicians or nurses three or four years ago, they would probably suggest that 20 percent of the patients that are in the hospital at that time probably did not need to be there and could have been treated in an outpatient setting or very, very differently.

So again, part of what we'll share with you are some initiatives that we're putting into place about right care, right place, at the right time.

Why now? Again we're trying to be innovative and look at some of the changes that are taking place in health care. As I mentioned earlier, the State of Maryland is at the forefront of this innovation. We've seen more changes in the State of Maryland in the last three years than I did in the prior 27 years that

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I was here.

My comments about new technology, some of us are using this with our grandchildren or our children. How do we use that technology to have a physician/patient interaction or a physician/physician interaction? We've also been collaborating with Union in Cecil, which is a hospital in Elkton, Maryland, about 20 miles northeast of us. How do we collaborate with service delivery? Certainly the unmet delivery of health needs, we've been providing inpatient behavioral health services at Harford Memorial for 25 years. Many people may not realize that. With our plans, we're proposing the behavioral health component as a big component of what we're proposing to do. This is independent of the crisis that we're seeing across the county, state and nationally with opioid addiction.

When we think about 20 years, today compared to 20 years ago, there are probably about 10 percent more physicians coming out of

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training then there were 20 years ago. Yet our population in the state and across the country has probably doubled. So we ask ourselves how are we going to continue to manage that patient population across the country, across the county, as our population has changed, and we're seeing not nearly as many physicians coming to work here in the county as we used to see historically. These are the drivers of what is driving our actions at this point.

Under the old model of care, which is something that we experienced up until three or four years ago, that a patient would present to the emergency room, tested, treated, discharged and probably repeated that again. Under the new model, as I referenced earlier, it's about prevention, managing care, and then also care coordination, how do we care and coordinate that care for that patient once they're discharged instead of waiting for them to come back to the hospital? And again it's really an attempt to

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how do we prevent unnecessary hospitalization and over time improve the health and the patient's quality of life.

How many of you have recognize this picture, Harford Memorial Hospital, literally an institution in Havre de Grace that's been in this block of Union Avenue and Revolution Street and Lewis Lane for over a hundred years. When you look at this, there are a number of things that probably jump out at you that I'll share with you. Look at the number of roof lines. That would suggest that there have been a number of additions that have been built over time. Look also at the fact that it's congregated in a residential area. And again it doesn't allow a whole lot of flexibility from a growth or expansion standpoint. So we evaluated this. I wanted to share this with you as well.

Portions of this building date back to the 1940's. The most recent portion is back to the 1970's. So think about how health care has

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changed over that period of time.

So as we evaluated what we wanted to do, we asked ourselves what are our options. So we had a number of advisors walk us through this. The general consensus from an architectural standpoint or an engineering standpoint or from a construction standpoint is that facility is really beyond its useful life.

A number of numerous infrastructure issues that currently properly meet the fire and safety codes, accrediting, properly licensed in the state. There are a number of infrastructure issues that we recognize would cost a lot of money to continue to try to upgrade.

Renovations, whether it would be asbestos in there, et cetera, would be very, very costly. As you saw from the aerial view, it's landlocked, and oftentimes it's difficult to get down to that location in Havre de Grace.

Lastly, I think one of the things that we have realized time and time again, our

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patients, our physicians, families and team members actually expect more modern facilities. When you think about somebody that's coming out of training today and what they're used to seeing where they trained or where they did a residence or fellowship versus what they may see when they come to that facility, they certainly ask themselves is this the place I want to be to try to provide care.

So from our perspective, which we shared this with our medical staff and board of directors, we would be better served transitioning from that location on Union Avenue to a new location that we view as the Bully Rock property instead of trying to renovate or rebuild on that location there on Union Avenue.

What I have up here on the slide is a profile of Harford and Cecil Counties. It gives you the geographic location and the drive times from Havre de Grace to Upper Chesapeake Medical Center, and from Havre de Grace to Union in

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Cecil. Harford Memorial is right here in this circle. Where the star is is the property that we refer to as the Bully Rock property that we're proposing to relocate to. If you look approximately 20 miles to the northeast, you see Union Hospital in Elkton. And then approximately 20 miles to the southwest, you see Upper Chesapeake Medical. So again, this location we are proposing to build a freestanding medical facility, specialty hospital, is roughly equal distance between those two locations. And one of the things that's unique about the State of Maryland that many people don't appreciate is really looking at regionalizing care. I think the best example that I can share with you as I walk through this is when you look at an organization like the University of Maryland Medical Center and the Shock Trauma system that's here in the State of Maryland for trauma patients, as you may or may not know, the model that's here in the State of Maryland is actually

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one that's recognized nationally and internationally as the preferred model. Here in the State of Maryland, there are actually five trauma centers. Probably the one most familiar to all of you is Shock Trauma at University of Maryland Medical Center. There's also a trauma center at Johns Hopkins Bayview, serves Baltimore and the central part of the state, there is also a trauma center in Salisbury at Peninsula Regional, Prince George's County, Prince George's Hospital there is a fifth in Washington County. So we have five trauma centers across the state. Really the intent is for those patients that have trauma and need trauma care, regionalizing that care to these five locations results in better patient outcomes and better mortality statistics as far as the number of patients that come out of that hospital alive as opposed to not.

As we look at this regionalization of care proposal, we're proposing a similar type of care in Harford County. University of Maryland

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in Bel Air would be accommodating to handle more complex surgical and medical patients in addition to intervention in cardiology, cardiac care and obstetrics, a similar profile of services that you have approximately 20 miles to the Northeast in Elkton being Union in Cecil. What we're proposing for University of Maryland Upper Chesapeake, Havre de Grace, again, is a different level of care where we have emergency care, short-term medical care, 48 hours or less, behavioral health, and outpatient services. And as we're proposing that what we're looking at, 90 percent of the patients that receive care at Harford Memorial Hospital today would be able to receive that care at the facility that we're proposing at Bully Rock.

The next level of care that you see around the state in Harford County is urgent care, whether it's the urgent care office that we have at Choice One or Patient First, these are the different elements of care that we see not

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only in Harford County but around the state. We're proposing from this reorganization of care, how do we address from a physician manpower standpoint and from an access of care standpoint.

What I wanted do is one of the questions that have come up in some of the other forums is with what we're proposing, how would a patient access care in what we're proposing to build in the 2020 timeframe and what that might look like.

What I would ask Dr. Barrueto to do is walk through the six different scenarios of patients under this premise of right care, right time, and right setting. I think this will give you a perspective when we talk about regionalization of care how we anticipate patients being evaluated, treated, and followed up on in a number of different examples.

So again Dr. Barrueto, he's been with us on the medical staff at University of Maryland Upper Chesapeake Health for approximately 10 years. For the first year, he worked in our

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emergency department. For the next seven years he was the Medical Director For Emergency Services between our two hospitals. And then for the last year and half, he's been our Chief Medical Officer and Medical Director for our two hospitals.

DR. BARRUETO: Thank you. Everybody here hear okay? Great. Ten years, time goes by when you're having fun. What I'm going to go over here today are some clinical scenarios on how the access to medical care would actually occur in a future freestanding medical facility.

The first one we're going to talk about is the 60-year-old male who is retired, smoking, and is displaying signs of a stroke, slurred speech, facial droop. This is a particular case that we had to actually address from a regulatory standpoint. Current state, that person would be transported to Harford Memorial Hospital. They would receive the clot busting drug TPA, and as long as they were within that four-and-half-hour

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window from the time of onset of symptoms, we would be able to safely treat that patient and then transfer them to Upper Chesapeake. That's what we do current state.

So since a freestanding medical facility hasn't been created before in the State of Maryland, we actually had to work with our colleagues at MIEMSS and Upper Chesapeake Health as well as the Maryland Hospital Association to create a pilot that will allow us to be in an acute stroke-ready facility at a freestanding medical facility, a lot of semantics, a lot of work, to basically say if we can do what we do now at Harford Memorial, we will be able to do at the freestanding medical facility. That ambulance crew will have the same short drive, that patient will have the same short time from what we call the door-to-needle, when the drug actually enters into the bloodstream. We are able to maintain that short timeframe, that specifically this really did affect Havre de

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Grace the most with this particular initiative. We were able to get it passed. It's amazing that we had to pass regulations four years in advance of actually opening the doors. But I guess we believe in delayed gratification.

We had to make sure that everything that we could do currently at Harford Memorial we could do at the freestanding medical facility. That person will be able to receive emergency care. This is definitely a high risk patient, and their care would be taken care of at the freestanding medical facility.

Probably an additional benefit with the freestanding medical facility is if there's a new intervention within the six hours from onset of symptoms where we actually have to fly the patient for what's called an interventional treatment where we actually, kind of like a cardiac catheterization, you insert a wire into the artery, and you can actually break up and take out the clot, only instead of from the heart

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your taking it from the brain. And the current Harford Memorial Hospital, we have to put them in an ambulance to get to the helicopter pad to then get them downtown where there's two facilities, a third one actually at Sinai that can actually do it. So University of Maryland, Johns Hopkins, and Sinai are able to perform this procedure.

So now with the freestanding medical facility, we'll have the helicopter pad a stone's throw away from the Emergency Department entrance. So the speed at which we're able to transfer patients will actually be improved with the new facility.

The next one is probably a more common occurrence. This has a patient who had outpatient knee replacement surgery at the Bel Air campus and returns to their home in Havre de Grace. From there, we never want to see this, but this person develops a post-op infection two weeks later. This person who would normally go to Harford Memorial Hospital would still go to

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the Havre de Grace campus to receive their care, and with the new telehub and teleconsultations ability that we'll have imbedded within the freestanding medical facility, we very well may be able to care for that patient solely at that campus, and if the patient did need surgery or further revision, they would be able to transfer at that time.

This one unfortunately is a very common one that we have seen during the opioid crisis. This is almost not just a daily event but it's during at least one of our shifts for every physician in both emergency departments. A suspected overdose, possible suicide attempt would immediately be taken to the Havre de Grace campus close to the facility there with the new behavioral health hospital that would also have the 35-bed and increased ability to be able to care for these patient. It would be able to -- the freestanding medical facility will be able to run smoother with the crisis beds embedded within

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it as well. And these patients would follow the typical pattern that you would see essentially unchanged within Harford County. There's some regionalization that would occur between ourselves and Union.

Then we have a 30-year-old construction worker who obtains a jobsite injury and has a large cut on his leg. This is one where most would probably try and jump toward the Emergency Department. But it does lend itself toward the possibility of at least starting in an urgent care facility, and then, if the injuries are too great, to immediately transfer to the emergency department. I think that's something we're seeing more and more of, the urgent care centers are trying to handle some of the more basic wounds on what we call the walking wounded type injuries.

And finally, 50-year old female, type 2 diabetic, needs followup, blood work, and help with managing the disease. This is where the

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Population Health Initiatives that we have been working on now for several years and will be more mature as we start getting into Vision 2020, we'll be able to have outreach to that patient. There will be an office building on the same campus for the freestanding medical facility, so that the patient will be able to see their clinic appointments. We will have our own outreach and will promote education. There are so many more resources that we have for diabetic patients, I'm excited to see how well we'll be able to manage those patients so they can stay where they want to stay, which is home.

8-year-old female, chronic asthmatic with suspected flu, been using the rescue inhalers ineffectively and the parents bring the patient to the Emergency Department. This person would still go to the Havre de Grace campus. The same emergency physicians that currently staff Harford Memorial will be the same high quality crew that will be staffing the Havre de Grace

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campus. It will be a brand new double-the-size Emergency Department with the same excellent staffing and team members to be able to keep that place humming and being able to provide that high quality care.

Another example, a 65-year-old, and this would be reminiscent of the big accident we had back in May with the bus that overturned on I-95. You have a serious automobile accident. EMS determines that this particular patient needs to be flown out by helicopter to receive care. That's done at the scene.

Currently with the trauma system that we have, the best way to care for the trauma patient is decrease the time to the facility that has all the support service, the trauma surgeons who do this on a regular basis. It's one of the reasons that Maryland has one of the best outcomes in the nation when it comes to trauma care.

The freestanding medical facility won't be a trauma center. But, yes, it will have the

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ability to stabilize and resuscitate those patients and be able to transfer them quickly to the appropriate trauma center should that be required.

Also with regard to mass casualty events, all the capabilities that we currently have, and if you were to transplant the bus accident from now that occurred this year to 2020, the method of the disbursement of patients, everything would have happened almost identical, maybe a little more easily just because of ease of access and being right there on 95.

So I'll turn it over.

MR. SHELDON: What we want to look at now are half a dozen different clinical situations, as we talk to our medical staff and some of our patients on how that would play out with what we're proposing.

What we're proposing to do that we name this University of Maryland Upper Chesapeake Medical Center Havre de Grace. When the facility

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originally opened back in 1911, 1912, it was Havre de Grace Hospital, which transitioned in the 1940 to Harford Memorial Hospital, University of Maryland Upper Chesapeake Medical Center Havre de Grace and rename the facility Bel Air University of Maryland Upper Chesapeake Medical Center Bel Air. What we're proposing as part of this freestanding medical facility, and again it's a concept that's been in place in the state for many years, with some changes in regulation and legislation we're able to expand the scope of services offered there.

How many of have been to the emergency room of Harford Memorial Hospital? So remember that not only as patients but also some of you as team members, as you think about the experiences, it's a very small, confined space, and oftentimes not the privacy or some of the amenities that you would like.

What we're proposing to do in the freestanding medical facility is have six triage

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areas. Today we have two. We will still have 20 treatment bays, but we'll also have four behavioral health evaluation bays as well. The current emergency room is roughly 8,000 square feet. What we're proposing to build is closer to 20,000 square feet. So almost double the amount of space. Again, for better accommodations for our patients. As Dr. Barrueto said, same emergency physicians, same nursing staff and clinical support.

We would have laboratory services, x-ray services, and cardiology testing that we would need to treat our patients as you come to the emergency room. That's what we're proposing as part of the Emergency Department.

As Dr. Barrueto mentioned, this would be designated, as we work with MIEMSS, state emergency medical services organization, as a stroke-ready facility.

If any of you were having a stroke and you were close enough to the freestanding medical

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facility, with what we propose to do, that the ambulance could actually take you to the freestanding medical facility instead of having to take you to Bel Air or up to Elkton.

So again, as you know, if any of you know anybody having a stroke, the quicker that you get intervention, the better probability that you would have, the better outcome, the better clinical results.

Again what we're working with is to do this as a pilot, literally the first organization in the state that will be able to do this. You will continue to have the access for that care at the freestanding medical facility and less disruption to an organization like Level Fire Hall in the distance that they would have to transport patients.

Heliport access. What many folks don't realize is there is a heliport in Havre de Grace. Over by Stancil Field at the National Guard Armory. If a patient needs to be flown out from

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Harford Memorial Hospital today, they have to be put into an ambulance, driven eight minutes over to the National Guard Armory and airlifted off from that location.

What I will show you is that in the plan, that there will be a heliport on location there at the freestanding medical facility, and in many respects very comparable to what we have at Upper Chesapeake Medical Center. We certainly are closer to I-95. And again, what many people don't realize is that what happens with many patients, we have more patients come from Aberdeen than they do from Havre de Grace. From a convenience standpoint, certainly much more accessible, maybe not quite as accessible to folks that live in downtown Havre de Grace, but much of our service area, better access.

Another service that is unique, this is new for us in the State of Maryland, is to be able to house patients in what's referred to as an observation status where they can be there up

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to 48 hours. These are for patients that are too sick to be discharged, but not quite sick enough that they need to be up on a traditional medical surgical floor. These are patients that we generally see that may be in the hospital for 18 to 48 hours.

Today at both of our hospitals about 30 percent of the patients that we actually have staying in the hospital on any given day are in this observation bed status. For that patient that again is too sick to be discharged, not quite sick enough for the traditional medical surgical acute care, we would still be able to accommodate this patient population, and we're proposing to build 11 observation beds as part of what we're proposing for this.

Today, in either of our hospitals, 30 percent of our patients are currently in that observation status. A new feature that we're proposing with this as well.

When it comes to the behavioral health

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portion of this, if you heard me speak before, I talked about the Behavioral Health Pavilion. You may appreciate in the State of Maryland for health care services there are certain licensed categories that facilities fall into. What we're proposing to do with the behavioral health component, it actually falls under the designation from a license standpoint is a special psychiatric hospital. We're characterizing it as a behavioral health facility. Not only will it have inpatient, and as I mentioned earlier, we've had inpatient behavioral health care at Harford Memorial for 25 years, inpatient, outpatient and partial hospitalization.

It will offer recovery, treatment, and support at one location. We will continue to serve adults, which we do today, but we're also proposing to build one of our nursing units in the behavioral health portion from a geriatric patient population.

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When you look at the fastest growing population that we have in the county, it's our patients that are falling into that category of 60 or older. As I mentioned, a dedicated emergency room component with four behavioral health evaluation bays. Today we have two, and they are a part of the emergency room. This would be adjacent to the emergency room, but also part of this behavioral health services. And then the pavilion would offer the patient hospitalization and outpatient services. This would be a locked unit. There would be a secured unit.

People ask me, isn't this going to be close to a residential area. When you think back to that slide that I showed you earlier about Harford Memorial Hospital, you're literally across the street from a residential neighborhood, and the facility has been there for 25 years.

As we've talked to the Havre de Grace

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City administration and law enforcement, safety for our patients or safety for our community with behavioral health that close to residential areas has not been an issue in the city for law enforcement nor for our community.

Recognizing that this behavioral health component is a large piece of what we're dealing with here in the county, we thought it was something that was a very important portion to be able to service the county.

As we talk about this, and I ask you how many know somebody that has a cardiac illness, most people will raise their hand, or somebody who that has a cancer diagnosis, most people will raise their hand.

When we talk about behavioral health, certainly not one that people want to talk about regularly, we find 40 to 50 percent of the public know someone that has had behavioral health or a psychiatric issue, probably need outpatient or inpatient treatment. We have a secure unit for

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treating similar types of patients that we treat today.

A third component of this is also part of what we're planning is actually a medical office building. That would be adjacent to the freestanding medical facility. We're proposing primary and specialty care physician offices as part of this, radiology, infusion, outpatient rehab, and laboratory services. The services that many of you probably get today at Harford Memorial Hospital, you would also be able to get in this particular location.

And then a third component of this that we're actually very enthused about is we're proposing working with a number of organizations to see if we can create a concept that ties in the traditional fitness that you might find with the YMCA or Bel Air Athletic Club, with rehab, cardiac rehab, pulmonary rehab, and tie into elements of whether that's yoga, acupuncture, and try to build off of this into a very different

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prevention and wellness type of facility that we're proposing to build on this campus. This would be a second building that we're proposing to build right there on that campus.

What we're proposing is a 48-patient-behavioral-health-bed hospital that would be part of this behavioral health psych specialty hospital, an emergency room as part of the freestanding medical facility with 21 treatment rooms, 6 triage rooms, 4 behavioral health evaluation bays, and also 11 bays for observation patients.

That's the scope of what we're proposing for the facility. We thought another item important to point out is the scope of services that we currently offer at Harford Memorial Hospital today and where those services would be available in the future.

Over here in the left column, you see health care services. So you see medical surgical capability, observation, surgery,

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emergency care, behavioral health, et cetera.

In the yellow column are those services that are currently available at Harford Memorial Hospital today.

In the tan column are the three types of services. So one is freestanding medical facility, the second being the office building, and third is behavioral health building.

Next you can see that the majority of the services currently offered at Harford Memorial Hospital today would be on that proposed medical campus at Bully Rock. And then the inpatient acute care services and the surgery would be available at Upper Chesapeake Medical Center or Union in Cecil.

So we've looked at this profile of distribution of services, 90 percent of the patients that we're currently treating at Harford Memorial today would be able to get their services as you can see outlined in the tan section.

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Approximately 90 percent of the patients that we're seeing today would still be able to get those services at the Bully Rock facility.

So some of the goals for this campus, certainly are efficient, high quality care. We're trying to create an environment that has positive healing energy. Even using the example of the emergency room going from a facility or 8,000 square feet to a facility with 20,000 square feet, contemporary, innovatively designed facilities, we think this will be nationally recognized.

As we have talked to individuals in the State of Maryland, this is really the first time this is being proposed in the State of Maryland. We think it will catch interest in other locations around the state, and people may want to look at what we're doing from a national perspective. We think this will have greater visibility in proximity to I-95. We will build it in such a way that it will be expandable in

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the future.

When you look at what we did in Bel Air in Upper Chesapeake Medical Center that was designed in such a way that we could expand that facility as well.

We also think this will help address some of the health needs that have been very, very prominent for many of us here in Harford County.

So again, when we come back to this photo, one of the questions that we have been asked, the second question that I've been asked every time I start talking about what we're proposing to do with Harford Memorial in Havre de Grace, what are we going to do with Harford Memorial and the building. Probably a question that many of you may have written down on your index cards.

We have approximately nine acres in addition to the building which is about 400,000 square feet from the 1940's to 1970's. What we

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did about a year ago was engaged a real estate brokerage firm by the name of Cushman & Wakefield. Cushman & Wakefield is actually the second largest real estate broker in the Baltimore metropolitan area.

We engaged them about a year ago. We asked them, with our board of directors, to look at a number of perspectives. What's happening in the demographics here in the county specifically in the eastern end of the county? What does the employment base look like? What are the transportation needs, and how do those serve Havre de Grace? They actually conducted over 40 stakeholder interviews with our medical staff, with our board of directors, with folks from Economic Development, from the Chamber of Commerce, Harford County Council, Havre de Grace Council, Harford Community College, some of the community groups that are in Harford County, really looked at a wide range of future development strategies.

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As we look at this going forward, they concluded their work about six months ago, the desired goals are we plan -- University of Maryland Upper Chesapeake plans on selling the property. We are not developers. We're healthcare providers, health care services providers. We are not developers. We've asked Cushman & Wakefield, to have greater clarity on the timing of our project, to be able to position this property, to act as our broker to broker it to different development groups and/or organizations.

That will happen once we get clarity on the timeline, once we get clarity on the approval, and then once we have clarity on our construction, if you're currently living in a home and you want to sell it, you can't really start putting it on the market until you know what your timeframe is and when you want to exit. That's kind of the lemon that we're in right now. We recognize also, as we've talked with the city

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of Havre de Grace and had multiple conversations with the leadership from the City of Havre de Grace and others in this room, we recognize the need to have sustainable community benefit. We don't want to leave an eyesore for the City of Havre de Grace.

As I've had conversations with the City leadership for the better part of two years, we have been, in their own words, we have been a responsible community steward for over 100 years, and now we will continue to be. We wanted to have a sustainable community benefit, but it also needs to make good business sense.

As we look at brokering this and how it is sold, as we have conversations with our leadership and the City of Havre de Grace, we want to make sure it makes business sense for the City of Havre de Grace. The last thing we want to see is something that if there's a business component of it, is constantly turning over because it's not sustainable. So sustainable

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community benefit, and also business sense.

The timing of this would be when we transition the development up the Bully Rock. Obviously, we wouldn't be relocating until all of the construction that we need to do is completed. Also we've talked to the folks from Cushman & Wakefield, their preliminary thought is that it might be some combination of mixed use, some combination of retail and residential. What that looks like today, we don't know. A lot of that is dictated on the economy.

How many of you were here in 2007 when the base realignment was announced? Many of you were, right? There was a mad rush that we were going to see a rapid influx of military personnel and contractors, whether it's from New Jersey, whether it's from the Southeast.

If you look around Route 22, you're looking over a lot of commercial office buildings that have been developed and are currently unoccupied.

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So certainly when we look at this, it's what's the economy going to look like four years from now. I think that will dictate the time from a development standpoint. What we don't want to do, as we've had this conversation with our board leadership, we do not want to leave this as an eyesore for the City of Havre de Grace or residents in the community.

A lot of this will be driven from what happens from the economy standpoint. I guess the best example I that can share with you, did any of think when gas was almost $4 a gallon three years ago, and that it would be $2.19 the 1st of September 2017. Granted that may change with the current problems down in Houston. But that will be factored into this as well.

Once we get clarity on our timeline, we will then have greater clarity on the timing of when this property will be brokered by Cushman & Wakefield for potential development, and then we'll go through that process and working with

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the City of Havre de Grace and others to make sure that what a developer proposes makes sense.

But again, it's our intent to actually sell the property and we want to get a good development on the application.

When we talk about the Bully Rock property, and let me orient you for a minute. Here you see Interstate 95 heading north. You see Route 155 coming down to the right, and Bully Rock Parkway serpentines across the center of the page.

And in 2007 to 2010, we actually purchased this 97 acres of property. And one of the challenges that the board put out to those in leadership positions was: How do we position Upper Chesapeake Health to give us the greatest flexibility that we would need in the future to see what health care looks like?

By securing this property ten years ago, it has given us a great deal of flexibility. That's 97 acres. Over the last five years, we

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had the property annexed into the City of Havre de Grace and done a number of things to make sure when that time came for us to move forward with our project much of the work we could do with the City of Havre de Grace, State Highway Administration and Department of Transportation we would have that in place so we wouldn't be waiting on annexation and Highway Administration approval to move forward.

We've spent the last five or six years working with colleagues in the City and around the state in order do that.

I'm going to orient you to where we're proposing to build. To orient you, here's Interstate 95, 155 and Bully Rock Parkway. What we're proposing to do is build our medical campus on this area that you see outlined there. That's what we're referring to as phase one. That would be the first phase of our development.

Again, in order to do anything on that site, as the folks from the City know, you need

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to put water and sewage, and we will need to expand Bully Rock Parkway. So that's all the work that we need to do before we can actually start building anything. The Paddocks is down in this location, and 155 is right over here to the right.

What we're proposing to do, as I come back to my earlier comment, again 155 is here, 95 is here. 155 is over here to the right. So this area in the green is this area that you see here on the slide.

So what we're proposing to do initially is actually two buildings. The bottom portion here is what we're referring to as the freestanding medical facility and special psychiatric, 120,000 square feet or so. Then the second component would be a medical office building which would house some of the physician services and outpatient services that I talked about a little earlier.

So we would have one building that would

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house both the psych specialty hospital and behavioral health component and the freestanding medical facility.

A couple of other things, the helipad that I talked about would actually be right here in this location. We would have two entrances off of Bully Rock Parkway. Once we know the road implications and engineers and the City of Havre de Grace, we recognized that there would need to be two entrances from a patient access and public access standpoint, and also the helipad. We've designed this in such a way that there's apparent building flexibility to expand vertically or horizontally.

The next approach to the medical office building, which is separate from the state approval process that would go through at the state level with the Maryland Health Care Commission.

This is an artist's rendering. You can see a couple of these lines over here to my left,

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your right. The freestanding medical facility and psychiatric specialty hospital behavioral health building would be on the right, and then an office building would be adjacent to that on this property as well. And this pond here, it's an existing pond. It's got fish in it, I've been told. Folks want to go over there and fish, we'll see.

We're really trying to take advantage of the topography, of the presence of the water on the property.

So when we talk about some other expansion that's part of this as we've had conversations with the Maryland Health Care Commission, which is the state health planning agency, is proposing to do an expansion at Upper Chesapeake Medical Center located in Bel Air. It's hard to believe that if you went onto this location 20 years ago, there was nothing there. I mean, that's how much that changed course from a health care delivery standpoint.

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We opened the facility approximately 17 years ago in the fall of 2000. It was originally a 100-bed facility. It's now close to 185 beds. We've added a cancer center, a medical office building, a parking garage, additional surface parking. This was a photograph by a drone.

What we're proposing to do is actually build a bed tower on top of the Cancer Center that we opened in the fall of 2013. And that structure was designed in such a way that we could go up vertically and accommodate additional expansion.

What we're proposing to do is to build three floors on top of the Cancer Center. Today the Cancer Center is at this height. And what we have proposed with our application to the Maryland Health Care Commission is that we would build three floors on top of the Cancer Center. One floor would be shell space. As we look at our demand, we don't feel that we need to build all of this out. We want to build in such a way

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that we have the flexibility to come back in a future time and do something with that space. It's analogous to building a house and coming back to build a basement later on. We want to try to take advantage of building this at one time.

Then we would build two floors of patient beds on the fourth floor and fifth floor area. This floor would be patients in observation status 48 hours or less so we can collocate those patients to only one location. And then private medical surgical beds on the top floor.

And again, as you may know in Bel Air, a portion of our beds are private rooms and a portion are semiprivate. We're proposing to build all of these as private rooms, which is the current design, which are traditionally in new hospital construction.

As we look at this, we actually have two construction projects will be going on

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simultaneously. One is the construction of the bed tower here in Bel Air, and the second is the construction of what we're proposing to build at the Bully Rock property. Both of those projects would start simultaneously so they would be completed simultaneously.

That's important so when we do transition, we're able to move patients from Bel Air or to the freestanding medical facility psych specialty hospital simultaneously.

That's what we did with the Fallston facility of Upper Chesapeake Medical Center back in the fall of 2000. We literally moved all of our patients simultaneously all in one day.

So let me stop here. If folks have questions that they want to send to the center of the room or get another drink, we have probably another 15 or 20 minutes of material that we wanted to share with you.

We wanted to give folks an opportunity to get something to eat or drink and collect any

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questions that folks have.

(Recess.)

MR. SHELDON: I'm going to answer one question that somebody came up and asked me. I showed you the picture earlier of four granddaughters, and people were saying what's that mark on your forehead? Their father is bald, and I have a little more hair than he does. They decided they were going to take a curling iron and curl my hair.

Just kidding. As we transition here, as you talked earlier about much of what we're doing transforming health care. I want to introduce Sharon Lipford, who is the Executive Director of Healthy Harford here in Harford County.

As we talked about this concept earlier of right care, right time, right setting, I think you'll find that some her comments and some of the material that she will share with you puts in the concept of right time, right care, and right setting in a way that you may not appreciate as

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much as you will after you hear Sharon talk.

I'll turn it to over to Sharon Lipford.

MS. LIPFORD: Good evening. So as Lyle has talked about, we really are in an opportunity where we can transfer health care and move care into the communities.

A year ago Upper Chesapeake Health and Union Hospital received a grant, and the purpose of the grant really was to develop and take health care into the community. Through that, through the grant, we were able to develop what's called the Watch Program Wellness Section Teams of Cecil and Harford County.

These are outreach teams that go into the community and serve people in their homes. The Watch Team is comprised of nurses, social workers, community health care works and a pharmacist. The goal is to serve people who have Medicare with chronic illnesses. Us, our neighbors and family and friends, because of their serious medical illnesses, are coming to

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the hospital repeatedly. The Watch Team focuses on folks that have those complex medical issues.

Out goal is to serve people, to meet their medical needs, help with care coordination, and to provide the resources so that they can stay in their homes and in the community.

This is a complicated slide. It essentially shows how the flow of a person that is coming into care can receive care. The starting point is the Emergency Department inpatient observation or a PCP as our primary care doctors.

So people can come in and be referred through any of those areas. If they have complex medical issues, they will be referred to the Comprehensive Care Center. That's where the person gets intensive medical intervention and support, help with medications, and connections to resources back into the community.

From there, the referral is made to the Watch Program, which includes the social workers,

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nurses, community health workers, and the pharmacist. Everybody is talking to each other. All the treatment providers are talking to the primary care physicians as well as the community based care teams.

When we designed the Watch Program and the regional partnership, we were very mindful to think about it in a regional perspective. We have two Watch Teams dedicated to Harford County. We have one team that serves both sides of the Susquehanna, so that it serves both the Harford County side as well as the Cecil County side.

And then we have one team that's dedicated to Cecil County. We have four teams total. The dots that you see, we have two Care Centers, one located in Bel Air, and the other Care Center is located in Elkton.

So I wanted to give at least two quick examples of how the Watch Team and the Care Center have helped create change in the community.

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So the first is a 57-year-old man who presented to the emergency room 11 times. He was admitted six times, all of this since 2016. This person is a vulnerable adult who has very complex issues, mental health, congestive heart failure, respiratory and high blood pressure, and diabetes. He was referred to the Care Center where the Care Center helped him get insurance. So he's trying to take care of himself and get well without any insurance.

The Care Center helped him do that. They then referred him to the Watch Program who was able to help him get his medication, get connected to the primary care doctor and find a group home in the community, a place to live. What we find is that folks oftentimes, not only do they have very complicated medical issues, but they also have social issues which hinder their ability to be well.

We served a woman who had diabetes. She was having a hard time maintaining the proper

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levels of her insulin and would come back to the emergency department. Through the intervention of the Care Center and the Watch Program, what we figured out is that she needed glasses. We helped her get glasses so she could take her medications properly, and she hasn't been back.

Let me give you another example. We worked with a woman, 81 years old, she has Medicare, she has a primary care doctor who helps oversee her care. She was admitted to the emergency room and the inpatient hospital in January, and then she was transferred to a nursing facility. She then came back to the Emergency Department and then was referred to the Comprehensive Care Center.

What they were able to do was not only address her in a very holistic way, but also worked with her husband who was confused and unsure how to best be able to help his wife. This woman then was referred to the Watch Program. Our team went out, spent time with her

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to help both her and her husband understand the illnesses, to really educate them and help her become well, and then to provide other support, the social support, such as being referred to the Office on Aging.

There are lots of community -- wonderful community programs in Harford County. The purpose of the Regional Partnership Grant is to use the services that we have in place in the hospital system, take it out into the community through the Watch Program, and then make a connection to all of our partners, such as the Office on Aging, the Health Department, West Cecil, Beacon, all of the primary care doctors, specialty doctors, to knit those services together and to communicate with each other.

Any questions? Can I just say also that last year we -- again, we had this program in operation for one year. We served over 500 people. Of those 500 people that we served, 60 percent of them never came back to the hospital.

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So our goal is to improve, to work as a team together, and to improve that person's quality of life.

MR. SHELDON: So again, when we look at this, and we think this is an example of something that's truly transformational. For these patients, two or three years ago, and again, these are individual that on average had five or more emergency room visits, or three or more admissions in a year, and as Sharon said, with the 600 or so that her team interfaced with through this Watch Program, 60 percent reduction in the number of ER visits or hospital admissions for that patient population, which is really pretty remarkable, right care, right center, right time.

Another aspect that we wanted to talk about was the impact for our team members which is what we call our employees at Harford Memorial Hospital. We have about 780 team members that work at Harford Memorial Hospital. Of that 770

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about, 135 are actually Havre de Grace residents. So the majority of our team members literally are coming from other parts of the county, or other counties. Of those 770 people, about 460 of them are full-time team members, and another 100 or so are part time. 106 are what are referred to as PRN, they may work one hour a week or an hour a month. So that 408 or so that are full-time members.

When you look at this from the perspective, what this does for the 780 team members? When we get ready to transition, where do those individuals go? What type of job opportunities are available for them? What locations might they be in?

So obviously, we have many of our team members will go to the Bully Rock property, Upper Chesapeake Medical Center Havre de Grace. Some of those will transition to Bel Air. So if you think about those individuals, for example, that are on behavioral health that are currently at

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Harford Memorial Hospital, we would suspect that all of them that want to would have the opportunity to transition to the Behavioral Health Pavilion at the Bully Rock property.

Individuals that may be part of the medical surgical floor would have the opportunity to transition over to Upper Chesapeake Medical Center as we expand beds over there.

Some of those individuals may decide they want to go to Union in Cecil or some to the Outpatient Surgery Center, or some could go to another University of Maryland facility. Just as a broad example.

Again, keep in mind that we're planning this transition probably three-and-half years from now. When we talk about this job mapping, when we get closer to this transition, we're probably looking at doing this job mapping probably 18 months before we make that transition.

Between now and then, we may have

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individuals that want to relocate, individuals that will decide to retire. Again, we don't want to get too far out in front of ourselves, but we also want to make sure that we're doing the proper work that we need do with this.

About two weeks ago we had a conversation, a meeting with the Department of Labor Secretary here in the State of Maryland, just to talk about the thoughts they may have or opportunities that they suggest that we look at.

We're planning to put together a work group not only hospitals, Harford County Government, Susquehanna work force, the two community colleges, to see how we all tie in this together when we get to that point.

We wanted to share a number of examples of how we want to try to approach this. In this particular case, a clinical team member, a clinical team member could be a respiratory therapist. It could be a physical therapist. It could be a radiology technician. It could be a

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laboratory technician. What are the opportunities for that type of individual? So some of those individuals would go to the new Havre de Grace campus near Bully Rock. We have a laboratory. We will have imaging. We may be in need for cardiac techs.

So individuals that have those skill sets could transition over to the Bully Rock property, or they could decide they want to go over to Bel Air. Some of these folks could go to the Bel Air campus.

We also recognize that some of our team may decide they want to get a different level of competency training and work in a different clinical environment. We see that time and time again.

There may be other internal career development opportunities, or they may be able to apply to positions at some of the other University of Maryland facilities.

So once again, as we think about this

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with this type of individual, or there may be an opportunity in our Medical Office Building that's on that campus, because we'll have an outpatient laboratory, outpatient imaging, and some of those outpatient services.

We think there are a variety of options for the individual that's in a clinical role.

When we also look at this from a support team member standpoint, so an individual in that category may be somebody in food service, may be somebody in environmental services, facilities or plant operations or medical records.

Again, a similar type of scenario. Some of those individuals may be relocating over to the Havre de Grace campus. Some may decide they want to go to Upper Chesapeake Medical Center. Some may decide they want to take advantage of the Career Planning Or Tuition Reimbursement Program and decide to take another direction with their careers. Some could look at other UM facilities or other career development

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opportunities.

One of things that we've done very, very well with Upper Chesapeake for many, many years, is career development and promotion from within. If you look at our leadership team, department managers, hospital leadership and senior leadership, 160 individuals, probably 60 percent, have been promoted from within. We spend a lot of time evaluating that and assessing how that would work for our team members.

Another example that, a very specific one, is a nurse at Harford Memorial that has critical care experience, so we have a small Intensive Care Unit at Harford Memorial. What are some of those opportunities, where they can transition to Upper Chesapeake Medical Center, work in the ICU there. They could work in our Cardiac Catheterization Lab in Upper Chesapeake Medical Center, and we found that for many years that many of these nurses are interested in going to the operating room or recovery room. We see

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that happening today. We also find that many of those individuals have asked permission to go on for additional training and may decide they want to become a nurse practitioner. We've actually just started a Nurse Practitioner Fellowship Program with the University of Maryland School of Nursing, which we kicked off the 1st of July. Harford Memorial will have 17 individuals in the Nurse Practitioner Program rotating through different clinical sites at our facilities. Or they may decide that they want to go into the Emergency Department.

These are things we see realtime. They may decide to transition to an outpatient setting or pursue a leadership development track.

Something else that's very different that we've seen develop over the last 10 to 15 years are the number of individuals that have an RN background by training and education but have moved into different types of clinical roles for their next nurse education, whether that's care

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management, whether that's working with our Watch Teams out in the community, whether that's going to homes, or hospice.

So again, a number of different opportunities that we see for folks again that we think are real possibilities.

So, as I said, as we get greater clarity on our timeline, we will put a lot more detail to this job mapping. Right now, anticipating three or four years away, to do that right now we think is premature until we have greater clarity on our timeline.

As I've said in many different forums, we're committed to make sure we're a responsible employer, and we have over 3300 team members part of University of Maryland Upper Chesapeake Health. We want folks to make sure they're focused on providing patient care and not worrying about what's going to happen with their jobs.

So another question that we've been

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asked is: What's the timeline for all of this? We actually started these conversations with the agencies at the state level that have regulatory approval for this almost three years ago, literally. It was October of 2014 when we started these conversations.

Again, what's the planning, what's the preparation, what's the reaction, what's the role, et cetera, that we want these individuals and organizations to play? We started engaging our elected local officials, whether that was with the Havre de Grace City Council, with the County Council, whether that was with our Harford County delegation, back in the fall of 2015.

We had to get legislation approved in Annapolis in order to be able to continue this work, and that legislation got approved in the 2016 legislative session.

And then once the legislation got approved, we needed to get approved state regulations, which were literally just approved

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about two months ago in June of 2017.

So again, that's the work that we've been doing with our local delegation and agencies at the state level in order to put the pieces into place, similar to what we've done with the City of Havre de Grace, to make sure the that what we understood we would have to do from a water and sewer standpoint at that property as well.

Where we are right now, in the summer of 2017, it's been a fast summer. If you're like me, you were looking for a blanket last night when you went to bed. When you got up this morning, it was 54 degrees at my house.

But we actually filed the applications with the state agency, with the Maryland Health Care Commission. We filed those applications about three weeks ago. It was three applications. It was a Certificate of Need that was required for the special psychiatric hospital, and then there was two Certificate of

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Exemptions, one was for the freestanding medical facility, and the second was for the proposed bed addition that we're proposing in Bel Air.

As we've had conversations with the individuals from the Maryland Health Care Commission, in our conversations we've said, you know what, based on our conversations with the other agencies, we're going to say that this is going to take a year for us to get approval. So let's say for this conversation that we think that that approval will be in the summer of 2018.

As I mentioned earlier, in order to do any construction at that Bully Rock property, there's site development that needs to take place. Obviously there's a significant amount of grading and dirt work that needs to be done. We need to bring water and sewage to the property, build a water tower. That's work that we would anticipate, assuming that we get the approval in the timeframe outlined here, we would start that site development in the summer of 2018 timeframe.

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We expect that to take up to nine months or so. And then we would propose starting construction probably two years from now, again, after we secure the approval and then after we do the site work.

So the earliest that we think that we would actually be in that facility is the end of 2022, early 2021 timeframe, contingent upon the approval from three regulatory agencies at state the level. We have been having conversations with them for the better part of almost about three years. It's a very elaborate process, one that's very well thought out. We're working through very diligently to try to keep this moving along.

Another question that I've had is: What has been the medical staff's reaction to this? One of the things that we have done over the last year or so was actually -- you see the names of the individuals that are the chairs of our respective medical staff did this, whether it's

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anesthesia, psychiatry, OB/GYN, emergency medicine, medicine, et cetera, the group unanimously has endorsed what we're proposing to do. They actually sent a letter of support, and testified in Annapolis for us two years ago. And we have had conversations with the folks from the state EMS recognizing or acknowledging their support of what we're doing with this proposed project.

We've also secured support from our Harford County Executive Barry Glassman, also secured support from the Cecil County Executive. We've also secured letters of support from our Harford County Council and Harford County EMS and letters of support from the Chamber of Commerce and some of our local delegation at the state level.

We spent a lot of time working over the last two years or so with over 80 meetings with a variety of different groups to generate these letters of support, and we submitted our

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applications about three weeks ago.

Let me wrap up there and thank you all for coming this evening. You've been -- what we wanted to do, and I'm starting to lose my voice, I am going to turn this microphone over to Kathy Kraft, and Kathy is going to go through the questions that you've jotted down.

I have a number of individuals in addition to Sharon Lipford and myself and Dr. Barrueto, Jeff Matthai, Robin Luxon, Vice President, Corporate, Planning, Marketing, and Business Development at University of Maryland, Martha Mallanee, Dr. Angela Ries, president of our medical staff, Dr. Michael Abraham, who is Chairman of our Emergency Department, and Dr. Tim Chizmar, who is director of our EMS, and Dr. Richard Lewis, who is Chairman of Department of Psychiatry. I wanted to have some of these individuals that are more technical excerpts respond to some of these questions as opposed to myself.

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MS. KRAFT: We have a lot of questions to answer this evening. Some good ones, as I can see. My goal tonight is to help us get through as many of these as we can. So I'm going to start at the beginning, as Lyle suggested, to give our panel an opportunity to respond to the questions to you.

If there is a lot of discussion about a particular question, I may move us on to the next one and leave time at the end if we have it to come back to that. So let's get started. I'm going to move back. Let's get to the first one.

Will University of Maryland Upper Chesapeake Medical Center Havre de Grace be heart attack ready?

I'm going to turn that over to either Robin to respond to that. Will the new facility be heart attack ready? Dr. Barrueto?

DR. BARRUETO: I'm just going to speak briefly on the Upper Chesapeake side. I have asked Dr. Abraham to speak on the Emergency

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Department side. As far Harford Memorial Hospital currently does not have a cath lab. We do not perform cardiac catheterizations. When an ST elevation, myocardial heart attack comes to Harford Memorial, we transfer it to Upper Chesapeake where our cath lab currently resides.

The capabilities of the Emergency Department would remain the same between both facilities. So heart attack ready, if it's equating it to an acute stroke ready, the ability for our facility to receive these patients would be the same regionalization plan that has already occurred. So Mike, do you want to speak to the ED.

DR. ABRAHAM: I'm Dr. Mike Abraham. Currently, if a person walks into the Emergency Department at Havre de Grace, Harford Memorial has a stroke or a heart attack, we treat the patient there by putting the patient in an ambulance and sending them to Upper Chesapeake for a cardiac catheterization. If a person was

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to walk into this freestanding medical facility, the treatment would be exactly the same thing. We would be transferring them with ambulance care to Upper Chesapeake for an intervention.

If the patient called 911 and an ambulance went to the area, then to the patient's house, they would send an EKG to either Upper Chesapeake or to the freestanding medical facility, and at that point we would decide whether the patient could go directly by transport and bypass the freestanding medical facility and go directly to Upper Chesapeake. That's currently what we do now. There wouldn't be much of a difference from current protocol.

MR. SHELDON: Wasn't the question being asked historically if a patient presents whether today to Harford Memorial for the future freestanding medical facility and is transferred by ambulance to Upper Chesapeake Medical Center, intra-hospital transfer, the patient would not have responsibility for that ambulance bill.

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That would be covered by Upper Chesapeake, and our plan is to have that ambulance on site. If that patient were to go to another facility similar to what we have today besides Upper Chesapeake Medical Center, that would still be billed to the insurance company, and the patient would have to work that through with the insurance company. If it's the freestanding physical facility, Upper Chesapeake Medical Center, we would be absorbing that cost of the medical transport.

MS. KRAFT: The next question is for Dr. Richard Lewis.

Will the behavioral hospital offer detox or other treatment for substance abuse disorder?

DR. LEWIS: So we do not plan to have any additional services specifically for substance abuse disorders. In psychiatry, we are all trained as psychiatrists, but have always, in the years of our practice, treated substance abuse disorders. So we have for years treated

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substance abuse disorders. Unfortunately, when patients have significance psychiatric illnesses, they're more likely than not to have significance substance abuse. So when our patients come to us in the clinic, when they come to us on the unit, we treat both their depression and anxiety and psychiatric issues, but also alcohol and opioids and other substance.

We work with the community to do more and coordinating services, but no specific substance abuse disorder services.

MS. KRAFT: Lyle, the next question is for you.

Will Union Hospital be part of the University of Maryland Upper Chesapeake Health?

MR. SHELDON: I have no idea. I don't know. We have worked with Union in Cecil for probably six or seven years on some very specific collaborations, and one is specifically around behavioral health. We've worked with them around our Watch Teams that Sharon Lipford talked about.

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We've worked around geriatric services. But today I couldn't tell you what their long-term plans would be and how that will pan out. Right now, we want to work on some of these clinical service lines that I mentioned already.

MS. KRAFT: How is the elimination of the Affordable Care Act, if done, going to affect this hospital plan, and what will it do to the Certificate of Need?

MR. SHELDON: So the Affordable Care Act was, in effect, federalization, the significant impact that it has had Maryland in particular is expanding the number of individuals that have Medicaid coverage. What we have seen over the last three or four years is we've seen a number of individuals with Medicaid coverage increase by about 300,000 people over the course of this year, or since the Affordable Care Act was implemented.

Regardless of what happens at the federal level, our principal responsibility will

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continue to be to care for and treat patients regardless of ability to pay, regardless of race, sex or gender.

So we don't anticipate how we deliver care being impacted in any way with what will happen with the Affordable Care Act.

Regarding how that will impact anything that the Maryland Health Commission does from a planning standpoint, I'm not in a position to respond to that. My guess is they will be evaluating the approval process of that independent of the Accountable Care Act.

The Affordable Care Act is more for coverage of individuals as opposed to the provision of health care services.

MS. KRAFT: Dr. Barrueto, how will this affect the existing urgent care facilities like Patient First?

DR. BARRUETO: I think all emergency departments and facilities are going to be collaborating more with the urgent care

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facilities. It really should not affect urgent care as it stands right now. If anything, we have seen some migration of low acuity patients to the urgent care setting. But I actually believe that at this particular area, it's pretty well saturated. We've seen a lot of that already leave the Emergency Department. So the short answer is there should be no effect.

MS. KRAFT: What is the difference between the terms hospital and freestanding medical facility?

MR. SHELDON: A hospital is a licensed category in the State of Maryland of, and there are a number of requirements you have to have, medical surgical building, emergency room, surgical capabilities, you have to have physician staff that are able to cover the Emergency Department for services. And it's an S-1 type of license category.

A freestanding medical facility is a different type of licensure category. Again that

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really is focused around emergency type services, and then with the most recent legislation and regulations that were passed, it can also offer capability to have an observation status. It's a very, very different type of licensed facility.

So again, one would have medical surgical, ER, what the freestanding medical facility, ER, the Emergency Department component and the capability for observation in addition to the ancillary services to support the Emergency Department.

MS. KRAFT: I have another question for you, Lyle. Observation status is not covered by insurance. So who pays for that service?

MR. SHELDON: Didn't I already answer that, Joe?

MR. HOFFMAN: Most insurance companies, including Medicare, cover observation status, generally up to 48 hours.

MR. SHELDON: One of the provisions with the observation status that's proposed for the

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freestanding medical facility is you have to be consistent with that 48-hour to midnight that Joe Hoffman was referencing to be consistent with what's in place at the federal level with Medicare.

MS. KRAFT: Dr. Chizmar, I'm going to turn it over to you. I hope I ask this correctly. Nonemergency patients in Havre de Grace are more difficult to transport to new campus solution? So I think the question is: Are they more difficult to transport? And if there's any clarification needed around that, let me know.

DR. CHIZMAR: I'm the EMS medical director for Harford County. I work clinically in both ERs, Harford Memorial, and Upper Chesapeake. The answer to your question, the ambulance traffic in and out of Havre de Grace, the impact on Harford County based EMS services would be on the order of about one ambulance every other day that now goes from Havre de Grace

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going to Bel Air. When you look at our numbers, the only people who are excluded from coming to the new freestanding facility are priority one patients who are in need of intensive care and heart attacks. We would be able to take the strokes, and by new regulation priority two would still need urgent medical attention. And priority three, which are all what they call nonemergency transports, they account for about 75 to 80 percent of our transports. All of those patients would still come to the new freestanding facility.

I hope that answers the question. It works out to all but 100 patients out of 4,000 that we transport from Harford County based fire companies to Harford Memorial would skip over in the future as opposed to now.

MS. KRAFT: Road infrastructure. What are the plans for road improvements off of 95?

MR. MATTHAI: My name is Jeff Matthai with Morris Ritchie Associates, the civil

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engineers for the project. The traffic study was prepared by Traffic Group, who is the traffic engineering company that was hired by Upper Chesapeake.

The traffic study was approved by State Highway Administration and the City of Havre de Grace. It was broken up into five phases and the ultimate build-out would be the last phase obviously. Ultimately, Bully Rock Parkway will go from two lanes to four lanes. The intersection of 155 and Bully Rock Parkway will be expanded. Traffic lights will be expanded to add additional right and left turn lanes, and 155 will be widened out to the bridge that crosses 95.

Unfortunately, I didn't bring the traffic study with me, so I don't have the exact breakdown of the phases, but I can stay after this and give you my information, and you can contact me, and I get you the exact breakdown of what will be done at the end of each phase.

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MR. SHELDON: Could you comment on what's required to be done as part of the medical campus development?

MR. MATTHAI: The phase one is the medical campus, which would be the freestanding facility and the MOB, and I believe phase one, there are no traffic improvements required for Bully Rock Parkway or 155. They come later with the rest of the development.

UNIDENTIFIED SPEAKER: Has everything been approved?

MR. MATTHAI: The traffic study?

UNIDENTIFIED SPEAKER: So everything is approved and ready to go? If you were to start today, you would build the roads, and you're ready?

MR. MATTHAI: No. Right now we're in the preliminary engineering.

UNIDENTIFIED SPEAKER: You're still under study?

MR. MATTHAI: The design has to be done.

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UNIDENTIFIED SPEAKER: Why was the exit off the ramp way directly to the facility? If I look at the map, I see an easy way in rather than going all of the way around Bully Rock Parkway. I don't know whether that was studied at all. If it was, why wasn't that done?

MR. MATTHAI: I'm not the traffic engineer. I know the ramps are something that the state -- actually the State Highway on ramps, they're owned by the Maryland Transit Authority. I don't believe -- the way the configuration is, I'm not sure that would work. I don't think you can come right off the ramp into the facility.

UNIDENTIFIED SPEAKER: You come right off the ramp onto 155, and it's two lanes to the light, and at rush hour it is a mess today. So if major changes don't happen up there, you're going to have tons more accidents, people trying to make a left-hand turn to go to Churchville off of 155. It's a nightmare.

MS. KRAFT: I'd like -- let's do a

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couple of more comments on this topic. We'll bring it back at the end so that we can continue to get through the stack of questions.

So a couple of other questions followup? There were some hands.

UNIDENTIFIED SPEAKER: Do you anticipate -- I would think you would anticipate ambulances and traffic coming off of Pulaski Highway when you leave Bully Rock through the golf course section onto Pulaski Highway, there's no traffic light there, which makes it very difficult sometimes for Bully Rock residents or anyone coming that way to make a right- or left-hand turn, particularly a left-hand turn, to go to Havre de Grace and get across that traffic, particularly at certain times of the day. I think there's been a request and suggested that there be a light at that section right there. I would hope that that's also being looked at too. Otherwise, there's -- there's a problem there now.

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MR. MATTHAI: Again. That's a State Highway road, and there are certain trips when they study that they're required to meet the requirements of putting a traffic light in.

UNIDENTIFIED SPEAKER: May we ask you to bring these things up to the people who are making these plans, that question in particular, because that's one frequently asked by the residents at Bully Rock.

MR. MATTHAI: I also know that the City of Havre de Grace is involved in the process. They've reviewed the traffic study. I will bring that up.

MS. KRAFT: We'll take one more comment from the gentleman in the back.

UNIDENTIFIED SPEAKER: My understanding from what you said earlier is that there will be no road improvements for the medical facility, for the freestanding and the other facility. So all this discussion about widening the road and putting in additional turn lanes may be many

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years down the road, depending upon whether or not the retail aspect or the hotel or whatever else may go on the other 40 or 50 acres.

MR. MATTHAI: That's correct.

UNIDENTIFIED SPEAKER: There are concerns about ambulances getting off the highway and off of 155 and Bully Rock Parkway. There's no changes being made because of the buildings for the hospital, that changes?

MR. MATTHAI: That's correct.

MS. KRAFT: We will come back to this once we get through the cards. I will keep that out. But let's move on to the next question. Also a little bit around some of the infrastructure that's a question for Lyle. I'm going to ask you to turn the microphone over to him.

The question is: As a matter of interest, how many proposals have you received for things like gas stations, convenience stores, since it stands to reason this is the only exit

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in Harford County that doesn't have either one?

MR. SHELDON: None, because we haven't done anything to market the property, promote the property. We haven't talked to anybody from a development standpoint. As we presented the master site plan to the City of Havre de Grace in 2012, there was some master program planning to go ahead and say what are some of the retail or commercial options that could go on that location. But we've had no direct conversations with anybody as far as what other type of development would or could take place there, other than what we've talked about regarding the freestanding medical facility and the office building and psychiatric specialty hospital.

MS. KRAFT: Dr. Barrueto, I'm going to ask you to comment on this.

Harford Memorial is now not even fully staffed or has minimal staff for the emergency room. To be admitted, they have to be transported to Bel Air.

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DR. BARRUETO: It's a statement.

MS. KRAFT: It's not really a question. It's just a comment around staffing for the emergency room and being admitted, if someone needs to be admitted having to go to Bel Air.

DR. BARRUETO: Harford Memorial Hospital sees 28,000 patients a year. It remains fully staffed in the Emergency Department. It's fully staffed with board certified emergency physicians. It is also supplemented with physician assistant coverage and has some of the best performance metrics within the Maryland emergency medicine network.

As far as that beginning part, they are fully staffed. There may be a little bit of a misconception. There are some services that are not available at Harford Memorial Hospital such as pediatrics. We do not have an inpatient pediatric unit. OB, we do not have a labor and delivery unit. If you do have some complex critical care needs, you could be sent down to

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University of Maryland or to Upper Chesapeake. But we do have the intensive care unit and IMC med/surg unit, telemetry unit, so for right now the services that we transfer out are those service lines that we currently do not have. I've named some. Others would be thoracic surgery, neurosurgery, and a few other subspecialties.

MS. KRAFT: Lyle, I have a couple questions for you.

Why wasn't a hospital considered since the area has HAZMAT, APG, two major highway conversions, two railroads and the bay instead of the 48-hour service that's provided?

MR. SHELDON: As we evaluated our options, as I said, three years ago, four years ago, five years ago, and it goes back to that concept that I talked about from a regionalization of care standpoint, what's sustainable over time. And as we had conversations with folks from the leadership

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level and the state level, there was a general consensus that to try to build a small acute care hospital in Havre de Grace, which is probably not sustainable or practical for the long term, and there was the general consensus that consolidating the inpatient beds in Bel Air and the surgical capacity made a lot more sense when you look at the availability of physicians and drive times for the different locations. We did spend a lot of time evaluating that.

It was the thought of our medical staff leadership and board leadership that consolidating those services in Bel Air long term just made a lot more sense, not only from a cost standpoint and from an ability to provide the physician levels of coverage we would need over time.

A lot of thought went into has conversation. Our general feeling was that that would not be sustainable as we transition Harford Memorial Hospital.

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UNIDENTIFIED SPEAKER: I hear what you're saying. When I heard your arguments tonight that you said the reason why they're moving to the Bully Rock property is Harford Memorial is landlocked. The presentation tonight, it also appears that Bel Air is landlocked because you're building up. You don't have any room to build out. You've got to build up. My question is: With that in mind, doesn't it make more sense to establish a full service hospital at the Bully Rock property, a lot of the roads expand and a lot of adequate space, so that you don't -- you're not basically landlocked that you have in Bel Air?

MR. SHELDON: One of the comments that I made in my earlier conversation was the physician manpower supply and demand that we're experiencing here in Harford County is a real issue for us. If we were to go back 20 years or 25 years in Havre de Grace, we probably had two or three or four times the number of physicians

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that we have today. When we forecast out with the number of physicians interested in coming to a smaller community like that, that doesn't necessarily have the opportunity for growth like Bel Air does, we just did not think that it was going to be sustainable to be able to attract the number of physicians that we would need to have to meet the requirement to keep an acute care licensed facility in that location.

As we looked at that, the physician manpower shortages are a real issues for us, and how do we manage that in a way that is practical that addresses the physician availability that we have. That's one of the reasons, for example, that we don't have OB services, that was the small number of obstetricians in the county. We made the decision 17 years ago to have OB performed at one location.

It's the same thing with neurosurgery or vascular surgery or thoracic surgery. When you have one neurosurgeon in the county, is it

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realistic that they're going to be able to cover two hospital emergency rooms or one thoracic surgery. We just did not see over time that we'll be able to sustain the type and quality of physician that we would need do that as well.

UNIDENTIFIED SPEAKER: I understand where you're coming from. Was any consideration given to, because of Bully Rock -- where the Bully Rock property is located, it's right in between Shock Trauma and Christiana. My thought was wouldn't it be better to have the full service hospital in the Bully Rock property, and was any consideration given to moving behavioral health to Bel Air?

MR. SHELDON: So again, as a real life example, with many of our physicians that live in the Fallston, Bel Air, or Baltimore County area and thus having probably four times the number of physicians on our medical staff in Bel Air as opposed to Havre de Grace, to get those physicians or providers that may live in Monkton

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or Baltimore City or may live in Bel Air, to try to come up to cover an emergency room that may then be an hour drive was just not a practical solution. And we have been very active in trying to recruit physicians to the Havre de Grace community. But as we look out over time, we think that recruiting is going to continue to be more and more of a challenge.

We thought collocating those services in Bel Air was going to allow us to have the best coverage of physician capability in the county. And so that was one of the practical reasons as we looked at this.

MS. KRAFT: What about the case where someone who is sent for testing but then they need to be admitted for emergency surgery, then they have another transportation need. Medicaid will not pay for a second ambulance. What about the case where someone was sent for testing, and then they needed to be admitted for emergency surgery, so there's a transportation issue

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between the facilities?

DR. BARRUETO: In this instance, when we're talking about regionalization, that patient would be transferred. Upper Chesapeake Health would be handling the cost of that transport, and that patient would be taken down to Upper Chesapeake for the services, surgical or otherwise.

I also wanted to take a brief moment to actually talk about the improvements in care, when we talk about regionalization of care. When we talk about the trauma care that occurs in the state, we have regionalized it to five separate facilities that handle these complex trauma cases, and now we have some of the best outcomes with regards to trauma care in the nation.

When we talk about regionalization of cardiac care, when you have your heart attack, we have now regionalized that to Upper Chesapeake Health, Upper Chesapeake Medical Center, where we have some of the best outcomes for cardiac

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catheterization in the state. We have one of the busiest cath labs in the state. If I have a heart attack, I want to be somewhere within Harford or Cecil County and be taken to Upper Chesapeake Medical Center for my heart attack. Hopefully that's not soon. But for the most part, these regionalization projects are occurring across the nation when it comes to Emergency Department care with freestanding medical facilities, urgent care, emergency departments, with cardiac catheterization. These are care systems, and we are now developing one with stroke care as well, where you're going to get your TPA, the clot busting drug, and then be sent to a tertiary care facility where you may get a catheterization to try and remove clots.

Those are other big reasons that we are trying to improve the care within these counties by making sure that we have the best expertise and put patients with these complex illnesses, diseases, injuries, in the hands of the best docs

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and team members.

MS. KRAFT: I understand that the new hospital will have a full service ER with all related services. If so, I assume that patients having a heart attack will then go to Havre de Grace rather than Bel Air as they are now directed; is that right?

DR. BARRUETO: If they walk into the freestanding medical facility or if they walk into Harford Memorial Hospital, they are immediately, upon identification of a heart attack, sent to Upper Chesapeake Medical Center. That is what happens both now and what will happen in the future state.

MS. KRAFT: What happens to ER patients that require more than 48-hour inpatient care? Are they then transferred to some other hospital, and how and who transfers them? Do they get all new doctors? How is this beneficial to the patient?

DR. BARRUETO: Great question. We're

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talking about coordination of care here. Going through, a patient who is admitted through the freestanding medical facility into observation, goes through 48 hours of care and has determined that they need more care, the benefit for the freestanding medical facility, also to be honest, with Harford Memorial Hospital and Upper Chesapeake Medical Center is we are all on the same electronic medical record. We actually have more or less the same medical set. There are some that are solely collocated within the medical center, some within Harford Memorial Hospital, but we would be able to coordinate the care either through Telehealth or with a handoff to a new physician that would be able to take care of that patient.

The benefit to the patient is if we have identified something that requires more than observation care and requires that inpatient care, requires a specialty care, that will be solely located within Upper Chesapeake Medical

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Center, which has almost all of the specialties that they would need to be able to care for that patient.

MS. KRAFT: My final one for you. How will the new facility meet stroke center certification requirements?

DR. BARRUETO: The new facility would have new requirements called the Acute Stroke Ready Regulations that we have put forward as a pilot. They have some strict criteria with regards to transportation times, door-to-needle time, many of the things we already do with regards to stroke center designation, which is what Harford Memorial currently has. The big difference would an acute stroke-ready facility has a two-hour time commitment to be able to transfer those patients to the stroke center. So that would be the one additional piece. There's also a telestroke requirement that is required in these acute stroke-ready facilities. We would have that additional benefit of the telestroke.

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MS. KRAFT: What are the transport arrangements to transfer a patient from Upper Chesapeake to the University of Maryland campus in downtown Baltimore?

DR. BARRUETO: Currently, we have Express Care which provides transportation between Harford Memorial, Upper Chesapeake, to University of Maryland. That same system would apply as what we have currently. We would probably expect the same number of transfers to the Medical Center in downtown Baltimore as we have currently, maybe even less, as we start increasing services at Upper Chesapeake Medical Center.

For the most part, I think you would not see transfers between our two campuses and the center necessarily increase.

MS. KRAFT: And who pays for that transfer? That may be Joe or Lyle, I'm not sure.

DR. BARRUETO: I think it's been said before. Those costs, when they are done with the facilities within our system, will be handled by Upper Chesapeake.

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MS. KRAFT: Robin, this may be one you want to think about, and maybe we'll come back to it. Do you have a slide showing the current number of beds in Harford County broken down by now and in the future.

MS. LUXON: I'll provide a short brief answer. For fiscal year `18, which starts in July of this year for us, the projected bed need between both facilities in Bel Air and Harford Memorial is 285 beds. Our projected bed need in the year 2024 is 306 beds between Bel Air and Bully Rock Havre de Grace campus, which includes observation stays and freestanding medical facility and the behavioral health facility.

So that's the short answer. But we are required, and through our analysis we broke that down into different categories of beds, med/surge beds, observation beds, or psychiatric beds.

UNIDENTIFIED SPEAKER: The growth in

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this county with the new apartment complexes alone, if you go up Route 1 toward Dennison, at Old Joppa Road, there's a new massive community, you have Tollgate Road now goes all of the way through, and there's a new apartment complex that has 190 new apartments. You have the Section 8 housing in Aberdeen on Beards Hill Road. There is a tremendous growth of not only new construction, but also from a rental perspective in Harford County.

So I guess I'm really, with this other gentleman, why we don't have a new hospital, but to increase from 285 beds today, in 2020 to increase to 306, how is that helping the community?

MS. LUXON: We all feel that growth happening in Harford County and western Cecil County. There will be multiple factors that come into play when we look at utilization and projected utilization. There also is an expectation, as Lyle spoke about, that health

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care is changing, and there's an expectation that the use rates, so that the need for individuals to actually have an cute inpatient stay is expected to continue to decline, not only in the State of Maryland, but across the country.

There's an expectation that our state regulatory agencies have that organizations will actively work to decrease that use rate, and that's why as we think about health care in the future and all that Lyle outlined this evening is how do we look to deliver care in different settings in order to meet those needs. That's all part of the plan and part of our projections. We update that every year. As things change and utilization changes, we would make adjustments, and we would work with the state regulatory agencies to adjust our bed needs accordingly.

UNIDENTIFIED SPEAKER: I know that there's a five-day wait to get into the detox today, and we're having this huge heroin epidemic. But I guess we can be confident that

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at least we're in a state where we have the big three, Hopkins, MedStar and University of Maryland. So we do have other choices that we can go to.

MS. LUXON: Also as a part of the University of Maryland system, we are working very hard to have a regionalization of care approach. Your points around detox and behavioral health needs is really a critical need, and we're focused on behavioral health planning and scope of services.

UNIDENTIFIED SPEAKER: How many beds do you have today for that, and how many beds will you have at the new facility?

MS. LUXON: In behavioral health specifically?

UNIDENTIFIED SPEAKER: Yes, specifically.

MS. LUXON: 27, and we're planning for 40 inpatient behavioral health beds. As Lyle mentioned, with a new area of focus and service

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that we don't offer currently, a dedicated geriatric unit, which we don't offer currently at Harford Memorial, so increasing to 40 inpatient beds.

MR. SHELDON: I'm going to follow up on one other comment about some of the growth that you're talking about. One of the things that people may not appreciate is when we look at that new growth, I'll use the example of I have four grown children, three of them live here in Harford County, other than an emergency room visit or a delivery, the probability of those children of mine using a hospital is probably pretty remote.

In general, when we would look at the growth, for example, some of what you were talking about with those apartments, it's generally a younger population.

The other piece of this, as Sharon talked about, when we look at those senior citizens that we're working through with our

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Watch Program, traditionally what you find, whether it's in Harford County or the State of Maryland or across the country, 10 percent of patients represent about 70 percent of the hospital utilization. As Sharon has mentioned with work that her and her team are doing with those patients that are the biggest utilizers, with her continuing response with the programs we're doing in community outreach, 550 patient she was interfacing with this past year, we saw a 60 percent reduction in patient intervention in a hospital.

I think one of the challenges that we have and one of the challenges as we talked to the State Planning Commission, forecasting what that need is five years from now or ten years from now and not getting into a situation where we overbuild or not having enough capacity to meet what we think is the demand, so this is very, very much a moving target. There's a decrease of utilization for some of our sickest

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patients. And for that percentage of our population which is a younger population, they don't put much of a demand on general services other than department of obstetrics. That's the dynamic we're dealing with as we look at some of our planning.

MS. KRAFT: Dr. Barrueto, what's the difference between an observational patient and a regular medical surgical patient?

DR. BARRUETO: The one thing is an observation patient isn't just one that we just look at. It's a little more than that. There is a general sense, there's a clinical criteria that we put forward that helps us estimate how long it will take us to care for that patient with a general cutoff of 48 hours, saying we've gone as far as we can with observation, and now you have to go into an inpatient stay.

With regards to is the care different, it's a continuum of care. So you're still testing, analyzing, trying different treatments.

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I'll give you an example with a chest pain patient. If you actually have chest pain, have an EKG that is normal, and laboratory tests conclude heart enzymes that are negative, over 90 percent of those patients will enter into an observation status, because we know that we can care for those patient very rapidly within a 24 to 48 hour period of time, safely, quickly, diagnose them and treat them and get them on their way home.

But then there are other diagnoses that we know that are more difficult and harder to treat, and sometimes we know right out of the gate we will have to put them directly into inpatient status.

MS. KRAFT: I know we talked about this in the presentation. Would you remind them the number of observation beds in the new facility?

DR. BARRUETO: 11 beds is what we're planning on.

MS. KRAFT: I'm going to switch to the

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flu. During the months of flu season, how is one hospital going to deal with the increased census when both hospitals now are fuller now that Harford Memorial Hospital will be closed?

DR. BARRUETO: So as we stated, we're going to have an increase of 60 beds over in the Upper Chesapeake Medical Center campus. Flu is one that tests every system across the state as well as across the nation. When we have a bad flu season, we all feel it. Our capacity is pushed to the limits, and we all try our best. During light flu seasons, that looks a little better. Heavy flu seasons, we have all dealt with increased boarding in the Emergency Department as well as you may see the diversion of ambulances to other facilities when one is completely overwhelmed.

As far as total capacity within the Harford and Cecil County zone, I still am confident we will have those capabilities.

MS. KRAFT: Will surgical services

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suffer once Harford is closed?

MS. LUXON: Currently, we have surgical service capabilities at Harford Memorial. As Lyle indicated, we're planning to transition that surgical capacity to Bel Air, and we, at the same time, as a part of this project, we are looking to pursue the opening of an Ambulatory Surgery Center on the Bel Air campus. I'm not sure if I completely answered the question with that comment. I guess I answered the question.

MS. KRAFT: Dr. Lewis, what percent of behavioral health patients are anticipated to be outpatient and substance abuse patients?

DR. LEWIS: I don't have percentages for you. I can tell you that at Harford Memorial Hospital, we have always done the bulk of our business outside of the locked units, providing consultation to the general hospital, emergency room evaluations, and having a busy clinic with the case management, psychotherapy, group therapy. I predict in the coming new hospital

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that that portion will grow, because with our population health efforts, our goal is to get to people when they are having mild to moderate symptoms, not the severe symptoms that lead to hospitalization. That proportion of the substance abuse disorders in our population is great, it's great in the general population. Exact numbers are hard to come by. We have historically always treated those disorders and symptoms and will continue do so at the new hospital.

MS. KRAFT: There is a question around concern with the psych hospital and potential loss of value in homes. Is there anyone that -- Lyle, can you speak to that?

MR. SHELDON: I don't know how to respond to that, because it's interesting, we talked to both residents in Havre de Grace and the Bully Rock community. Some have thought the development on the Bully Rock property, regardless of what it is, will be value added.

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Others have suggested that it may not be. I think a lot of that is predicated by what happens in general with the economy as opposed to anything specifically we may be doing there at that Bully Rock property. But not being in the real estate business, I can't comment anymore than that.

MS. KRAFT: No mention of western Cecil County as being part of the cover territory. I think that was covered in the presentation.

MR. SHELDON: Currently, we're getting about 20 percent of the patients that we see at Harford Memorial come from western Cecil County, and we would anticipate that those patients that need behavioral health or Emergency Department or those patient that are currently coming to us for outpatient services would still be able to secure those services at the freestanding medical facility or specialty hospital. Those patients that would generally require acute medical surgical hospitalization would probably end up at

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Union in Cecil as opposed to the facility at Bel Air.

MS. KRAFT: This one is about helicopters. How many are in Harford County, and who has them? Dr. Chizmar.

DR. CHIZMAR: Actually, I'll allow Jeff to correct me if I'm wrong. We don't currently have any MedEvac helicopters in Harford County. The closest we have is at Martin State Airport. In the summertime, they'll do what they call dynamic deployment where they'll come up to Elkton or Cecil County, during the busier times of the year. There are eight State Police helicopters actively in service at any given time.

And then commercial in the State of Maryland, inter-facility transports are handled by private vendors, such as PHI or Hopkins. There are no actual medical helicopters that are routinely stationed in Harford County. You're 100 percent correct. That is a huge issue that

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needs to be brought to the attention of legislators in Annapolis.

UNIDENTIFIED SPEAKER: I guess I asked the question because at the earlier statement in the presentation the talk about how much quicker people would have been transported if the bus had crashed on 95, and it really doesn't matter, because there's only a finite number of helicopters. Union Hospital doesn't even have a helicopter pad. They just got funding if I read my little letter. They don't even have a pad. Even if we had pads, we still need helicopters. So the transportation is going to kind of be the same. When you're looking at traveling from here to Bel Air during rush hour, it's an hour up 22. And 95 on the weekends, and I mean, it's just kind of baffling for the whole infrastructure of the county and the traffic and the continual building and no road improvements. When they do put up a new stop light, even like at Paradise Road and 155, there's no turn lane. So it's

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just -- I live right by this station, and this is one very busy little place. These ambulances roll all the time. It's just really scary, but to say that the accident would have been handled faster, we were lucky that the State Police boys were behind that truck and knew what to do to the bus when they got there. But really having the hospital in Havre de Grace or up on top of the hill, really does not improve that type of transportation at all.

DR. CHIZMAR: From an incident like that when you have a mass casualty incident, those patients were scattered to five different hospitals across two states. The majority of them went to Harford Memorial. Twelve of them went to Harford Memorial, nine to Bel Air, and the remaining nine were scattered from AI Dupont in the north to Shock Trauma in the south.

UNIDENTIFIED SPEAKER: I'm saying that that statement was incorrect.

DR. RIES: I don't think it was that the

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crash victims would have gotten out safer or faster. I think what the statement was meant to say is that if you are currently at Harford Memorial in the ER with a cervical spine injury or a traumatic injury and you are decompensating rapidly, we have to now load you into an ambulance, drive you to a helipad, which does lead to an amount of instability that no trauma doctor would like to see. So where we think the benefit comes is not necessarily from an accident, which as Tim has said, those trauma docs and those EMS docs are calling that right away. They're sending people directly to Shock Trauma. That's why helicopters land on 95 and leave. Where it's going to help is, heaven forbid, an older person falls in their home, we're worried about a brain bleed, a neck fracture, right now, if you're at Harford Memorial, and we have to get you down to Shock Trauma, we're taking that potentially unstable patient, putting them in ambulance, driving them

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to a helipad. So cutting out the ambulance part and having the helipad right there does actually save critical minutes and prevents some movement of a patient that we would hope would not have to be done.

UNIDENTIFIED SPEAKER: But the ambulance wouldn't take them to Harford Memorial.

DR. RIES: That happens where a patient comes in after what is believed to be a minor fall, we get a CAT scan, whether it's Bel Air or Havre de Grace. If there's a traumatic brain bleed, we're sending it out, even now currently.

UNIDENTIFIED SPEAKER: They don't have to go to a helipad. They land helicopters on I-95.

DR. RIES: They do. Currently in Havre de Grace, you can't land a helicopter. We do not have authority to land a helicopter in Havre de Grace. I said, not talking about the accidents, because you are correct, car accidents will always land where EMS needs them to land. But

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for a hospital, there's very strict regulations within a town as to where they can land.

MS. KRAFT: We have a pile of questions for Robin about roofs. Will there be roof gardens on these large flat roofs? If not, why not?

MS. LUXON: I do like that question. It's green sensitive. In all honesty, our planning thus far for the facility is it will be a green facility. We have not gotten to that degree of detail of planting the plantings on the roof. We've seen what we've done in the Bel Air campus. We really are sensitive to the environment and wanting to maintain that in our facilities.

UNIDENTIFIED SPEAKER: The purpose of the idea is to plant that idea rather than to plant the garden, right.

MS. LUXON: Exactly.

UNIDENTIFIED SPEAKER: Because the transformation occurs to the environment at well.

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MS. LUXON: I appreciate that.

UNIDENTIFIED SPEAKER: Thank you very much for a very thorough presentation. I've heard a lot about coordination of facilities and campuses, but I haven't heard -- maybe I missed it -- anything about the family of the patient. And my specific question would be: If you're transporting a patient to University of Maryland in Baltimore, and they're senior citizens, they might be used to driving to Havre de Grace and Bel Air, but going down to Baltimore City is a little bit scary. And have you take into consideration about the family of the patient who has to go to that particular area.

MS. KRAFT: Do you want to repeat the question? If the question related to when a patient needs to be transported to Baltimore, there can sometimes be challenges for the family, if I'm understanding correctly, to get to Baltimore to be with their loved one, so how do we handle that?

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MS. LUXON: Currently, we have in place with the University of Maryland, there is a shuttle that is for patients and families to assist in transportation to the medical center downtown. That service is available now, and we've perceived that that will continue when this transition takes place.

MR. SHELDON: Let me thank you for spending two-and-a-half hours on a Wednesday evening. I normally spend that much time with Troop 965 on Thursday evenings which is the Boy Scout Troop that's here, and Alex Peterson who is a long time member of Level Fire Hall, Level Fire Hall is one of our charter sponsors. Being active in Boy Scouts, we've spent a lot of Thursday nights preparing for camping outings.

We'll continue to provide updates on our website with the information that's provided there in front of you. I'm happy to stay around or give you my business card for anybody that's interested.

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Thank you for your interest in Harford Memorial Hospital and enjoy the rest of your evening.

(Whereupon, the hearing concluded at 8:34 p.m.)

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STATE OF MARYLAND SS:

I, Linda A. Crockett, a Notary Public of the State of Maryland, do hereby certify that the proceedings above took place at the time and place indicated. I further certify that the proceedings were recorded stenographically by me and this transcript is a true record of the proceedings.

As witness my hand and notarial seal this 12th day of September, 2017.

My commission expires December 1, 2020

Linda A. Crockett
Notary Public