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EVELIUS & JONES LLP
ATTORNEYS AT LAW

April 13, 2018

VIA EMAIL & FIRST CLASS MAIL

Ms. Ruby Potter
ruby.potter@maryland.gov
Health Facilities Coordination Officer
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: Request for Certificate of Need Exemption
University of Maryland Laurel Regional Hospital
Partial Response to Additional Information Questions Dated July 23, 2018

Dear Ms. Potter:

On behalf of Dimensions Health Corporation *d/b/a* University of Maryland Capital Region Health ("UM CRH"), University of Maryland Laurel Regional Hospital ("UM LRH"), and University of Maryland Prince George's Hospital Center, we are submitting six copies of applicant's partial Response to Additional Information Questions Dated July 23, 2018 in the above-referenced matter. This Response addresses questions 1 through 13 of the July 23 request. A WORD version will be forwarded in a separate email.

We hereby certify that a copy of this submission has also been forwarded to the appropriate local health planning agency noted below.

Sincerely,

Thomas C. Dame

Mallory Regenbogen

Mallory Regenbogen

Enclosures

#635594
013849-0001

cc: Kevin McDonald, Chief, Certificate of Need
Paul Parker, Director, Center for Health Care Facilities Planning & Development, MHCC
Suellen Wideman, Esq., Assistant Attorney General, MHCC
Pamela Creekmur, Health Officer, Prince George's County
Neil Moore, President & CEO, UM Capital Region Health
Sherry Perkins, PH.D., RN, Executive VP & COO, UM Capital Region Health
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Dimensions Health Corporation *d/b/a* University of Maryland Capital Region Health
University of Maryland Laurel Regional Hospital and
University of Maryland Prince George's Hospital Center

Request for Exemption from Certificate of Need Review to
Convert University of Maryland Laurel Regional Hospital to a Freestanding Medical Facility

Responses to Additional Information Questions Dated July 23, 2018

University of Maryland Capital Region Health (UM Capital Region Health) discovered in preparing its responses that Table 1 in the FMF Application, which provides a comparison of University of Maryland Laurel Regional Hospital (UM LRH) and statewide admission trends, does not provide as realistic a comparison due to the inclusion of departmental transfers as admissions. Inclusion of departmental transfers results in duplicate counts of patient admissions, which skews the overall admission trends. Table 35 below shows FY 2013 to 2017 admissions trends with exclusion of departmental transfers. This revised table more clearly shows the contrast in admissions trends between UM LRH and the State. From FY 2013 to FY 2017, admissions at UM LRH declined 35.5% while the Statewide admissions declined 7.6%. With the exclusion of the obstetrics admissions due to UM LRH's closure of that program, the admissions decline is 23.6% and 8.3%, respectively.

Table 35 (Revised Table 1)
UM LRH v. Statewide Admissions Trend
FY2013 - FY2017

	Fiscal Year					
LRH	**2013**	**2014**	**2015**	**2016**	**2017**	**% Change**
Med/Surg Acute	3,204	3,008	2,707	2,422	2,193	-31.6%
Psychiatric Acute	821	777	678	886	757	-7.8%
Rehabilitation	904	730	629	478	727	-19.6%
Chronic Care (1)	-	129	145	148	89	0.0%
Obstetrics Acute	914	850	703	196	-	-100.0%
Total	**5,843**	**5,494**	**4,862**	**4,130**	**3,766**	**-35.5%**
LRH % Change		***-6.0%***	***-11.5%***	***-15.1%***	***-8.8%***	
Statewide						
Med/Surg Acute	456,736	431,577	423,601	422,427	412,940	-9.6%
Psychiatric Acute	32,533	34,256	34,184	32,938	32,716	0.6%
Rehabilitation	7,332	7,879	7,571	6,641	6,125	-16.5%
Chronic Care (1)	-	129	2,987	3,254	3,373	0.0%
Obstetrics Acute	68,091	68,615	68,947	68,364	66,622	-2.2%
Total	**564,692**	**542,455**	**537,290**	**533,624**	**521,776**	**-7.6%**
LRH % Change		***-3.9%***	***-1.0%***	***-0.7%***	***-2.2%***	

Note (1): Revenue center wasn't included in the count of admissions until FY2014
Source: HSCRC Annual Filings

Acceptability, COMAR 10.24.19.04C(3)(c)(v) and (vi)

1. Please list each outpatient service to be provided at the freestanding medical facility (FMF) for which the applicant is seeking rate regulation.

Applicant Response

UM Capital Region Health is seeking regulated rates for the following outpatient services to be provided at the proposed Freestanding Medical Facility:

- Emergency services;
- Observation services;
- Ambulatory surgery services;
- Associated diagnostic and other clinical ancillary services required to support the emergency, observation, and ambulatory surgery services;
- Partial hospitalization/Intensive outpatient behavioral health program;
- Wound care program, including hyperbaric oxygen therapy.[1]

2. Please document that the applicant has received a determination from HSCRC, issued pursuant to COMAR 10.37.10.07-2D, regarding each outpatient service to be provided at the FMF for which the applicant is seeking rate regulation.

Applicant Response

University of Maryland Medical System (UMMS) has worked directly with HSCRC staff over the past several months to solidify the list of services to be offered as regulated at the UM Laurel Medical Center. The services to be offered were initially approved by the HSCRC during the negotiations related to revenue and rates that culminated with a letter from Donna Kinzer in November 2017 (see Exhibit 13). Since that time, UMMS has made slight modifications to the list of services and communicated those changes to the HSCRC throughout the process.

3. Please document that the revenue projections provided to MHCC for the proposed FMF are consistent with the rate of reimbursement HSCRC will authorize in establishing global budget revenue for the proposed FMF.

Applicant Response

The revenue projections provided to MHCC for the FMF are based on the revenue proposal set forth and agreed to by the HSCRC in November 2017 (see Exhibit 13). UMMS is currently working with HSCRC staff to develop the FY 2019 global budget revenue and corresponding rates for the FMF using a methodology consistent with the principles outlined in November. UMMS will be filing an HSCRC Rate Application in August 2018 at the recommendation of the HSCRC Staff, which will establish the revenue and rates as previously agreed.

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[1] Wound care services are currently rate regulated and provided in a separate building on the UM LRH campus. UM Capital Region Health intends to continue providing rate regulated wound care services in this separate building on the campus of UM Laurel Medical Center.

Financial Assistance and Charity Care, COMAR 10.24.19.04C(7)

4. Simply and directly state the eligibility criterion that will be used at the proposed FMF to qualify patients for charitable or reduced charge services. Are these criteria in the policy at Exhibit 6?

Applicant Response

The eligibility criteria used to determine whether patients qualify for charitable or reduced charge services are included in the Financial Assistance policy provided in the FMF Application as Exhibit 6. This policy will apply to UM Laurel Medical Center.

As indicated on pages 1-3 of the policy, UM Capital Region Health is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for emergent and medically necessary care based on their individual financial situation. With limited exceptions, UM Capital Region Health provides financial assistance based on indigence, lack of sufficient insurance, or high medical expenses. UM Capital Region Health determines coverage amounts, in part, based upon 200-500% of income as defined by federal poverty guidelines.

In circumstances where UM Capital Region Health does not have a financial assistance form on file for patient, it uses presumptive eligibility criteria to determine eligibility for financial assistance, which are described on pages 3-4 of the policy.

As indicated on page 7 of the policy, medical financial hardship assistance is also available, with limited exceptions, to patients who do not otherwise qualify for financial assistance, but for whom: (1) their medical debt incurred at UM Capital Region Health facilities exceeds 25% of the family annual household income, which is creating medical financial hardship; and (2) who meet the income standards for this level of assistance.

Under section 2(c) of the Procedure section on pages 4-5, the policy states that UM Capital Region Health will provide a determination of probable eligibility within two business days following a patient's request for charity care services, application for medical assistance, or both.

Attached as Exhibit 14 is one-page flyer available to patients regarding UM Capital Region Health's financial assistance program, which summarizes the eligibility criteria in the section titled "How We Review Your Application."

Service Area ED and FMF Use, COMAR 10.24.19.04C(8)(a)

5. Provide the basis for the statement on page 21, "The emergency departments of these other hospitals (Doctors Community, UM Baltimore Washington, UM PGHC, Howard County General, and Holy Cross of Silver Spring) are fully utilized." Table 5 indicates that ED visit volume at three of these five hospitals declined between 2013 and 2017. It also indicates that cumulatively, ED visit volume at the five hospitals declined 1.5% over this same period.

Applicant Response

While total ED visits declined from 2013 to 2017 at three of the five hospitals with the most ED visits originating from LRH's ED service area, their volume of ED visits per treatment space in FY 2018 ranged from 1,043 visits per treatment space at Doctors Community Hospital to 1,332 visits per treatment space at UM Baltimore Washington Medical Center (see Table 36 below).

Table 36
Analysis of Total ED Visits at Hospitals
Serving UM LRH Service Area Residents

ED Visits

Hospital	2013	2014	2015	2016	2017	2018	2013-2018 % Change
Doctors Community Hospital	50,729	51,445	57,043	57,439	56,765	57,352	13.1%
UM Baltimore Washington	103,000	99,517	99,188	95,708	92,600	86,594	-15.9%
UM PGHC	51,881	49,646	49,756	50,333	48,273	49,428	-4.7%
Howard County General	77,184	73,432	75,880	78,072	77,636	78,088	1.2%
Holy Cross of Silver Spring	92,134	86,709	86,985	71,363	79,414	77,223	-16.2%

ED Treatment Spaces

Hospital	2013	2014	2015	2016	2017	2018	2013-2018 % Change
Doctors Community Hospital	55	55	55	55	55	55	0.0%
UM Baltimore Washington	66	66	68	68	65	65	-1.5%
UM PGHC	47	47	46	46	46	46	-2.1%
Howard County General	55	55	55	74	74	74	34.5%
Holy Cross of Silver Spring	61	61	61	64	64	64	4.9%

ED Visits per Treatment Space

Hospital	2013	2014	2015	2016	2017	2018	2013-2018 % Change
Doctors Community Hospital	922	935	1,037	1,044	1,032	1,043	13.1%
UM Baltimore Washington	1,561	1,508	1,459	1,407	1,425	1,332	-14.6%
UM PGHC	1,104	1,056	1,082	1,094	1,049	1,075	-2.7%
Howard County General	1,403	1,335	1,380	1,055	1,049	1,055	-24.8%
Holy Cross of Silver Spring	1,510	1,421	1,426	1,115	1,241	1,207	-20.1%

Sources: ED Visits = HSCRC Annual Filings and Experience Reports; ED Treatement Spaces = MHCC Annual Report on Selected Maryland Acute Care and Special Hospital Services, FY2018

In its publication on Emergency Department Design; A Practical Guide to Planning for the Future, the American College of Emergency Physicians (ACEP) identifies a high range of 1,250 visits per treatment space for Emergency Departments with 50,000 to 95,000 annual visits. The average visits per treatment space at the five hospitals identified above in Table 36 are more than 83% of the ACEP guideline. Their capacity to receive more ED visits is, therefore, limited. Even combined, these hospitals would have difficulty absorbing all of the approximately 26,000 ED visits seen at UM LRH in fiscal years 2017 and 2018.

These five facilities' capacities to absorb additional ED visits, especially during peak or surge periods, is evident from the number of yellow, red and other Emergency Department alerts during FY 2018 (Table 37 below). These five hospitals' alerts exceeded those at UM LRH, which was on alert less than one hour a day. The other five hospitals were on alert from 1.5 to 6.0 hours a day. This amount of time on alert will further limit the ability of these hospitals to serve the patients that have historically received emergency care at UM LRH.

Table 37
Maryland Institute of Emergency Medical Services Systems
FY2018 Emergency Department Alerts

Hospitals	Yellow Alert		Red Alert		Other Alerts		Total Alerts		
	#	Tot Hours	#	Tot Hours	#	Tot Hours	#	Total Hours	Hours / Day
Doctors Community Hospital	100	640.3	39	626.0	8	25.0	**147**	**1,291.2**	**3.5**
Baltimore Washington Medical Center	140	882.4	21	207.3	212	286.6	**373**	**1,376.3**	**3.8**
Prince Georges Hospital Center	7	16.9	34	459.8	51	81.9	**92**	**558.6**	**1.5**
Howard County General Hospital	103	521.2	4	31.4	37	80.2	**144**	**632.8**	**1.7**
Holy Cross Hospital	202	1,305.4	44	804.2	31	64.2	**277**	**2,173.8**	**6.0**
Laurel Regional Medical Center	27	93.1	19	219.2	6	11.7	**52**	**323.9**	**0.9**

Source: MEIMSS County / Hospital Altert Tracking System

Yellow Alert
The emergency department temporarily requests that it receive absolutely no patients in need of urgent medical care. Yellow alert is initiated because the Emergency dept is experiencing a temporary overwhelming overload such that priority II and III patients may not be managed safely. Prior to diverting pediatric patients, medical consultation is advised for pediatric patient transports when emergency departments are on yellow alert.
Red Alert
The hospital has no ECG monitored beds available. These ECG monitored beds will include all in-patient critical care areas and telemetry beds.

Availability and Accessibility of Emergent, Urgent, and Primary Care Services, COMAR 10.24.19.04C(8)(b)

6. Address the plans of University of Maryland Capital Region Health to assure cost effective use of the proposed FMF by developing and marketing lower cost alternatives for patients not needing the level of emergency center care in operation at the proposed FMF. Does UMCRH operate urgent care settings in the service area of the proposed FMF? Will UMCRH develop urgent care centers in the service area of the proposed FMF?

Applicant Response

UM Capital Region Health and UMMS established a Community Engagement Team, involving perspectives from multiple disciplines including its marketing team, to optimize community interaction and transparent communication regarding the conversion of UM LRH. The Community Engagement Team has engaged in numerous activities to educate the community on the proposed freestanding medical facility, including the services to be provided and types of conditions to be treated at the freestanding medical facility. As part of this educational process, UM Capital Region Health has developed materials, including presentation slides and a flyer, to inform community members of the types of health symptoms and conditions that necessitate seeking emergency care versus urgent care. See Exhibits 15 and

16. Members of the Community Engagement Team and UM Capital Region Health leadership presented these materials at several community health fairs and outreach events identified in the Community Engagement Team overview attached as Exhibit 17. UM Capital Region Health has also shared the flyer with local primary care offices for distribution to patients. It intends to continue engaging in similar educational activities to ensure the community is aware of the appropriate lower cost alternatives to emergency care such as urgent care, primary care, and specialist services.

UM Capital Region is also engaged in discussions with ChoiceOne, UMMS's urgent care partner. ChoiceOne is a national company that develops and operates urgent care centers. UM Capital Region and ChoiceOne are in the process of examining the feasibility of developing an additional urgent care center in the UM LRH service area. However, given the saturation of urgent care centers already present, as identified in Table 6 of the FMF Application, the parties are carefully evaluating the need for additional urgent care services within the service area.

FMF Capacity for Emergency Care, COMAR 10.24.19.04C(8)(d)[

7. **The justification offered for the treatment capacity proposed assumes the status quo with respect to time patients will spend in the ED and will spend boarding in the ED and in turnaround times for testing. This would appear to be justified if this status quo represents a demonstrated high level of efficiency in ED operation by UM Laurel Regional Hospital (UM LRH). Can this high level of efficiency by the converting hospital be demonstrated? If not, why must a new setting for emergency care, detached from the general hospital setting, be planned without improvements in these operational characteristics?**

Applicant Response

UM LRH is engaged in ongoing process improvement initiatives regarding throughput of patients from arrival at the ED through discharge. UM LRH has improved and reached industry benchmarks for laboratory, radiology, and EVS ED turnaround times. In addition, UM Capital Region anticipates that its new contract with commercial ambulance vendor, Procare Ambulance of Maryland, Inc., initiated in July 2018 that includes performance metrics of 30 minutes for critical care and ALS patient transports and 90 minutes for BLS patient transports. Procare has agreed to dedicate an ambulance for UM Laurel Medical Center and an additional 6-7 ambulances to support UM Capital Regional Health. Based on UM Capital Region Health's recent trial run with Procare at the UM Bowie Health Center and the performance metrics agreed to in the new contract with Procare, UM Capital Region is confident that interfacility transport services between UM LRH and UM PGHC or other facilities will be more efficient going forward which will decrease boarding times for patients needing a higher level of care at UM LRH and the proposed UM Laurel Medical Center.

UM Capital Region Health has also implemented other process improvement measures including improving Radiologist turnaround time with the reinitiation of nighthawk services and the issuance of an RFP for radiology services, which will further improve turnaround time for clinical interpretation. In July 2018, physicians and nursing started to flex staffing to adjust to patient volumes and acuity. Nursing is also in the process of maximizing triage protocols and training. There are plans to create a second triage room and optimize mobile registration to decrease the incidence of patients leaving without being seen and patient wait times. The inpatient staffing challenges at UM LRH that have affected throughput will no longer be a factor

once UM LRH converts to a freestanding medical facility. UM Capital Region anticipates cross training the staff at the UM Laurel Medical Center to improve efficiency.

Emergency services are needed at the UM Laurel Medical Center to continue to support the local community and provide access to care. The UM Laurel Medical Center will continue to serve as an emergent care location and work in conjunction with local urgent care centers, physicians, healthcare facilities, EMS providers, educational institutions, businesses, and community organizations to provide this care. UM Capital Region is in frequent communication with outside providers and entities in order to coordinate provision of emergency services. For example, UM LRH's emergency physicians communicate daily through the base station with community EMS providers regarding Priority 1 and potentially unstable Priority 2 patients to determine the appropriate level of care and destination, which will continue to occur at the FMF. Community urgent care centers communicate with emergency services for patients who need to be transferred or seen for conditions that are not appropriate for that level of care. In addition, numerous physician practices surrounding UM LRH transfer unstable patients for emergency care.

In March 2018, UM Capital Region health implemented the National Emergency Department Overcrowding Study (NEDOCS) at UM PGHC in order to improve communication and throughput throughout the system. The NEDOCS score provides an objective, quantitative score that gives a hospital wide approve to improve the patient throughput and reduce the Emergency Department wait times and overcrowding. Attached as Exhibit 18 is the NEDOCS system numerical and color codes chart that is discussed in detail at UM Capital Region Health's morning huddle of leaders across all facilities as well as by text and email communication. UM Capital Region Health plans to use a master teletracking bed board system that will include the UM LRH and UM Laurel Medical Center patients to help improve efficiency in transferring and placing patients. It also uses the OneCall system, an internal communication system, to improve communication among UM PGHC, UM LRH, and UM Bowie Health Center for efficiency in transporting patients between these facilities. UM Capital Region anticipates that the NEDOCS tool will help UM PGHC better manage its ED operations and reduce the number of hours that the facility must go on color alerts due to capacity issues. These systems and processes will facilitate quicker escalation and prioritization of patients requiring transfer and inpatient care after they are clinically stabilized UM LRH and the UM Laurel Medical Center.

UM Capital Region also recently implemented a new leadership structure which will oversee the entire ED service line at UM PGHC, UM LRH, and University of Maryland Bowie Health Center. This consolidation of ED leadership will further promote collaboration, communication, and efficiency within UM Capital Region and between UM Capital Region Health and UMMS.

8. **Why is the FMF described as having 20 treatment spaces rather than 24 when referencing the capacity planning guidance in ACEP's Emergency Department Design? Please provide the basis in this ACEP publication for the applicant's position that behavioral health treatment spaces are excluded (or "carved out" to use the terminology on page 34) from consideration when using the capacity planning criteria.**

Applicant Response

On pages 8-9 of the FMF Application, the FMF is described to include:

1. An emergency department with two (2) triage rooms at 110 square feet each, 20 exam rooms at 140 square feet each (including one trauma/resuscitation room at 280 square feet), four patient toilets, and two staff toilets, as well as related staff and support spaces, including an ambulance entrance and decontamination facilities;

2. A behavioral health crisis center with four (4) exam rooms at 140 square feet each and one patient toilet and related staff and support spaces;

The reason for planning for and describing them separately is fully consistent with ACEP Guide. On page 218 of the ACEP Guide, it states:

> ***Designing the Behavioral Health Services Area***
>
> The first step in identifying your physical space needs for behavioral health care is to identify the intended services and corresponding length of stay. How long will you need to hold patients after initial diagnosis and stabilization? Will you transfer patients to psychiatric inpatient floors or outpatient services within your own hospital? Or, will you be at the mercy of the receiving facilities and transport services when referring patients to appropriate outplacement locations? Review all possible operational scenarios to determine the quantity of behavioral health patient care spaces.

In accordance with this guidance, UM Capital Region Health projected the need for behavioral health treatment bays separately (or "carved" them out) from its non-behavioral health treatment bays. Both the need assessment and the separate placement are consistent with the ACEP Guide. On the same page, the ACEP Guide states:

> The behavioral health care unit should be designed in a location with direct access from both the ambulance entrance and the walk-in entrance. The intent is to place the behavioral health care zone in an accessible area while still limiting, or eliminating, all cross-circulation with other emergency department patients.

UM Capital Region Health has attempted to accomplish this through its proposed design. There is nothing in the ACEP Guide that prohibits the separation of the behavioral health zone from other treatment zones when using the capacity planning criteria.

Observation, COMAR 10.24.19.04C(8)(e)

9. Can the operational experience of UM LRH be demonstrated to represent a high level of efficiency in the provision of observation services? If not, why must a new setting for emergency care detached from the general hospital setting be planned without improvements in these operational characteristics?

Applicant Response

UM LRH anticipates that its emergency physician group will manage and oversee provision of observation care at the UM Laurel Medical Center, which will allow for operational efficiency due to continuity of care management with clinical protocols and guidelines supported by case management. This model helps to avoid the duplication of work and improved clinical communication and documentation of care. Technology will also support efficiency improvements at the UM Laurel Medical Center. UM Capital Region is considering consolidating its clinical documentation into a single EMR System, which will include care flow templates and order sets. With the declining utilization of inpatient beds, there is a need for enhanced focus on population health initiatives and care transitions to avoid unnecessary admissions and decrease overall health care cost. UM LRH primarily uses case managers for inpatients, but intends to transition these case managers to support emergency and observation care at the UM Laurel Medical Center. The utilization and expertise of the case managers will support the clinical decision for admission or observation criteria, as well as a focus on the social determinants of health and potential avoidable utilization. There will be appropriate provision and coordination of resources to meet patients' needs. The current length of stay for the observation level of care at UM LRH is approximately 26 hours. With increased focus on case management and care transitions, UM Capital Region Health anticipates that for some clinical conditions there will be decreased admissions, cost of care, and length of stay.

Utilization, Financial and Staffing Projections, COMAR 10.24.19.04C(8)(f)

10. **See (f)(iii). Pages 47 to 49 only address the utilization of one "other outpatient service," outpatient surgery. Does this mean the outpatient surgery is the only outpatient service other than emergency services and observation services that the applicant projects regulated charges?**

Applicant Response

The UM Laurel Medical Center expects to offer the following regulated outpatient services on its campus:

- Emergency
- Observation
- Surgery
- Psychiatric Intensive Outpatient Program (IOP) / Partial Hospitalization Program (PHP)
- Wound Care, including Hyperbaric Medicine

Similar to the Emergency, Observation, and Surgery services, the IOP / PHP and Wound Care programs reflect a continuation of regulated services currently provided at UM LRH. The historical utilization of these two programs declined from FY 2016 to FY 2018, but with the recent affiliation with UMMS, Wound Care utilization is expected to level off at the FY 2018 level (see Table 38 below). The IOP / PHP program is expected to grow with the addition of an addictions-focused IOP.

Table 38
UM LRH's Historical and FMF Projected Outpatient Service Utilization
FY 2016 – FY 2024

Department	Two Most Recent Years (Actual)		Current Year	Projected Years					
	FY 2016	FY 2017	FY 2018	FY 2019	FY 2020	FY 2021	FY 2022	FY 2023	FY 2024
Emergency Department	28,620	26,533	25,863	23,959	21,704	21,704	21,704	21,704	21,704
Psych Emergency Department	-	-	-	1,904	1,904	1,904	1,904	1,904	1,904
Observation	1,301	1,443	1,407	1,984	1,822	1,822	1,822	1,822	1,822
Same-day Surgery	1,986	1,883	1,901	1,948	1,997	2,016	2,035	2,055	2,074
Wound Care	4,880	4,492	4,115	4,115	4,115	4,115	4,115	4,115	4,115
IOP / PHP	254	227	229	331	434	538	588	593	599

The IOP / PHP services will be offered in the FMF. The Wound Care program is currently located in a separate building on the UM LRH campus. It will continue to operate in this same building on the campus of UM Laurel Medical Center.

The IOP / PHP services will be offered in the FMF facility. The Wound Care program is currently located in a separate building on the UM LRH campus. It will continue to operate in this separate building on the campus of UM Laurel Medical Center.

11. Identify the physician staffing costs associated with operation of the proposed FMF. Are these costs included in Tables J, K, and L? Please clarify.

Applicant Response

Included in the financial projection for the FMF are $4.4 million of professional fees in FY 2019 growing to $5.0 million by FY 2024 for physician services to be provided at the FMF. These professional fees reflect payments for physician services to be provided in the following departments:

- Emergency Room
- Observation (Hospitalists)
- Surgery
- Anesthesiology
- Radiology
- Pathology
- Mental Health
- Wound Care

In addition to the professional fees, there is $1.4 million of support to Dimensions Healthcare Associates in FY 2019 growing to $1.9 million by FY 2024 that is included in the financial projection to fund operating losses at four (4) growing to six (6) physician practices on or near the UM Laurel Medical Center campus. This support is classified as contractual services in Tables J and K provided as Exhibit 1 of UM LRH's FMF Application. Neither the professional fees nor the contractual services are considered labor related costs, so they are not included in Table L.

Construction Cost, COMAR 10.24.19.04C(8)(h)

12. Regarding the extraordinary cost adjustments claimed for Minority Business Enterprise Premiums ("MBE") for site costs, building costs, and fixed costs, explain why it is appropriate and necessary to claim such adjustments. Why should it cost more than market rates to include MBEs in the firms constructing the proposed project?

Applicant Response

Generally, construction projects do not have goals related to inclusion of Minority Business Enterprises in their construction projects because including MBE requirements may not be the most competitive pricewise. Hiring MBE subcontractors or using MBE suppliers is not the least expensive option. However, UMMS and local government share the same priority and mission of inclusion of MBE contractors and suppliers in construction projects. UMMS attempts to include 25% of the construction projects' costs to go to MBE qualified subcontractors or suppliers. Accordingly, UMMS embeds the higher MBE costs in its estimates and budgeting. UMMS believes that the cost of using MBE subcontractors and suppliers is not represented in the average cost of hospital construction, and therefore, makes this adjustment in the MVS analysis.

13. Explain why the MBE adjustments were estimated at 4% and why you consider this figure to be conservative.

Applicant Response

UMMS consulted with its cost estimators/construction managers on the impact on project budgets of targeting 25% inclusion of MBE subcontractors or suppliers as part of its projects, and their conservative estimate is that it adds 3-4% to the costs, compared to projects that do not include MBE subcontractors or suppliers. This estimate has been confirmed through UMMS' experience with past construction jobs. UMMS now uses this percentage in all of its construction cost estimates.

August 3, 2018

Table of Exhibits

Exhibit	Description
13	HSCRC Response to UMMS Letter Regarding PG Health Care Reconfiguration
14	Financial Assistance Program Summary
15	Urgent-vs-Emergent Care Flyer
16	UM LRH - Patient Care Scenarios
17	Community Engagement Overview
18	NEDOCS scores / color codes

Table of Tables

Table	Description

EXHIBIT 13

November 21, 2017

Henry J. Franey
Chief Financial Officer
University of Maryland Medical System
250 W. Pratt Street, 24th Floor
Baltimore, MD 21215

Dear Mr. Franey:

Thank you for your letter dated October 30, 2017 (Attachment A) outlining financial considerations for the transition of Laurel Regional Hospital ("LRH") to a Freestanding Medical Facility ("FMF"). As you are aware, the HSCRC previously wrote a letter to the Maryland Health Care Commission (Attachment B) in connection with the Prince George's Hospital replacement facility CON review, expressing our support for using system-wide approved global budgets ("the GBR") as services are consolidated and redistributed within the Dimensions System. We expressed our view that we supported this approach to obtaining the capital funds that would be needed to pay the debt service on the new Prince George's Regional Medical Center. In addition, the State and Prince George's County are providing considerable support for the building project, which will not need to be funded out of the GBR.

The HSCRC also understands that there are a number of transition steps necessary to modernize, improve, and reconfigure the delivery of care in the two facilities and in Prince George's County. The HSCRC remains committed to working closely with UMMS and Capital Region Health, formally Dimensions System, as you work through this multi-year process.

We favor your approach that new revenue will not need to be added to the Maryland health system to support this reconfiguration. UMMS has provided a number of details and assumptions about the expected flow of funds. HSCRC supports reasonable revenue redistribution to accomplish this project and modernization, and we will work closely with you as the changes materialize. HSCRC also understands that the system may take some time to improve its efficiency, and that the capital costs may contribute to the need for higher retained revenues. HSCRC will plan to look at the facts and circumstances, which will include system needs, the impact on Medicare and other payers, the disposition of services, the level of cost per case and per capita, and other factors as needed.

Thank you for all of the information you have provided and for the opportunity to work closely with you to improve and modernize care for the residents of Prince George's County.

Sincerely,

Donna Kinzer
Executive Director

EXHIBIT 14

UNIVERSITY of MARYLAND
CAPITAL REGION HEALTH

Help for Patients to Pay Hospital Care Costs

If you cannot pay for all or part of your care from our hospital, you may be able to get **free** or **lower cost** services.

PLEASE NOTE:

1. We treat all patients needing emergency care, no matter what they are able to pay.
2. There may be services provided by physicians or other providers that are not covered by the **hospital's** Financial Assistance Policy.
3. Services provided at one of the UM Capital Region Health clinics may be considered for financial assistance at that clinic or practice. You can call 301-618-6979 or 301-618-2273 if you have questions.

HOW THE PROCESS WORKS:

When you become a patient, we ask if you have any health insurance. We will not charge you more for hospital services than we charge people with health insurance. The hospital will:

1. Give you information about our financial assistance policy or
2. Offer you help with a counselor who will help you with the application.

HOW WE REVIEW YOUR APPLICATION:

The hospital will look at your ability to pay for care. We look at your income and family size. You may receive free or lower costs of care if:

1. Your income or your family's total income is low for the area where you live, or
2. Your income falls below the federal poverty level if you had to pay for the full cost of your hospital care, minus any health insurance payments.

PLEASE NOTE: If you are able to get financial help, we will tell you how much you can get. If you are not able to get financial help, we will tell you why not.

HOW TO APPLY FOR FINANCIAL HELP:

1. Fill out a **Financial Assistance Application Form**.
2. Give us all of your information to help us understand your financial situation.
3. Turn the Application Form into us.

PLEASE NOTE: The hospital must screen patients for Medicaid before giving financial help.

OTHER HELPFUL INFORMATION:

1. You can get a **free copy** of our Financial Assistance Policy and Application Form:
   - *Online* at www.umcapitalregion.org
   - *In person* at the Financial Assistance Office Prince George's Hospital Center, 3001 Hospital Drive, Cheverly, MD, 2nd floor, Eligibility Services/Financial Assistance Program
   - *By mail* by sending your request to:

     Financial Assistance Program
     Prince George's Hospital Center
     3001 Hospital Drive 2nd Floor
     Cheverly, MD 20785
2. You can call the **Financial Assistance Office** if you have questions or need help applying. You can also call if you need help in another language. Call: 301-618-3250.

Updated 02 01 2017

EXHIBIT 15

Emergency Room or Urgent Care?

When you or a family member needs immediate medical attention, you may not always need to visit the emergency department. **Use this reference guide** to help you decide your best choice for care.

When to Visit Emergency Room


Stomach or Chest Pain


Babies Needing Immediate Care


Eye or Head Injuries


Serious Burns


Stroke Symptoms (Numbness, paralysis, slurred speech)


Trouble Breathing


Heart Attack Symptoms (Chest pain with nausea, sweating, shortness of breath)


Severe Cuts (Requires stitches)


Possible Drug Overdose or Poisoning


Broken Bones


High Fevers

When to Visit Urgent Care


Allergic Reactions


Dental Pain


Sprains & Strains


Minor Cuts


Mild Fevers


Minor Burns


Pink Eye


Animal or Insect Bite


Cold & Flu Symptoms

When in doubt, dial 911

University of Maryland Capital Region Health

umcapitalregion.org

EXHIBIT 16

54 year old female

- Type II Diabetic
- Increased thirst
- Elevated blood sugar on finger stick

Right Care

Non-emergency care	**Emergency care**	Complex care

Right Time

Prevention	**At risk**	High risk

Right Setting

Urgent care	**UM Laurel Medical Center**	Full service hospital

60 year old male

- Motor vehicle crash
- EMS determines if he needs to be flown out by helicopter to receive care*

*MIEMSS protocol and physician in charge determines appropriate site of care

Right Care

Non-emergency care	Emergency care	**Complex care**

Right Time

Prevention	At risk	**High risk**

Right Setting

Urgent care	**UM Laurel Medical Center**	**Trauma Center UM PGHC or UMMC**

27 year old female

- Depression
- Substance abuse
- Requires psychiatric evaluation

Right Care

Non-emergency care	**Emergency care**	Complex care

Right Time

Prevention	At risk	**High risk**

Right Setting

Urgent care	**UM Laurel Medical Center**	Full service hospital

30 year old male

- Seizure disorder
- Experiencing a seizure

Right Care

Non-emergency care	**Emergency care**	Complex care

Right Time

Prevention	**At risk**	High risk

Right Setting

Urgent care	**UM Laurel Medical Center**	Full service hospital

20 year old female

- Low-grade fever
- Persistent cough
- Sore throat

Right Care

Non-emergency care	Emergency care	Complex care

Right Time

Prevention	**At risk**	High risk

Right Setting

Urgent care	UM Laurel Medical Center	Full service hospital

19 year old female

- History of asthma
- Low-grade fever
- Shortness of breath

Right Care

Non-emergency care	**Emergency care**	Complex care

Right Time

Prevention	**At risk**	High risk

Right Setting

Urgent care	**UM Laurel Medical Center**	Full service hospital

EXHIBIT 17

UNIVERSITY of MARYLAND
LAUREL REGIONAL HOSPITAL

Overview: UM Laurel Regional Hospital Engagement Activities

To optimize community interaction and transparent communication, UM Laurel Regional Hospital (UM LRH) and UMMS established a community engagement team, involving perspectives from across multiple disciplines, including:

- Marketing, Communications & Community Health
- Ambulatory Services/Population Health
- Volunteer Services
- Executive Team
- Medical Staff Office
- External Affairs
- Project Management
- External Affairs

Community Engagement Team Members	
• Jania Matthews, Sr. Director, Media Relations & Corporate Communications • Cynthia Atkins, Medical Staff Office, UM LRH • Alison Brown, Sr. VP & Chief Strategy Officer, UMMS • Dr. Trudy Hall, Interim President, UM LRH • Lisa Hardesty, Performance Improvement Project Manager • Michael Jacobs, VP Community Health • Donna Jacobs, Sr. VP, Government, Regulatory Affairs and Community Health • Kristin Jones Bryce, VP External Affairs	• Karen Lancaster, VP Media Relations &Corporate Communications • Mary Lanham, VP Marketing • Hon. Valerie Nicholas, Volunteer Services Coordinator, UM LRH • Linda Pohland, Auxiliary President, UM LRH • Chante Sedwick, Sr. Director Marketing & Communications • Tiffany Sullivan, Sr. VP Clinical Integration & Ambulatory Services • Sabra Wilson, Community Health Program Manager

The team also engages with partners in Human Resources and external parties as appropriate to give visibility to activities and events. The group coordinates its efforts to engage the community on what they can expect from UM LRH now and in the future. Recent and future activities include:

Community Engagement Activities

- **Nursing Job Fair: December 6, 2017**
  A nursing job fair held at LRH to attract nurses to fill open positions across UM Capital Region Health System resulted in **39 RSVPs** prior to the fair and **46 attendees.** To-date, seven job offers have been extended and we anticipate extending 3-5 additional offers.

- **Community Health Fair: December 8, 2017**
  UM LRH hosted a community health fair and offered flu vaccinations, health screenings (blood pressure, cholesterol, podiatry and carotid artery screenings) health education and health lectures. **Thirty different** vendors participated (combination of internal specialty areas and external vendors) and **80 attendees** from Laurel and surrounding communities attended.

- **City of Laurel Health Fair: January 28, 2018**
  UM LRH participated in the City of Laurel's first health fair. We had a well-attended booth and provided **60 cholesterol screenings**, **30 flu shots** and **40 balance tests**. More than 150 people attended the event.

Marketing Collateral

- New brochure highlighting the services offered at UM LRH and to reinforce that the hospital remains open.

- Emergency Room vs. Urgent Care
  One-page document that outlines when to seek care from an emergency room or urgent care facility.

Forging Relationships for Collaboration

- Working closely with the City of Laurel's communications department to cross-promote activities/events via social media and utilize digital screens for additional promotion.

UNIVERSITY of MARYLAND
LAUREL REGIONAL HOSPITAL

Overview: UM Laurel Regional Hospital Engagement Activities

Community Outreach Activities

Organization/Group	Date
Laurel-area Pastor's Group	February 2018
West Laurel Civic Association	February 2018
Laurel-area Pastor's Group	April 2018

Advocacy Outreach Activities

Organization/Group	Date
The Institute for Creative Community Initiatives (ICCI), a nonprofit organization dedicated to empowering youth, adults, and families in vulnerable communities to address issues confronting their physical and mental health and overall well-being.	November 2017

Healthcare Outreach Activities

Organization/Group	Date
Patuxent River & Rehabilitation Center	January 2018
Selborne House of Laurel, Senior Living Facility	January 2018
Victoria Falls, Senior Living facility	February 2018
Laurel Beltsville Activity Center	February 2018
Cherry Lane Nursing Center	February 2018
Morningside	March 2018

Elected Officials

Organization/Group	Date
Prince George's County Council	January 2018
Mayor and New City Council Briefing	February 2018

Employee Outreach Activities

Organization/Group	Date
Employee Town Hall	August 2017
UM LRH Auxiliary	October 2017
Employee Forum on Transition	November 2017
Employee Town Hall	January 2018
Employee Forum on Transition	March 2018

EXHIBIT 18

Condition	Green	Yellow	Orange	Red	Black
NEDOCS Score (Performed every 4 hours)	<61	61-100	101-140	141-180	>180
Alternative Criteria	All of the following bed availability criteria: 1. ICU ≥ 3 2. IMCU ≥ 4 3. Telemetry ≥ 4 4. Med/Surg ≥ 4	Two of the following bed availability criteria: 1. ICU ≤ 2 2. IMCU ≤ 3 3. Telemetry ≤ 3 4. Med/Surg ≤ 3	Two of the following bed availability criteria: 1. ICU ≤ 1 2. IMCU <2 3. Telemetry ≤ 2 4. Med/Surg ≤ 2	All of the following bed availability criteria: 1. ICU = 0 2. IMCU = 0 3. Telemetry ≤ 1 4. Med/Surg ≤ 1	All of the following bed availability criteria: 1. ICU = 0 2. IMCU = 0 3. Telemetry = 0 4. Med/Surg = 0
Status	**Normal**	**Busy**	**Overcrowded**	**Severe**	**Disaster**
Notification *Notification emails to be sent at time of worsening change of status*	None	Hospital administration and management staff email	1. Hospital administration and management staff email 2. Text to ED, floor and hospital leadership	1. Hospital administration and management staff email 2. Surge Code Red announced overhead	1. Hospital administration and management staff email 2. Surge Code Black announced overhead 3. Repeat NEDOCS every 2 hours until clear
Huddle Participants *Participants are expected to respond unless cancelled by Nursing Supervisor, Bed Placement Director*	None	1. ED Charge Nurse 2. ED Physician 3. Administrative Coordinator or Bed Placement Director	1. ED Charge Nurse 2. ED Physician 3. Administrative Coordinatorr or Bed Placement Director	1. ED Charge Nurse 2. ED Physician 3. Administrative Coordinator or Bed Placement Director 4. Floor managers or Charge Nurse 5. Inpatient physician representative 6. Case Management 7. EVS supervisor 8. Radiology 9. Laboratory 10. Bed control and transportation	1. ED Charge Nurse 2. ED Physician 3. Administrative Coordinator or Bed Placement Director 4. Floor managers or Charge Nurse 5. Inpatient physician representative 6. Case Management 7. EVS supervisor 8. Radiology 9. Laboratory 10. Bed control and transportation 11. Hospital administrators or AOC (via phone off hours)
Huddle Topics	None	1. Present and anticipated ED Admissions 2. Potential ED Discharges 3. Administrative Coordinator will present available beds and staffing 4. Staffing issues and solutions	1. Present and anticipated ED Admissions 2. Potential ED Discharges 3. Administrative Coordinator will present available beds and staffing 4. Staffing issues and solutions 5. Reviewing potential downgrades of admitted patients 6. Contact transportation and EVS supervisors to prioritize ED patient placement	All Items as noted in 'Orange', plus: 7. Flex nursing and tech staff to ED to assist with patient care 8. Dedicated transporters will present to ED 9. Lab and radiology representation will review pending orders and increase staffing / presence if necessary 10. Case management to present barriers to inpatient discharge	All Items as noted in 'Red', plus: Consider Diversion Notify hospital leadership as to plan to address crowding issue.
ED Staff	1. Pull to full from triage 2. ATP use when triage provider absent 3. Fax report to floor for admitted patients	1. Pull to full from triage 2. ATP use when triage provider absent 3. Fax report to floor for admitted patients 4. Utilize triage and Result Waiting Area for patient placement where appropriate	1. Pull to full from triage 2. ATP use when triage provider absent 3. Fax report to floor for admitted patients 4. Utilize triage and Result Waiting Area for patient placement where appropriate	1. Pull to full from triage 2. ATP use when triage provider absent 3. Fax report to floor for admitted patients 4. Utilize triage and Result Waiting Area for patient placement where appropriate 5. Notify ED physician admitting teams of need for reevaluation / downgrade	1. Pull to full from triage 2. ATP use when triage provider absent 3. Fax report to floor for admitted patients 4. Utilize triage and Result Waiting Area for patient placement where appropriate 5. Notify ED physician admitting teams of need for reevaluation / downgrade
ED Charge	1. Pull to full from triage 2. Facilitate patient flow from ED to floor or discharge	1. Pull to full from triage 2. Facilitate patient flow from ED to floor or discharge 3. Communicate current needs to Administrative Coordinator / Bed Director 4. Work with ED physicians to facilitate dispositions	1. Participate in huddle 2. Facilitate patient flow from ED to floor or discharge 3. Communicate current needs to Administrative Coordinator / Bed Director 4. Work with ED physicians to facilitate dispositions 5. Request additional staff where needed 6. Contact transport as necessary 7. Consider flex nurse to assist with admissions and discharges	1. Participate in huddle 2. Facilitate patient flow from ED to floor or discharge 3. Communicate current needs to Administrative Coordinator / Bed Director 4. Work with ED physicians to facilitate dispositions 5. Request additional staff where needed 6. Contact transport as necessary 7. Consider flex nurse to assist with admissions and discharges	1. Participate in huddle 2. Facilitate patient flow from ED to floor or discharge 3. Communicate current needs to Administrative Coordinator / Bed Director 4. Work with ED physicians to facilitate dispositions 5. Request additional staff where needed 6. Contact transport as necessary 7. Consider flex nurse to assist with admissions and discharges
ED Attending	1. Minimize door to provider time 2. Utilize Results Waiting Area when appropriate	1. Minimize door to provider time 2. Utilize Results Waiting Area when appropriate 3. When possible, see and dispo patients from triage and Results Waiting Area	1. Participate in huddle 2. Minimize door to provider time 3. Utilize Results Waiting Area when appropriate 4. When possible, see and dispo patients from triage and Results Waiting Area 5. Work with charge nurse to coordinate discharges 6. Assist with contacting inpatient teams regarding downgrades	1. Participate in huddle 2. Minimize door to provider time 3. Utilize Results Waiting Area when appropriate 4. When possible, see and dispo patients from triage and Results Waiting Area 5. Work with charge nurse to coordinate discharges 6. Assist with contacting inpatient teams regarding downgrades 7. Assess need for additional provider / flex from less acute areas	1. Participate in huddle 2. Minimize door to provider time 3. Utilize Results Waiting Area when appropriate 4. When possible, see and dispo patients from triage and Results Waiting Area 5. Work with charge nurse to coordinate discharges 6. Assist with contacting inpatient teams regarding downgrades 7. Assess need for additional provider / flex from less acute areas

Administrative Coordinator or Bed Management Director	1. Ongoing rounding to determine needs within the hospital 2. Share staffing needs at daily huddle 3. Monitor need for surge policy activation regardless of NEDOC status 4. Enter NEDOCS data every 4 hours and coordinate notification	1. Ongoing rounding to determine needs within the hospital 2. Share staffing needs at daily huddle 3. Monitor need for surge policy activation regardless of NEDOC status 4. Assist with identification and facilitation of possible discharges 5. Enter NEDOCS data every 4 hours and coordinate notification	1. Participate in huddle 2. Ongoing rounding to determine needs within the hospital 3. Share staffing needs at daily huddle 4. Monitor need for surge policy activation regardless of NEDOC status 5. Assist with identification and facilitation of possible discharges 6. Coordinate notification of relevant services to respond to surge 7. Enter NEDOCS data every 4 hours and coordinate notification	1. Participate and coordinate response huddle 2. Ongoing rounding to determine needs within the hospital 3. Share staffing needs at daily huddle 4. Monitor need for surge policy activation regardless of NEDOC status 5. Assist with identification and facilitation of possible discharges 6. Coordinate notification of relevant services to respond to surge 7. Consider increase in floor staffing to accommodate volume 8. Consider flex of staff to ED 9. Enter NEDOCS data every 2-4 hours at the discretion of the Admin Coordinator and coordinate notification	1. Participate and coordinate response huddle 2. Ongoing rounding to determine needs within the hospital 3. Share staffing needs at daily huddle 4. Monitor need for surge policy activation regardless of NEDOC status 5. Assist with identification and facilitation of possible discharges 6. Coordinate notification of relevant services to respond to surge 7. Consider increase in floor staffing to accommodate volume 8. Consider flex of staff to ED 9. Enter NEDOCS data every 2 hours and coordinate notification
Transportation		Prioritize ED patient transportation	1. Contact ED charge nurse to determine need for dedicated transportation 2. Prioritize ED patient transportation	1. Present to ED to assist with transportation to floor or necessary diagnostics, Results Waiting Area or discharge 2. Prioritize ED patient transportation 3. Bring wheelchairs and/or stretchers to ED	1. Present to ED to assist with transportation to floor or necessary diagnostics, Results Waiting Area or discharge 2. Prioritize ED patient transportation 3. Bring wheelchairs and/or stretchers to ED 4. Consider requesting additional staffing assistance
Registration	Regular services	Regular services	1. Consider increasing staffing to accommodate front door volume 2. Coordinate bedside registration to achieve rapid patient placement	1. Consider increasing staffing to accommodate front door volume 2. Coordinate bedside registration to achieve rapid patient placement	1. Consider increasing staffing to accommodate front door volume 2. Coordinate bedside registration to achieve rapid patient placement
Bed Control	1. Notify ED when bed is available 2. Inform charge when bed available without admission order 3. One Call: Encourage direct admissions where possible	1. Notify ED when bed is available 2. Inform charge when bed available without admission order 3. One Call: Encourage direct admissions where possible	Prior tasks, plus: 4. Request holding orders from ED attending if bed available	Prior tasks, plus: 4. Request holding orders from ED attending if bed available 5. Notify NC or Bed Director, ED Charge Nurse about assigned bed regardless of EVS status so planning may begin	Prior tasks, plus: 4. Request holding orders from ED attending if bed available 5. Notify NC or Bed Director, ED Charge Nurse about assigned bed regardless of EVS status so planning may begin
Laboratory	Regular services		1. Prioritize ED studies 2. Prioritize studies for boarding patients in ED that may potentially be downgraded	1. Participate in huddle 2. Prioritize ED studies 3. Prioritize studies for boarding patients in ED that may potentially be downgraded 4. Explore sending phlebotomist to ED	1. Participate in huddle 2. Prioritize ED studies 3. Prioritize studies for boarding patients in ED that may potentially be downgraded 4. Explore sending phlebotomist to ED
Radiology	Regular services		1. Management will communicate any pending radiology studies to radiologist for prioritization 2. Explore staffing needs	1. Huddle participation. Discuss pending studies and reads 2. Communicate needs to oncall radiologist to improve TATs 3. Explore staffing needs	1. Huddle participation. Discuss pending studies and reads 2. Communicate needs to oncall radiologist to improve TATs 3. Explore staffing needs
Admitting Doctors	1. Conditional discharge orders 2. Preparation of discharge instructions in advance 3. Communication of plan with nursing		1. Conditional discharge orders 2. Preparation of discharge instructions in advance 3. Communication of plan with nursing 4. Reevaluation of boarding patients for downgrading 5. Identification of additional possible discharges	1. Participate in huddle 2. Conditional discharge orders 3. Preparation of discharge instructions in advance 4. Communication of plan with nursing 5. Reevaluation of boarding patients for downgrading 6. Identification of additional possible discharges	1. Participate in huddle 2. Conditional discharge orders 3. Preparation of discharge instructions in advance 4. Communication of plan with nursing 5. Reevaluation of boarding patients for downgrading 6. Identification of additional possible discharges
Inpatient Units	Regular services	1. Prioritize morning discharges 2. Encourage physicians to prepare discharges in advance 3. Communicate with patients and families plan in advance	1. Prioritize morning discharges 2. Encourage physicians to prepare discharges in advance 3. Communicate with patients and families plan in advance 4. Consider staggering staffing to allow for admissions as all hours (including shift change)	Prior tasks, plus: 1. Participation of management in huddle 2. Bring report on staffing and bed availability, as well as patient needs to huddle 3. Consider sending staff to take report on patients in ED and assist with needs / transport	Prior tasks, plus: 1. Participation of management in huddle 2. Bring report on staffing and bed availability, as well as patient needs to huddle 3. Consider sending staff to take report on patients in ED and assist with needs / transport 4. Consider inpatient hallway placement of boarding patients

Case Management	**ED Case Management:** **1. Assist with admission process** **2. Assist with placement of discharged patients** **3. Medication authorization prior to discharge** **4. Identification of frequent utilizers and appropriate management strategy**	**ED Case Management:** **1. Assist with admission process** **2. Assist with placement of discharged patients** **3. Medication authorization prior to discharge** **4. Identification of frequent utilizers and appropriate management strategy**	**ED Case Management continues** **Inpatient Case management:** **1. Identify discharge barriers** **2. Prioritize daily discharge**	**ED Case Management continues** **Inpatient Case management:** **1. Identify discharge barriers** **2. Prioritize daily discharge** **Both participate in huddle**	**ED Case Management continues** **Inpatient Case management:** **1. Identify discharge barriers** **2. Prioritize daily discharge** **Both participate in huddle**
Environmental Services	**Regular services**	**Regular services**	**1. Shift workers to prioritize cleaning dirty inpatient beds and ED stretchers**	**1. Supervisor participates in huddle** **2. Shift workers to prioritize cleaning dirty inpatient beds and ED stretchers** **3. Supervisor regularly communicates with Nursing Coordinator / Bed Director**	**1. Supervisor participates in huddle** **2. Shift workers to prioritize cleaning dirty inpatient beds and ED stretchers** **3. Supervisor regularly communicates with Nursing Coordinator / Bed Director**