GALLAGHER

GALLAGHER EVELIUS & JONES
ATTORNEYS AT LAW

February 28, 2024

VIA EMAIL & FEDERAL EXPRESS MAIL

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

Re: James Lawrence Kernan Hospital, Inc. *d/b/a* University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, LLC
Request for Exemption from Certificate of Need to Merge and Consolidate Portions of University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center

Dear Ms. Potter:

On behalf of the applicants James Lawrence Kernan Hospital, Inc. *d/b/a* University of Maryland Rehabilitation and Orthopaedic Institute ("UMROI") and University of Maryland Medical Center, LLC ("UMMC"), we are submitting an electronic version, via email and four (4) hard copies of their Responses to Additional Information Questions dated January 25, 2024 and related exhibits. We will be providing a WORD version of the responses under separate email.

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

If you have questions about the information provided above, please contact us at your convenience.

Very truly yours,

Ella R. Aiken, Esq.

Alison B. Lutich, Esq.

cc: Ben Steffen, Executive Director, MHCC

#871869
006551-0232

Wynee Hawk, RN, JD, Director, Center for Health Care Planning & Development, MHCC
Jeanne-Marie Gawel, Acting Chief, Certificate of Need, MHCC
Alexa Bertinelli, Esq., Assistant Attorney General, MHCC
Caitlin E. Tepe, Esq., Assistant Attorney General, MHCC
Stan Lustman, Esq., Assistant Attorney General, HSCRC
Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations, HSCRC
Allan Pack, Principal Deputy Director, Quality and Population-Based Methodologies, HSCRC
Letitia Dzirasa, MD, Baltimore City Health Commissioner
Tonii Gedin, Anne Arundel County Health Officer
Gregory Wm. Branch, MD, MBA, CPE, Baltimore County Health Officer & Director
Lauren Levy, JD, MPH, Cecil County Health Officer
Marcy Austin, Harford County Health Officer
Maura Rossman, MD, Howard County Health Officer
Dana Farrakhan, Dr. PH, MHS, FACHE, Senior Vice President, Strategy, Community and Business Development, UMMC
Scott Tinsley-Hall, Senior Director, Strategic Planning, UMMC
Marina Bogin, CPA, Vice President of Financial Services, Chief Financial Officer, UMROI
Julie Nemens, RN, MSN, Chief Administrative Officer & Senior Vice President, UMROI
Laura Kautz, RA, Director of Planning, Design & Development, UMMS
Alicia Cunningham, SVP Corporate Finance & Revenue Advisory Services, UMMS
Lucas Sater, Director - Revenue and Reimbursement, UMMS
Christopher Tully, Esq., Associate Counsel, UMMS
Emily Wein, Esq., Vice President and General Counsel, UMMC
Marty Chafin, FACHE, President, Chafin Consulting Group, NE
Craig Wheeless

Request for Exemption from Certificate of Need Review

Merger and Consolidation of University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center
Matter No. 23-24-EX-017

Response to Additional Information Questions Dated January 25, 2024, Questions 1, 3-10, 11 in part, 12-18, and 23-24

Applicants to respond to questions 2, 11 in part, and 19-22 no later than March 15, 2024

Background and Project

1. MHCC approved a modification to the original Cancer Center project for the construction of a nine-story addition on the east side of the North Hospital on October 19, 2023 (Docket No. 19-24-2438). Please provide an update concerning UMMC's progress in completing the nine-story Greenebaum Comprehensive Cancer Center.

Applicant Response

The Cancer Center project has completed the initial demolition phase and begun construction of the deep foundations. Support of excavation and foundations will begin in Mid-February 2024 and continue until April 2024.

[Applicants to respond to Question 2 no later than March 15, 2024.]

3. Please respond to the following:

a. Include a site diagram of UM ROI that identifies the current location of the 58 beds that will be relocated to UMMC and the future plan for that space.

Applicant Response

Please see **Exhibit 9**[1] attached. With respect to the future plan for this space, UMMS is in the process of evaluating long-term plans for delivery of services on the UMROI campus, as discussed more fully in response to Question 4 below.

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[1] Exhibits 1 through 8 are included in Applicants' Request for Exemption. Exhibits are consecutively numbered to continue from the Request, beginning with Exhibit 9 in this filing.

b. Regarding the type of services offered, list the top 10 CPT codes served in the TBI, SCI, and chronic care beds at UMROI now, and projected after the beds are moved.

Applicant Response

Please see **Exhibit 10** attached, which provides the top ten procedure codes served in the TBI, SCI, and chronic care beds at UMROI. The Applicants have provided the top ten ICD-10 codes as opposed to CPT codes, which are used for outpatient services only. The Applicants do not anticipate any change in the top ten codes after the beds are moved.

4. Please discuss the future plans and timeline for the remaining health care services provided at UM ROI.

Applicant Response

Over the last several years, UMMS has engaged in targeted strategic planning regarding the delivery of acute inpatient rehabilitation services at UMROI, with a focus on ensuring that Marylanders have access to the highest quality care in the most effective setting. This planning has involved an evaluation of both clinical and financial measures to identify the ideal care delivery model for the future. As a result of this strategic planning, UMMS determined that patients suffering from serious trauma, who receive world class trauma treatment at UMMC's Shock Trauma Center, would benefit most from receiving their post-acute care on the same campus, for reasons described more fully in the Applicants' Exemption Request. UMMS thus made the decision to pursue the current project to relocate UMROI's post-trauma acute inpatient rehabilitation service lines from UMROI to UMMC.

In addition to the decision to pursue the Exemption Request, UMMS also determined that a modern, freestanding acute inpatient rehabilitation facility may be the most effective setting to treat UMROI's current volumes of non-trauma rehabilitation patients. In June 2023, UMMS announced that it was investigating new locations in Baltimore County to provide such non-trauma rehabilitation care and that it plans to partner with local and state leaders to examine possible future uses for the current UMROI campus if a new freestanding facility is constructed. UMMS is also continuing to evaluate the continued provision of these non-trauma rehabilitation services at the existing UMROI campus.

UMMS is still engaged in the process of evaluating the cost-effectiveness of such a plan and the appropriateness of potential future sites to provide non-trauma rehabilitation care. At this time, UMMS has not yet identified a potential site or confirmed a decision to relocate these services. UMMS remains committed to preserving access to non-trauma rehabilitation services and intends to continue to provide such services at the existing UMROI campus as it continues to evaluate and finalize its long-term plans for the most clinically appropriate and cost-effective care for these services.

Concurrent with the relocation of the beds that are the subject of the Exemption Request to UMMC, UMROI's acute care hospital and surgical volumes will be absorbed by existing OR capacity and acute hospital capacity, primarily within the UMMS system. UMROI will also shift its outpatient clinic volumes to other UMMS campuses, primarily UMMC Midtown.

While UMMS continues to evaluate long-term plans for the location of the delivery of inpatient rehabilitation services in the region, including at a potential new freestanding facility, UMROI will continue to offer non-trauma-related inpatient rehabilitation services at the existing UMROI campus. Specifically, UMROI will provide neurology and stroke rehabilitation services and comprehensive medical rehabilitation services. UMROI intends to pursue an exemption from rate regulation from the HSCRC for all services that will remain on the UMROI campus after project completion.

5. **With the following questions, please respond to the project's budget and financial capacities:**

   a. **Please discuss whether UMMC and UM ROI will seek an adjustment to its global budget revenue (GBR) agreement and if so, what is the status of the negotiations with the Health Services Cost Review Commission?**

Applicant Response

UMMC and UMROI are not seeking a rate increase in connection with the project. The Applicants instead anticipate shifting GBR revenue, as described more fully in the February 14, 2024 Staff Recommendation, as adopted by the Health Services Cost Review Commission on February 14, 2024. *See* **Exhibit 11.**

   b. **Are the costs for closing these 58 beds included in UMMC's Project Budget, and if so, please identify these costs.**

Applicant Response

The cost of decommissioning the beds at the existing UMROI facility are not included in the project budget. UMMS and UMROI have separately budgeted for the closure of beds at UMROI apart from the Exemption Request, which concerns the relocation and merger of beds from UMROI to UMMC.

As described in response to Question 4, UMMS and UMROI are still investigating the most clinically appropriate and cost-effective option for the future of non-trauma services that UMROI currently provides. However, the parties expect that should UMROI operate non-trauma beds at the existing campus following completion of the Exemption Request project, the remaining beds at UMROI will move into the wing vacated by the relocated beds, as that wing is newer and in better condition. Some minor renovation and minimal infrastructure will be required, in the range of about $3 million.

Applicant Response

Please see the response to Question 5(a) above. Applicants do not seek a rate increase.

6. Please provide a table illustrating the number of psych beds in UMMC North Tower before and after in Stoler Tower, floors 9, 10, and 11, after. Please also confirm the following project information:

Table 20
Psychiatry Beds Before and After the Project

Before the Project							After Project Completion						
Hospital Service	Location (Floor/Wing)*	Licensed Beds: July 1, 2023	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count Physical Capacity	Hospital Service	Location (Floor/Wing)*	Based on Physical Capacity: Room Count Private	Semi-Private	Total Rooms	Bed Count Physical Capacity
ACUTE CARE							**ACUTE CARE**					
Child and Adolescent Psych	Child and Adolescent N11W	16	16	0	16	16	**Child and Adolescent Psych**	Child and Adolescent N11W	16	0	16	16
Adult and Geriatric Psych	Adult North12W, Geriatric North12E	28	2	13	15	28	**Adult and Geriatric Psych**	North11E and CAM 11 Adult/Geri Psych	22	0	22	22
TOTAL ACUTE		**696**	**517**	**72**	**589**	**661**	**TOTAL ACUTE**		**595**	**41**	**636**	**677**

See the response to 6(a) below for more details regarding the locations of the above referenced beds within UMMC, before and after the project.

a. The application inconsistently describes the loss of 26 "psychiatric beds" and "26 psychiatric rooms" on Floor 12 and 27 medicine beds on Floor 13 of the North Hospital. Please state where these beds will be relocated within UMMC (pg. 7 and 10).

Applicant Response

Adult and Geriatric Psychiatry Beds

Adult psychiatry is currently in the North Building, Floor 12, west wing. The unit has 15 beds (1 private, 14 semi-private). Geriatric psychiatry is currently in the North Building, Floor 12, east wing. The unit has 13 beds (1 private, 12 semi-private). Altogether, there are currently 28 adult/geriatric psychiatry beds.

As a result of the project, adult and geriatric psychiatry patient beds will move to a new unit on Floor 11 of the new Stoler Center with 22 private beds. The adjacent space in the North building, Floor 11, east wing, will be used as support space for both the adult, geriatric and child psychiatry populations. Sally-port entrances between the support space and both child and adult psychiatry units will be created to assure separation of these populations.

Medicine Beds

The 27 medicine beds that will be lost due to removing windows are as follows:

- 10 beds are in the North Building, Floor 10, east wing. They include 2 private beds and 8 semi privates.
- 11 beds are in the North Building, Floor 11, east wing. They include 3 private beds and 8 semi privates.
- 3 beds are in the North Building, Floor 12, east wing. They include 1 private bed and 2 semi privates.
- 3 beds are in the North Building, Floor 13, east wing. They include 1 private and 2 semi privates.

These 27 beds will be recovered within the 22 new private beds on Floor 10 of the Stoler Center and the new 16 private beds on Floor 9 of Stoler Center.

b. Are relocation costs for these beds included in the Project Budget? If so, please indicate where.

Applicant Response

$1,000,000 has been allocated to cover the costs of activation, including a move consultant, additional equipment, and staff coordination. Specifically related to Table E, $850,000 is allocated in line A.1.c.1 Movable Equipment; and $150,000 is in line A.2.d2 Non-CON Consulting Fees (other).

7. The applicant states that UMMC will locate adult and geriatric psychiatric services adjacent to the existing child psychiatric unit, allowing for one full-locked floor. Provide more detail as to how UMMC will develop two distinct therapeutic areas for treatment. Will the applicants segregate the adult and geriatric program from the child program, and what provisions will be in place for the care and safety of these two distinct patient populations?

Applicant Response

After project completion, all psychiatric beds will be located on Floor 11. Floor 11 has an East and a West wing, and will gain adjacent space in the new Floor 11 of the Stoler Center tower. The West wing is where the child/adolescent unit currently exists, and the project will not involve moving or renovating this space as it is now. The relocated adult/geriatric psychiatry unit will be located on the East side of Floor 11 in the North Tower plus Floor 11 of the new Stoler Center tower. Between the East and West wing is a common elevator bank by which the floor is granted access. This is where patients, staff, and visitors will be provided access to the floor. Both the East and West wings will have sally-ports separating them from the common elevator bank as an elopement prevention measure, and in compliance with best practice and code. The child/adolescent psychiatry and adult/geriatric psychiatry treatment spaces will be completely separate

from one another and will each be limited to their respective wings. The entirety of Floor 11 will be intended for and available only for psychiatric use, with access controlled. This will enable UMMC to consider and implement other safeguards, such as restriction on elevator access to leave the floor if feasible and necessary.

8. **On pg. 15, the applicants state that UMROI cannot accept patients with unique needs such as chemotherapy to acute impatient rehabilitation services. What other "unique need" patients are unable to utilize inpatient rehabilitation services and please quantify the number of those patients, including cancer patients that would benefit from the introduction of inpatient rehabilitation services at UMMS?**

Applicant Response

The patients UMROI cannot currently accept are those patients who are actively undergoing chemotherapy and radiation treatment for cancer. The Applicants project an average daily census of three to four of these patients will be able to be treated in the new units following project completion. This projection is based on UMMC's current cancer patient population and the clinical expertise of the UMMC Cancer Center's clinical staff. An affirmation of the Director of Nursing at the UMMC Cancer Center accompanies these responses.

9. **In the process of determining the relocation of UMROI to UMMC, please comment on the stakeholder considerations or support for the proposed project. How does the hospital plan to communicate with and involve the local community in the decision-making process and address concerns or feedback from residents? What are the community outreach plans to inform residents about the enhanced services available at the new rehab center?**

Applicant Response

Stakeholder Considerations

UMROI/UMMC considered the following as it relates to stakeholder considerations:

1. Patient convenience of TBI and Spinal cord patients – Patients will be able to transfer to the rehab service on the same campus without transporting via ambulance to another facility.

2. Targeted high volume patient populations that are transferred from STC to UMROI and patients that would likely need access to complex subspecialty care.

Resident Input

Once the proposed plans and options for the unregulated hospital of the UMROI program are finalized, UMMS will inform local community leaders and residents of the proposed enhanced /reconfigured rehabilitation services. At that time, UMMS will share the proposed plans with the community regarding the new enhanced rehabilitation service.

UMMS community outreach plan will include:

1. UMMS will host a town hall meeting to inform the community about the plan;

2. UMMS will send an email through local government official communication channels; and

3. UMMS officials will attend local community neighborhood association meetings to share and seek feedback of our plans.

10. What steps will be taken to minimize disruption for current patients and their families during the transition process? Will patients be transferred to UMMS or will UMMS just accept new patients?

Applicant Response

A significant activation planning effort will take place during the Phase 2 construction of the Stoler Center in order to prepare for the move and decommissioning of the beds at UMROI. It is anticipated that all patients will move in one to two days, per floor. During these transition days, some staff will be present at UMMC to receive patients, and the rest of the staff will travel to UMMC at the time their patients are transferred.

STATE HEALTH PLAN: Acute Care Hospital Services

11. Please respond to the following:

a. COMAR 10.24.10, State Health Plan for Facilities and Services: Acute Care Hospital Services, specifically information regarding charges, and cost effectiveness.[2]

[2] Applicants note that Question 11 identifies a subpart "a" only; it has no further subparts.

Applicant Response

Information Regarding Charges

[Applicants to respond no later than March 15, 2024.]

Cost Effectiveness

The Applicants propose a project involving limited objectives – namely, relocating the TBI and SCI inpatient rehabilitation service lines from UMROI to UMMC. The primary goal of this project is to reunify these acute inpatient rehabilitation services for patients who most frequently experience traumatic brain and spinal cord injuries following a traumatic event, with the world-class trauma care provided at STC on the downtown campus of UMMC. As a result, the only practical approach to achieving the objectives of this reunification, which will improve the efficiency, quality, and effectiveness of clinical care delivery for this highly complex patient population, is to undertake the project as outlined by the Applicants in their request for exemption from CON review. The Applicants are therefore not required to identify two alternative approaches that they considered for achieving the objectives of the project. *See* COMAR 10.24.10.04B(5)(b).

While the Applicants do not need to demonstrate that the approach determined for the project is more cost effective than certain alternatives, the Applicants emphasize that significant cost savings will be realized by undertaking the project at this time. Adding the additional four floors to the Stoler Center now, while it is currently under construction, will enable the Applicants to avoid many project development costs. The project will result in significant savings on escalation costs because the Phase 1 new work can be commenced approximately 12-18 months sooner than would be possible for a traditional freestanding project. For additional details regarding the cost savings associated with constructing the project concurrent with the construction of the original nine-story Stoler Center building, please see pages 4-5 of the Exemption Request.

STATE HEALTH PLAN: Acute Inpatient Rehab Services

Quality of Care

12. **Please provide documentation illustrating that UMMC complies with Medicaid/Medicare standards (pg. 26).**

Applicant Response

As a condition of licensure in Maryland, hospitals must be CMS certified. UMMC is licensed as an acute general hospital, meaning it maintains CMS certification. UMMC's hospital license was attached to the Exemption Request as **Exhibit 7**.

To maintain CMS certification, a state survey agency (or other authorized survey authority, such as the Joint Commission) conducts an initial survey and periodic resurveys, including complaint surveys, of a hospital to confirm that the hospital meets the applicable requirements for participation in the Medicare and Medicaid programs as set forth in Title 42 of the Code of Federal Regulations. UMMC is accredited by the Joint Commission and is periodically surveyed by that organization to determine UMMC's compliance with the conditions of participation in Medicare and Medicaid. UMMC's last Joint Commission survey was completed in May 2021. This survey confirmed that UMMC is in compliance with the applicable requirements to participate with Medicare and Medicaid. A copy of UMMC's Joint Commission accreditation is attached hereto as **Exhibit 12**.

13. **Please provide documentation that UMROI is currently accredited with the Commission for Accreditation of Rehabilitation Facilities (CARF) or a recognized accreditation organization for TBI and SCI services.**

Applicant Response

See **Exhibit 13**.

14. **Regarding subparagraph (b), as an existing acute inpatient rehabilitation service that seeks to relocate SCI and TBI services to a new location (UMMC), please respond to this standard with regard to whether UMROI meets all quality measures as required by federal regulations or State agencies.**

Applicant Response

As a condition of licensure in Maryland, special rehabilitation hospitals like UMROI are subject to inspection by the Department of Health to determine compliance with state and federal quality requirements, follow up on concerns identified by an accreditation department, investigate a complaint, or validate the findings of an accreditation organization approved by the Department of health. COMAR 10.07.01.07B. As a Joint Commission and CARF-accredited hospital, UMROI is subject to survey and oversight to evaluate and confirm its compliance with all applicable quality measures. As evidenced by its CARF and Joint Commission accreditations, UMROI is currently in compliance with all applicable quality measures. See **Exhibits 13, 14**.

15. **Please cite the source for the information provided on pg. 27 in the last full paragraph that UMROI has high marks in patient quality and satisfaction in its treatment of the SCI and TBI patients.**

Applicant Response

UMROI submits and receives outcome comparative data through Uniform Data Systems. UMROI's data is collected through the Inpatient Rehab Facility- Patient Assessment Instrument, which is then compared to regional and national data. Over 900

rehab facilities in the United States use this database. UMROI's patient satisfaction data is reported to it from Press Ganey, a national company that develops and distributes patient satisfaction surveys. Summaries of UMROI's outcome and patient satisfaction measures were provided in the CON Exemption Request in **Exhibit 8**.

Construction Costs

16. **On pg. 49, please provide the assumption or basis for the use of 40% cost adjustment included in the Cancer Center MVS analysis for the nine floors plus the mechanical penthouse.**

Applicant Response

The ten floors included in the UMMC Cancer Center project are comprised of nine floors of clinical, administrative, and public spaces plus a tenth floor for the mechanical penthouse. The relocation of certain beds from UMROI to UMMC adds four floors to the Cancer Center project. The resulting fourteen floors represent a 40% increase over the ten floors associated with the Cancer Center project. As such, many of the project related costs associated with the current inpatient rehabilitation relocation project are estimated to equal 40% of the comparable costs associated with the Cancer Center project. We applied this 40% assumption to the Cancer Center project cost adjustments (as included in the Cancer Center MVS analysis) to calculate the project cost adjustments for the current inpatient rehabilitation relocation project MVS analysis.

Safety

17. **Please specify what guidelines are directing the design of the acute inpatient rehabilitation and chronic care bed units at UMMC (pg. 55-56) (i.e. AIA guidelines, use of FGI metrics, general contractor, other sources).**

Applicant Response

The list of codes currently accepted by Baltimore City are provided in Table 21 below. In addition to these codes, the designers will also utilize the 2022 FGI Guidelines, which provide the minimum requirements for basic rehabilitation facilities. The designers will also need to consider feedback from UMROI clinicians regarding space required to properly care for, rehabilitate, and maneuver patients with severe, life-altering injuries. Nearly all of these patients require powered wheelchairs, which are larger than regular wheelchairs. Storage of these wheelchairs and specialty components is also greater than provided for in FGI guidelines. Similarly, the amount of gym space to support the rehabilitation of these kinds of injuries is significantly larger than FGI minimums.

Table 21
List of Codes Provided by Baltimore City

APPLICABLE CODES / STANDARDS

AUTHORITY HAVING JURISDICTION: *BALITMORE CITY*

(BCBFRC)

BALTIMORE CITY BUILDING, FIRE, AND RELATED CODES 2020

AND REFER TO THE FOLLOWING CODES:

INTERNATIONAL CODE COUNCIL		
IBC	INTERNATIONAL BUILDING CODE	2018
IECC	INTERNATIONAL ENERGY CONSERVATION CODE	2018
IFC	INTERNATIONAL FIRE CODE	2018
IgCC	INTERNATIONAL GREEN CONSTRUCTION CODE	2018
IMC	INTERNATIONAL MECHANICAL CODE	2018
IPC	INTERNATIONAL PLUMBING CODE	2018

ADDITIONAL GUIDELINES		
(ASHRAE)	ANSI/ASHRAE/IES STANDARD 90.1	2013
ASME	SAFETY CODE FOR ELEVAORS & ESCALATORS A17.1	2016

NATIONAL FIRE PROTECTION ASSOCIATION		
NFPA 1	FIRE CODE	2018
NFPA 10	STANDARD FOR PORTABLE FIRE EXTINGUISHERS	2018
NFPA 13	INSTALLATION OF SPRINKLER SYSTEMS	2016
NFPA 14	STANDARD FOR THE INSTALLATION OF STANDPIPE AND HOSE SYSTEMS	2016
NFPA 70	NATIONAL ELECTRICAL CODE	2014 2017
NFPA 72	NATIONAL FIRE ALARM AND SIGNALING CODE	2016
NFPA 101	LIFE SAFETY CODE	2018

ACCESSIBILITY GUIDELINES		
ADA	ADA STANDARDS FOR ACCESSIBLE DESIGN BY THE U.S. DEPARTMENT OF JUSTICE	2010
MAC	MARYLAND ACCESSIBILITY CODE	2012

Financial Feasibility

18. On pg. 58-59, the applicants state that "other acute care facilities within the UMMS system" may receive referrals "in the event UMMC lacks capacity for patients [who need to be admitted to the inpatient rehabilitation unit] but who exceed the unit's level of care capabilities." Please indicate which facilities these are.

Applicant Response

Following completion of the project, UMMC's acute inpatient rehabilitation unit will have the highest level of care capabilities of all inpatient rehabilitation units in the State. As a result, if a patient exceeds the unit's level of care capabilities, such patient would require transfer to an acute general hospital inpatient unit. UMMC will admit patients in need of inpatient acute general hospital level of care from the UMMC inpatient rehabilitation units so long as it has available inpatient beds. If necessary, UMMC would treat the patient in its Critical Care Resuscitation Unit for emergent concerns. In the event that UMMC lacks available inpatient beds, the University of Maryland Access Center will be responsible for identifying an available and appropriate bed for the patient. Patients would be transferred to other UMMS acute general hospitals with an appropriate inpatient

bed, including but not limited to UM Midtown, UM St. Joseph's Medical Center, and UM BWMC.

STATE HEALTH PLAN: Chronic Care

[Applicants to respond to Questions 19 through 22 no later than March 15, 2024.]

23. **Regarding UMMC's Tables G, H, J, and K, please clarify whether these tables represent Revenue and Expenses in millions (000) or as reported.**

Applicant Response

These tables are reported in thousands (000).

Exhibit 2

24. **Regarding Exhibit 2, the line diagram for the proposed adult and geriatric psychiatric unit on Floor 11 shows 22 patient rooms, but narrative states there will be an 20 beds after project completion. Please reconcile and confirm whether the adult & geriatric psychiatric unit will have 22- or 20-beds after project completion.**

Applicant Response

There will be 22 fully-private adult and geriatric psychiatry beds following project completion.

Table of Exhibits

Table of Tables

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/8/2024

Date

DocuSigned by:
Suzanne Cowperthwaite
F99506B99DC04A2...

Suzanne Cowperthwaite, DNP, RN, NEA-BC
Director of Nursing
University of Maryland Marlene and Stewart Greenebaum Comprehensive Cancer Center

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Brian Sturm
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Brian Sturm
Vice President, Corporate Decision Support & Capital Planning
University of Maryland Medical System

#861759
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024	DocuSigned by: Craig Wheeless 0574DA73A9D44E1...
Date	Craig Wheeless, CHFP

#861752
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Dana Farrakhan
92D6FF1677BD42F...

Dana Farrakhan, Ph.D., MHS, FACHE
Senior Vice President, Strategy,
Community and Business Development
University of Maryland Medical Center

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2/6/2024

Date

DocuSigned by:
Daniel Shelly
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Daniel Shelly
Vice President of Operations
University of Maryland Rehabilitation & Orthopaedic Institute

#861756
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/12/2024

Date

DocuSigned by:
Jon Burns
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Jon P. Burns
Senior Vice President & Chief
Administrative Officer
University of Maryland Medical System

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Julie Nemens
28459F0637784E5...

Julie Nemens, RN, MSN
Chief Administrative Officer & Senior Vice President
University of Maryland Rehabilitation & Orthopaedic Institute

#861749
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Krishnaj Gourab
0551891879A9456...

Krishnaj Gourab, M.D.
Vice President & Chief Medical Officer
University of Maryland Rehabilitation & Orthopaedic Institute
Medical Director, Post-Acute Services
University of Maryland Medical System

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

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Kristie Snedeker, DPT
Vice President
UM R Adams Cowley Shock Trauma Center

#861758
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/23/2024

Date

DocuSigned by:
Laura Kautz
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Laura Kautz, RA
Director of Planning, Design & Development
University of Maryland Medical System

#861754
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Linda Whitmore
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Linda Whitmore
Director of Project Development
University of Maryland Medical Center

#861753
006551-0232

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Lori Patria
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Lori Patria, M.S.
Director of Rehabilitation Services
University of Maryland Rehabilitation & Orthopaedic Institute

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/26/2024

Date

DocuSigned by:
Lucas Sater
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Lucas Sater
Senior Director, Reimbursement and
Revenue Advisory Services
University of Maryland Medical System

I hereby declare and affirm under the penalties of perjury that the facts stated in the Response to the January 25, 2024 Requests for Additional Information regarding the Request for Exemption from Certificate of Need Review to Merge and Consolidate University of Maryland Rehabilitation and Orthopaedic Institute and University of Maryland Medical Center, and the attachments thereto, are true and correct to the best of my knowledge, information, and belief.

2/6/2024

Date

DocuSigned by:
Marina Bogin
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Marina Bogin, MBA
Vice President of Financial Services,
Chief Financial Officer
University of Maryland Rehabilitation &
Orthopaedic Institute

EXHIBIT 9

CR**Goodman**ASSOCIATES
ARCHITECTURE ■ INTERIOR DESIGN ■ PLANNING
912 COMMERCE ROAD, ANNAPOLIS, MARYLAND 21401
V: 410-841-2570 F: 410-841-2575
WWW.CRGOODMANASSOCIATES.COM

SEAL

I CERTIFY THAT THESE DOCUMENTS WERE PREPARED OR APPROVED BY ME, AND THAT I AM A DULY LICENSED ARCHITECT UNDER THE LAWS OF THE STATE OF MARYLAND, LICENSE NO. [illegible], EXPIRATION DATE [illegible]

ISSUE	DATE	NUMBER

CLIENT
UNIVERSITY of MARYLAND REHABILITATION & ORTHOPAEDIC INSTITUTE

PROJECT TITLE
UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE (UMROI) MASTER PLAN

DATE 12.06.18

CRGA PROJECT NUMBER XX.XXX.X

DRAWING TITLE
MASTER PLAN - TERRACE LEVEL

DRAWING NUMBER
MP - 01

EXHIBIT 10

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Reimbursement and Revenue Advisory Services

compassion | discovery | excellence | diversity | integrity

UM Rehabilitation and Orthopaedic Institute

Trauma Brain Injury & Spinal Cord Injury - Top 10 Procedure Codes (All Procedures)

FY 2023

Rank	Proc_Code	Procedure Code Description	Count
1	F07Z9ZZ	Gait Training/Functional Ambulation Treatment	539
2	3E0G76Z	Introduction of Nutritional into Up GI, Via Opening	107
3	0CJS8ZZ	Inspection of Larynx, Endo	92
4	0BJ08ZZ	Inspection of Tracheobronchial Tree, Endo	70
5	0B21XFZ	Change Tracheostomy Device in Trachea, External Approach	62
6	F08Z4ZZ	Home Management Treatment	61
7	F07Z8ZZ	Transfer Training Treatment	46
8	F0736ZZ	Therapeutic Exercise Treatment of Neuro Body	44
9	F07Z4ZZ	Wheelchair Mobility Treatment	44
10	F07Z5ZZ	Bed Mobility Treatment	44
		All Other	359
		Total	1,468

Note: Count includes all procedure codes on an account and not just primary procedure. Procedures only counted once if they appeared multiples times on an account.

EXHIBIT 11

University of Maryland Rehabilitation and Orthopedic Institute

Trauma Reunification Project

Staff Recommendation

February 14, 2024

Overview and Hospital Request

On November 15, 2023, the University of Maryland Medical System (UMMS) provided a Letter of Intent (LOI) on behalf of UM Downtown Baltimore hospitals - University of Maryland Rehabilitation and Orthopedic Institute (UMROI), University of Maryland Medical Center (UMMC) and University of Maryland Medical Center Midtown Campus (UMMC Midtown) - requesting to move global budget revenue in future years from UMROI to UMMC and UMMC Midtown with no intended reduction in net services. Specifically, the LOI outlined that UMMS, as part of its "Trauma Reunification Project," will transfer from UMROI, as early as the second quarter of 2027, 25 acute inpatient rehab traumatic brain injury beds, 18 acute inpatient rehab spinal cord injury beds, and 5 chronic care beds to UMMC, as well as 10 dually licensed acute inpatient rehab and chronic beds to UMMC.[1] Together, these system realignments constitute 27 percent of UMROI's global budget. Concurrent with the relocation of beds to UMMC, UMROI's medical and surgical acute care volumes, approximately 48 percent of UMROI's global budget, will be absorbed by existing operating room capacity and acute hospital facilities, primarily those within the UMMS system, at which time UMROI plans to close its four acute care hospital beds. UMROI's pediatric dental surgical volumes will be relocated to the UMMC downtown campus and UMMS intends to relocate UMROI's dental clinic volumes to UMMC Midtown. UMMS also intends to shift UMROI's outpatient clinic services to other UMMS campuses including the UMMC Midtown Campus. Finally, for the remainder of UMROI's care delivery (25 percent of revenue) UMMS is investigating new locations for the construction of a freestanding facility to provide non-trauma acute inpatient rehabilitation care, inclusive of neurology and stroke, in a modern setting. Until a site is identified, which UMROI envisions will be approximately 60 beds, the hospital will continue to provide these services and chronic care at its existing campus. UMROI intends to pursue an exemption from rate regulation from the HSCRC for the special acute inpatient rehabilitation and chronic care hospital that will remain at its existing campus.[2]

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[1] While Rehabilitation and Chronic beds are similar, there are some distinct differences that can be best captured by the patient characteristics and services: Rehab - a) Regular, direct individual contact by a physiatrist or physician of equivalent training and/or experience in rehabilitation who serves as their lead provider; 1 COMAR 10.24.09, p.4. (b) Daily rehabilitation nursing for multiple and/or complex needs; (c) A minimum of three hours of physical or occupational therapy per day, at least five days per week, in addition to therapies or services from a psychologist, a social worker, a speech-language pathologist, and a therapeutic recreation specialist, as determined by their individual needs; and (d) Based on their individual needs, other services provided in a healthcare facility that is licensed as a hospital . Chronic - a) Requires frequent physician intervention (on average, three visits per patient per week) b) Requires continuous intensive professional nursing services and intervention from a registered nurse. Examples include, but are not limited to, frequent deep tracheal suctioning (more frequently than six times daily), total parenteral nutrition, serious wound (such as, multiple stage III or stage IV decubiti) care, and management of acute medical exacerbations appropriate to the resources of the chronic hospital. c) Has a medical condition that is sufficiently complex to require continuous monitoring, and requires an intensity of resources that is not available in alternative non-acute hospital settings.
https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/001000/001816/unrestricted/20061831e-0007.pdf

[2] See Appendix A for Bed Categorization Schedule

For a complete itemization of UMROI's Trauma Reunification Project, please see exhibit 1 below:

Exhibit 1: UMMS Itemized Proposed Global Budget Adjustments for UMROI

Service	Revenue	Trauma Reunification Project Action
Spinal Cord Injury (SCI) – Acute	$14,597,507	**Shift to UMMC; FMF Analagous (Component 1)**
Traumatic Brian Injury (TBI) – Acute	$12,933,003	**Shift to UMMC; FMF Analagous (Component 1)**
Comprehensive Rehab (CMR) – Acute (30%)	$5,246,268	**Shift to UMMC; FMF Analagous (Component 1)**
Traumatic Brian Injury (TBI) – Chronic	$5,903,230	**Shift to UMMC; FMF Analagous (Component 1)**
Spinal Cord Injury (SCI) – Chronic	$1,750,141	**Shift to UMMC; FMF Analagous (Component 1)**
OP Orthopedic Surgery - Faculty (74%)	$18,716,635	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Dental Surgery	$7,161,790	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Pain Clinic	$7,001,036	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Clinics	$4,442,966	**Absorb into UMMC DTC or Midtown (Component 2)**
IP Surgery - Faculty	$3,363,523	**Absorb into UMMC DTC or Midtown (Component 2)**
OP therapy (68%)	$3,350,170	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Dental Clinics	$1,259,385	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Surgery - Non-Ortho	$177,150	**Absorb into UMMC DTC or Midtown (Component 2)**
OP Orthopedic Surgery - Non-Faculty	$12,577,903	**Dissipate to other acute provider (Component 3)**
OP Orthopedic Surgery - Faculty (26%)	$6,684,513	**Dissipate to other acute provider (Component 3)**
IP Surgery - Non-Faculty	$2,751,973	**Dissipate to other acute provider (Component 3)**
OP Therapy (32%)	$1,546,232	**Dissipate to other acute provider (Component 3)**
OP Surgery – Other	$1,099,688	**Dissipate to other acute provider (Component 3)**
All Other	$153,769	**Dissipate to other acute provider (Component 3)**
Stroke (CVA) – Acute	$14,876,576	**Deregulate (Component 4)**
Comprehensive Rehab (CMR) – Acute (70%)	$12,241,292	**Deregulate (Component 4)**
Stroke (CVA) – Chronic	$5,036,843	**Deregulate (Component 4)**
Comprehensive Rehab (CMR) – Chronic	$4,483,401	**Deregulate (Component 4)**
Total	$147,354,995	

To effectuate this transition of services, UMMS submitted a Request for Exemption from Certificate of Need Review to the Maryland Health Care Commission, pursuant to which they will seek approval to relocate UMROI's traumatic brain injury ("TBI") and spinal cord injury ("SCI") acute inpatient rehabilitation service lines, along with associated chronic care beds, to UMMC. UMMC will construct four additional floors on top of the planned Stoler Center for Advanced Medicine and will renovate certain existing space in UMMC's North Hospital. The relocated rehab and chronic care beds from UMROI will occupy two of these floors, as well as a portion of existing space in the North Hospital, which UMMC will renovate to accommodate rehab services.

UMMS' request of the HSCRC is to allow the health system, whose aim is to consolidate physical capacity without reducing access, to retain 75 percent of UMROI's global budget revenue for volume that remains at UMMS regulated facilities, 50 percent of UMROI's global budget revenue related to volume that shifts to non-UMMS hospitals or to any unregulated facilities, and

exemption of UMROI from the Commission's Integrated Efficiency policy until such time as the Project is completed. This proposal will yield approximately $21.5 million in system savings (14.6 percent of UMROI's global budget revenue).

Background

UMROI is licensed as an acute care, specialty rehabilitation, and specialty chronic hospital in the Forest Park/Gwynns Falls community in southwest Baltimore City with 2 licensed medical/surgical/gynecological/addictions beds, 102 licensed rehabilitation beds, and 40 licensed chronic hospital beds, including 16 dually licensed chronic/rehabilitation beds. UMROI is a provider of orthopedic surgery, the largest state provider of outpatient pediatric dental services, and the largest inpatient rehabilitation hospital and provider of rehabilitation services in the state of Maryland. The Hospital's total approved revenue cap for Fiscal Year 2024 is $148,915,470. In CY 2022, which is a fairly representative year, approximately 23 percent of its revenues came from Baltimore city residents, 20 percent came from Baltimore county residents, 13 percent came from Anne Arundel county residents, 9 percent from Howard county residents, 8 percent came from Carroll and Harford county residents, 6 percent came from Prince George's county residents, 4 percent came from out-of-state residents, and the remaining 17 percent was derived from all other counties in Maryland.

From Fiscal Years 2014 through 2022, UMROI had an average regulated operating margin of 5.5 percent based on its annual filing Schedule RE reporting. Average total operating margin for the same period, inclusive of unregulated losses, most notably physician subsidies, was 3.3 percent. From 2014 through 2022, the operating cash flow margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization's operation, was 4.1 percent, yielding cash generation of $41 million.

Analyses

The HSCRC staff reviewed the Letter of Intent for consistency with existing policies (e.g., marketshift, deregulation) as well as prior facility conversions. Additionally, because the Commission does not have a formalized facility conversion policy, staff assessed savings from the UMROI conversion relative to the values outlined in the HSCRC Full Rate Application methodology, prior facility conversions, and site neutral rates for services that do not need to be performed in a regulated facility. In effect, staff have acquired additional statistics that help validate the reasonableness of system savings from this transformation.

A: Variable Cost Factors

UMMS' proposal for global budget adjustments is composed of four components that are detailed in exhibit 1 and highlighted in exhibit 2 below:

Exhibit 2: UMMS Proposed Global Budget Adjustments for UMROI[3]

	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3)Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	75%	75%	50%	50%		
Retained GBR @ UMMS	$30,323	$34,104	$12,407	$18,319	**$95,153**	65%
Redistribution of UM Rehab GBR						
Retained at UMMS	$30,323	$34,104	$12,407	$18,319	$95,153	65%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	10,108	11,368	-	-	21,476	15%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

Each component must be considered individually against existing Commission policies and prior facility conversion practices. In the absence of a planned transition, components 1 and 2 - the movement of services to another UMMS facility - would typically be handled through the Commission marketshift policy and would utilize a 50 percent variable cost factor to recognize the variable cost per unit that would be incurred by the facility providing new services, e.g., increased drugs, supplies, and hourly labor. UMMS has proposed a 75 percent variable cost factor to recognize some level of fixed costs that is necessary to provide these services (e.g., depreciation and interest, new base salaries), and to ensure the UMROI transformation results in system savings (14.6 percent) that is fairly similar to other facility conversions. Prior UMMS free-standing medical facility conversions resulted in savings of 13 percent for Dorchester Hospital, 12 percent for Harford Memorial, and 3 percent for Laurel Medical Center.[4]

Prior practice indicates that the Commission has allowed a 100 percent variable cost factor if the services are being transitioned to a facility substitute, e.g., a hospital converted to a free standing medical facility, and a 65 percent factor if the service is being transitioned to another facility within the health system.[5] The current UMMS proposal is not a facility substitute per se because the services are being transitioned to UMMC. However, the movement of rehab and chronic care beds will require the wholesale transition of salaried employees from UMROI as well as additional capital improvements (for which UMMS is not seeking additional rate support), because these services are highly specialized and UMMC currently does not have licensed rehab or chronic beds. Thus, for Component 1, a higher variable cost factor than is allotted by the marketshift policy is a valid request, and staff believe the prior practice of allowing 100 percent revenue retention is most appropriate given the transition is analogous to a facility substitute. Conversely, given the additional acute care bed capacity at UMMC and UMMC Midtown, which

[3] Source: UMMS/Berkeley Research Group; See Appendix B for Variations of Model

[4] Savings generated from Laurel transitioning to an FMF were used to finance additional debt associated with building a new hospital for Capital Region Medical Center. The savings were used to finance the remaining portion of the capital project that was not covered by the State or County

[5] Ex: The conversion of Dorchester Hospital utilized a 100 percent variable cost factor for services that were still provided by the Dorchester FreeStanding Medical Facility and 65 percent variable cost factor for services that were transitioned to Easton Hospital.

obviates the need for significant fixed cost investments, using a 100 percent variable cost factor makes less sense for acute care services (Component 2). However, staff do recognize that there will be additional fixed patient care and general overhead costs that will need to transition to UMMC because they cannot be absorbed by existing overhead, e.g., dietary services, medical records, and patient accounts, among others. Given an analysis of UMROI's costs indicate that these are approximately 24 percent of costs and staff anticipates some economies of scale, a 15 percent increase to the typical 50 percent variable cost factor seems reasonable.

Based on review of UMMS proposals, existing policy parameters, prior practice and analysis of estimated cost savings from the Full Rate Application and site neutral estimates (see next section), staff recommend that a 100 percent variable cost factor be utilized for trauma and chronic services (Component 1) and a 65 percent variable cost factor for acute care services in line with other conversions.(Component 2).

Staff are in agreement that a 50 percent variable cost factor is appropriate for Component 3 (Acute Care Shifted to Other Providers), as this approach is in line with the marketshift policy. However, staff do not agree that a 50 percent variable cost factor should be utilized for Component 4 (Shift to Freestanding), because although deregulation policy typically uses a 50 percent variable cost factor, it does so because the facility with dissipation to an unregulated space remains regulated by HSCRC global budget methodologies, i.e., a regulated fixed cost component still exists that requires funding support. In this case, UMMS is envisioning that a future freestanding facility will be exempt from HSCRC rate setting and thus each unit of service reimbursement will presumably reflect both variable and fixed costs, albeit at a significantly reduced rate, i.e., 43.1 percent of the current regulated rate. Again though, some level of fixed general overhead costs currently at the UMROI facility will be necessary to support the delivery of services in an unregulated setting, e.g., patient accounts, medical records, and general accounting, among other things. Given an analysis of UMROI's costs, which indicate that these are approximately 14 percent of costs, a 15 percent variable cost factor seems reasonable. To ensure that the deregulated services are not rationed in a future state, staff recommend that the retained revenue associated with the 15 percent variable cost factor ($5.5 million) be contingent on UMMS continuing to provide the projected volumes in a freestanding facility

The table below outlines staff's recommendation for each component of UMMS Trauma Reunification Project.

Exhibit 3: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities

	HSCRC					
	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3) Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	100%	65%	50%	15%		
Retained GBR @ UMMS	$40,430	$29,557	$12,407	$5,496	$87,890	60%
Redistribution of UM Rehab GBR						
Retained at UMMS	$40,430	$29,557	$12,407	$5,496	$87,890	60%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	-	15,915	-	12,823	28,739	19.5%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

B: Corroborating Statistics

As noted above, the Commission does not have a formalized facility conversion policy, which would dictate expected savings and appropriate variable cost factors, among other things (e.g., required maintenance of effort for access to care). While the Commission does have experience with several facility conversions and thus reasonable expectations of savings, relying on past practice alone is not sufficient because staff believe a future conversion policy would scale expected savings by current efficiency performance, i.e., a facility with excessive fixed costs will be expected to generate greater savings than a facility with limited excess capacity. This dynamic is particularly salient because UMROI is a relatively inefficient provider that was identified as such in the RY 2024 Integrated Efficiency policy. Therefore, staff have assessed two additional statistics to validate the reasonableness of the savings being put forward by the HSCRC Proposal delineated in Exhibit 3 ($28.7M, 19.5 percent).

The first statistic staff considered was the value outlined under the Full Rate Application policy. Under the Inter-hospital Cost Comparison methodology that is used to assess hospital cost efficiency per case, UMROI would incur a reduction of 27.11 percent.[6] While this value exceeds the UMMS proposed savings of 14.6 percent and HSCRC's proposal of 19.5 percent, staff notes that in a future facility conversion policy, rebasing hospitals to the statewide average cost per case with no allotment for profit to subsidize physician coverage and future recapitalization, as is the norm, would likely not incentivize any hospital to reduce excess capacity. Thus, staff would like to propose a strawman for future policy consideration that could also be used to assess the reasonableness of the Trauma Reunification Project. Specifically, staff propose that a future facility incentive conversion policy consider rebasing hospitals to the statewide average cost per case plus the historical statewide average regulated profit of 8 percent, which if implemented in this case, would yield a revenue reduction of 22.10 percent, excluding any negative scaling related to total cost of performance. This approach does not entirely align with HSCRC's savings proposal of 19.5 percent, but it is reasonably related and staff believe strongly that a future facility incentive conversion policy must a) recognize that acute care rates have historically cross subsidized low physician

[6] Under the complete Full Rate Application methodology, which further incorporates total cost of care performance, UMROI would incur a reduction of 30.16 percent, a increased reduction of $4.1 million relative to the ICC, because UMROI's attributed Medicare population is higher than its national benchmark average and the population has exceeded statewide total cost of care growth by 9.51 percent. However, given the proposed savings of at least $20.8 million would completely eliminate the TCOC scaling component of the Full Rate Application, staff have elected to eliminate TCOC consideration in this recommendation.

reimbursement rates in the State of Maryland; and b) create a reasonable incentive appealing enough to compel hospitals to remove excess capacity while also generating system savings.

The second statistic staff considered was the savings that would accrue to the public if rehabilitation and chronic services were deregulated and reimbursed at rates similar to other national freestanding rehabilitation facilities. Using MedPAR[7] data and limiting the analysis to national claims with a length of stay greater than 0 and less than 91, UMMS was able to demonstrate that UMROI's rehabilitation and chronic services would result in a rate that was 23.5 percent of the Spine and Traumatic Brain Injury regulated rates and 43.1 percent for Comprehensive Medical Rehabilitation.[8] As outlined below, this suggests that the potential savings opportunity for moving to a "site neutral rate" would be $50.7 million; however, a portion of these services, specifically the spine and traumatic brain injury rehabilitation, is significantly more resource-intensive and requires an intermediate step down setting before admission to a rehabilitation specialty hospital, skilled nursing facility, or home.[9] As such, the following table quantifies potential site neutral savings with and without the spine and traumatic brain injury rehabilitation, $50.7 million and $21.2 million respectively. Given the need for these specialized acute care services, staff recommend that the relevant statistic to determine the reasonableness of the savings from the Trauma Reunification Project is without the spine and traumatic brain injury rehabilitation, i.e. $21.2 million, which is in line with the proposed savings put forth by UMMS ($21.5 million) but less than the savings put forth by HSCRC staff ($28.7 million).

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[7] MedPAR data contains information about inpatient (IP) hospital and skilled nursing facility (SNF) stays that were covered by Medicare. MedPAR records are created by rolling up information for a single stay from individual IP and SNF claims. The data on these claims was originally submitted on the CMS 1450 or UB04. https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-fee-for-service-parts-a-b/medpar

[8] Rehabilitation and Chronic Services Deregulation Analysis Notes:

[1] Source: Maryland non-confidential data grouped under APR-DRG v38, Inpatient cases only, Separated by Daily Service code (8=Rehab, 9=Chronic, 1=Acute IP)

[2] Modeled CMS payments utilizing average CMS+coins/deductibles CY2022 MedPar LDS data - applied based on MS-DRG and LOS range, inflated for one quarter of CY23

[3] Limited to claims with payments >0, LOS <91, claims at freestanding rehab hospitals with an admit and discharge date in the data, excluded hospital-based rehab units

[4] Type of care categories (stroke, ortho, brain, etc) based on Rehab Impairment group assignment

[5] Assumption: Medicaid pays 88% of Medicare Fee Schedule, Medicare pays 100%, Commercial Pays 120% of Medicare Fee Schedule.

[9] For patients who cannot return home safely after post-acute care, transfer to a care setting that provides interdisciplinary comprehensive inpatient rehabilitation is most beneficial (DaVanzo et al., 2014; Nehra et al. 2016). For some patients with complex medical needs, an intermediate stepdown setting may be required before admission to comprehensive rehabilitation. For example, the setting may provide care through a Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited brain injury specialty program designed to meet the complex needs of the patient with TBI. Medicare patients with medical necessity who can tolerate 3 hours of therapy per day or 15 hours per week are eligible for admission for an inpatient rehabilitation case.
Source: NIH National Library of Medicine – Rehabilitation and Long-Term Care Needs after Traumatic Brain Injury. https://www.ncbi.nlm.nih.gov/books/NBK580075/

Exhibit 4: Potential Deregulation Savings from Rehabilitation and Chronic Services

Services with an Applicable Unregulated Rate Schedule

	Revenue	Site-Neutral Savings Opportunity	Algebra
Spinal Cord Injury (SCI) -- Acute	14,597,507	11,167,093	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) -- Acute	12,933,003	9,893,747	Rev. X (1-.235) for Spine & TBI
Comprehensive Rehab (CMR) -- Acute (30%)	5,246,268	2,985,126	Rev X (1-.431) for CMR
Traumatic Brian Injury (TBI) -- Chronic	5,903,230	4,515,971	Rev. X (1-.235) for Spine & TBI
Spinal Cord Injury (SCI) -- Chronic	1,750,141	1,338,858	Rev. X (1-.235) for Spine & TBI
Stroke (CVA) -- Acute	14,876,576	8,464,772	Rev X (1-.431) for CMR
Comprehensive Rehab (CMR) -- Acute (70%)	12,241,292	6,965,295	Rev X (1-.431) for CMR
Stroke (CVA) -- Chronic	5,036,843	2,865,964	Rev X (1-.431) for CMR
Comprehensive Rehab (CMR) -- Chronic	4,483,401	2,551,055	Rev X (1-.431) for CMR
Total Potential Site Neutral Savings Opportunity	77,068,261	50,747,882	A = sum of rev X (1-unregulated reimbursement rate)

Services that Cannot be Deregulated

	Revenue	Site-Neutral Savings Opportunity	Algebra
Spinal Cord Injury (SCI) - Acute Regulated	14,597,507	11,167,093	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) - Acute Regulated	12,933,003	9,893,747	Rev. X (1-.235) for Spine & TBI
Spinal Cord Injury (SCI) - Chronic Regulated	5,246,268	4,013,395	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) - Chronic Regulated	5,903,230	4,515,971	Rev. X (1-.235) for Spine & TBI
Non-applicable Site Neutral Savings Opportunity	38,680,008	29,590,206	B = sum of rev X (1-unregulated reimbursement rate)
Realizable Savings from Deregulated Pricing Model		21,157,675	C=A-B

C: Additional Considerations

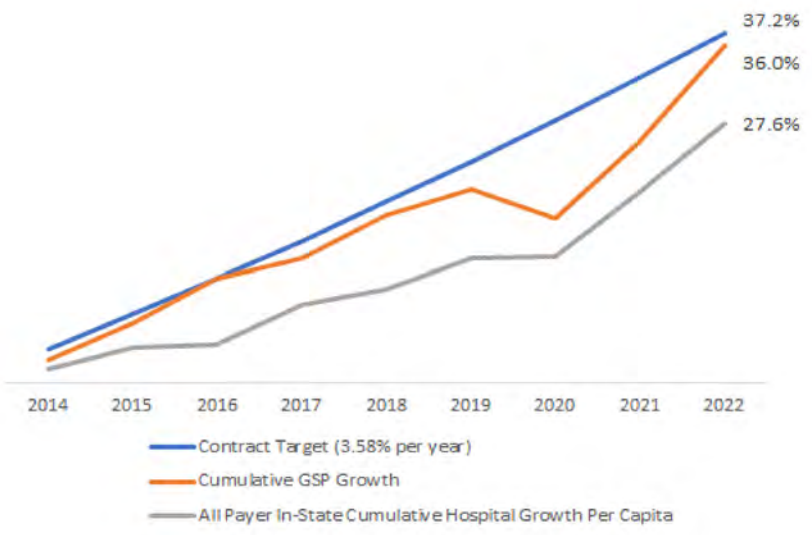
There are three additional considerations to examine in the proposed Trauma Reunification Project, namely 1) exemption from Commission's Integrated Efficiency Policy; 2) the degree to which system savings should be redirected to population health investments in line with goals of the Model and the Revenue for Reform Policy; and 3) accountability to ensure access to rehabilitation services is not compromised.

1) In RY 2024, UMROI incurred an inflation offset of $2.3 million through the Integrated Efficiency Policy, which they are currently trying to "buyout" from through the Revenue for Reform policy. In lieu of participating in this dynamic each year, which will presumably take 10 years to recoup the funding, UMMS has proposed as system savings ($21.5 million), UMROI is putting forward that system savings be scored when the project goes live in 2027 and in return the hospital be exempt from future Integrated Efficiency inflation offsets in RY 2025 and each year thereafter until the project is completed. In effect, the Integrated Efficiency policy is achieving one of its intended aims to compel hospitals to transform its care delivery model, but in this case in a more expedited manner. If the proposed savings amount is sufficient relative to the potential opportunity as outlined by the Full Rate Application methodology, staff believe this approach is a benefit to the system because savings and associated transformation occur at a faster rate. As such, staff strongly endorse this proposal and the idea generally that hospitals that come forward with a reasonable savings proposal be exempted from the Integrated Efficiency policy.

2) The second consideration is if the Commission should consider redirecting a portion of the Trauma Reunification Project savings to population health investments. Staff believe at a minimum that the $21.5 million (14.6 percent) put forward by UMMS as system savings should be returned to payers and the public writ large, as it aligns with prior practice that facility conversions generate 10-15 percent system savings. However, staff believe the additional savings that were identified in its

proposal ($28.7 million, a variance of $7.3 million from UMMS proposal) should be earmarked for population investments, and similar to other hospitals participating in the RY 2024 Integrated Efficiency policy be approved through the Revenue for Reform application process, which will repeated each year as long as the funding is not redirected to system savings. Staff's rationale on this is threefold: a) the intention of the Model is to use healthcare dollars for genuine care delivery transformation, not to simply generate savings as other models, e.g., the Inpatient Prospective Payment System, are for more effective at the latter; b) the Model currently does not require additional Medicare total cost of care savings to comply with contractual savings targets; and c) the main lever to achieve savings in the Model for all-payers continues to be the annual Update Factor, which to date has been quite successful at bending the cost curve relative to statewide economic growth - see exhibit 5:

Exhibit 5: Affordability Scorecard



3) Staff are concerned that rehabilitation services to be provided in an unregulated setting (Component 4) are not guaranteed, as is the case with regulated services, i.e., for hospitals to recoup their entire global budget, at least 95 percent of budgeted volumes must be provided in accordance with the Commission's corridor policies. When volumes are no longer under HSCRC purview, it is conceivable that a provider could reduce its service delivery to far less than 95 percent of anticipated services, which is particularly problematic because of the concerns about post-acute availability in Maryland and because the proposal allows UMMS to retain approximately $17.9 million (Component 3 and 4), which otherwise would not occur since UMMS is transitioning UMROI to an unregulated facility.

   For these reasons, staff assessed both actual risk if UMMS discontinues non-trauma rehabilitation services and inherent risk, i.e., the extent to which UMMS would create dissavings for its other regulated entities (UMMC and UMMC Midtown). Actual risk is rather straightforward: if UMMS reduces non-trauma rehabilitation services beyond an agreed upon level (to be defined by a future contractual agreement), the HSCRC will remove $5.5 million of retained GBR from the system that it

is retaining under Component 4 (see exhibit 3). Inherent risk is less straightforward because it requires quantifying lost variable cost savings from not transitioning patients from an acute care setting to a post-acute setting and reductions to net patient revenue, as extended length of stay in an acute care is often deemed medically unnecessary and thus results in payer denials. For an accounting of the inherent risk, see exhibit 6:

Exhibit 6: Risk Summary

	Data Inputs	
Total "Bucket 4" cases (All payor cases * 80% from UMMS)	684	*80% of UMROI cases are from UMMC, UM Midtown*
Excess acute days per case if no IRF (and patient must go to SNF)	5	
Total excess acute days if no IRF (and patient must go to SNF) -- assumed to be at UMMC DTC	3,420	*UMMS Cases * Excess Acute Days*
UMMC Med/Surg day rate	2,347	*UMMC DTC 4/1/2023 approved MSGA rate + 20%*
UMMC DTC charges related to excess days (gross) -- in thousands	$8,030	
	Cost of Excess Days	
95% denial of excess days (gross)	$7,630	*95% assumption per UMMS revenue cycle*
Opportunity cost of not backfilling volume (@ 50% VCF)	4,015	*50% VCF assumption*
Inherent Risk - UMMC DTC financial risk of not doing the case in IRF	**$11,645**	*Inherent Risk*
	Total Risk	
Actual Risk - Retained Revenue for Component 4	**$5,496**	*$36M Deregulated Services * 15% VCF*
Total Risk - Acutal Risk + Inherent Risk	**$17,141**	

Because the associated risk of this transition ($17.1 million) is reasonably similar to the retained revenue provided under Component 3 and 4 ($17.9 million), which are the only volume shifts that deviate from preexisting policy or practice, staff are confident that UMMS will maintain the projected non-trauma rehabilitation services in an unregulated setting. However, to further ensure that maintenance of current rehabilitation services, staff recommend that UMMS and the HSCRC enter into a contractual agreement, subsequent to the approval of this recommendation, that will codify service level agreements that UMMS must meet.

Recommendations

The HSCRC staff make the following recommendations:

1. Utilize a 100 percent variable cost factor to realign services rehabilitation and chronic care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center
2. Utilize a 65 percent variable factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center Downtown and Midtown Campus'
3. Utilize a 50 percent variable cost factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to non-University of Maryland Medical System facilities
4. Utilize a 15 percent variable cost factor to realign other rehabilitation services from University of Maryland Rehabilitation and Orthopedic Institute to an unregulated freestanding rehabilitation facility
5. Funding agreements for each realignment outlined in recommendations 1-4 are contingent on actual volume changes being equivalent to projected volumes. If volumes deviate from projected shifts, staff will adjust accordingly.
6. Exempt University of Maryland Rehabilitation and Orthopedic Institute from the Integrated Efficiency Policy in RY 2025 and each year thereafter until the Trauma Reunification Project is completed
7. Earmark $7.3 million from the proposed system savings for population health investments to be approved each year through the Revenue for Reform policy
8. Direct staff to enter into a contractual agreement with University of Maryland Medical System to codify service level agreements that the system must satisfy as part of this facility conversion.
9. Direct staff to develop a facility conversion policy in CY 2024 that will be used for all future care delivery realignments.

APPENDIX A: Bed Categorization Schedule

UM Rehabilitation and Orthopaedic Institute
Estimated Bed Capacity in Future State

	Bed Need to Accommodate Current ADC [1] (FY 2024 Dec YTD)				Estimated Future State		
	A	B	C = A+B	D = C/80%	E	F	G = E+F
	Acute Rehab	Chronic	Total	Bed Need (Actual ADC at 80% Occupancy)[2]	UMMC DTC	Estimated Unregulated Rehab Facility	Total
TBI	23.8	4.5	28.3	36.0	25.0		25.0
Spine	16.6	2.7	19.3	25.0	18.0		18.0
CMR	17.8	3.8	21.6	28.0		25.0	25.0
Stroke	17.5	4.6	22.1	28.0		25.0	25.0
Stroke					15.0	10.0	25.0
Stroke	75.7	15.6	91.3	117.0	58.0	60.0	118.0

Note:
[1] ADC represents actual FY 2024 Dec YTD
[2] 80% occupancy assumption consistent with CON methodology for calculating bed need
[3] These are estimates based on FY 2024 Dec YTD actual numbers, and subject to change in official CON filings

APPENDIX 1B: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (100% Variable Cost Factor)

	100% Variable Cost Factor					
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers	Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	100%	100%	100%	100%		
Retained GBR @ UMMS	$40,430	$45,473	$24,814	$36,638	$147,355	100%
Redistribution of UM Rehab GBR						
Retained at UMMS	$40,430	$45,473	$24,814	$36,638	$147,355	100%
Shift to Other Providers	-	-	24,814	15,754	40,568	28%
System Savings	-	-	(24,814)	(15,754)	(40,568)	-27.5%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

APPENDIX 2B: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (75% Variable Cost Factor)

	75% Variable Cost Factor					
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers	Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	75%	75%	75%	75%		
Retained GBR @ UMMS	$30,323	$34,104	$18,611	$27,479	$110,516	75%
Redistribution of UM Rehab GBR						
Retained at UMMS	$30,323	$34,104	$18,611	$27,479	$110,516	75%
Shift to Other Providers	-	-	18,611	15,754	34,365	23%
System Savings	10,108	11,368	(12,407)	(6,595)	2,474	1.7%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

APPENDIX 2C: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (65% Variable Cost Factor)

	65% Variable Cost Factor					
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers	Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	65%	65%	65%	65%		
Retained GBR @ UMMS	$26,280	$29,557	$16,129	$23,815	$95,781	65%
Redistribution of UM Rehab GBR						
Retained at UMMS	$26,280	$29,557	$16,129	$23,815	$95,781	65%
Shift to Other Providers	-	-	16,129	15,754	31,884	22%
System Savings	14,151	15,915	(7,444)	(2,931)	19,691	13.4%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

APPENDIX 2D: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (50% Variable Cost Factor)

	50% Variable Cost Factor					
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers	Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	$40,430	$45,473	$24,814	$36,638	$147,355	
Proposed Retention	50%	50%	50%	50%		
Retained GBR @ UMMS	$20,215	$22,736	$12,407	$18,319	$73,677	50%
Redistribution of UM Rehab GBR						
Retained at UMMS	$20,215	$22,736	$12,407	$18,319	$73,677	50%
Shift to Other Providers	-	-	12,407	15,754	28,161	19%
System Savings	20,215	22,736	-	2,565	45,516	30.9%
UM Rehab FY 2023 GBR	$40,430	$45,473	$24,814	$36,638	$147,355	100%

EXHIBIT 12

June 9, 2021

Bert O'Malley, Jr., MD
President and CEO
University of Maryland Medical Center
22 South Greene Street
Baltimore, MD 21201-1595

Joint Commission ID #: 6264
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 5/28/2021

Dear Dr. O'Malley, Jr.:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning March 6, 2021 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Please note, if your survey was conducted off-site (virtually): Your organization may be required to undergo an on-site survey once The Joint Commission has determined that conditions are appropriate to conduct on-site survey activity.

Should you wish to promote your accreditation decision, please view the information listed under the 'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Mark G. Pelletier, RN, MS
Chief Operating Officer and Chief Nurse Executive
Division of Accreditation and Certification Operations

EXHIBIT 13

carf INTERNATIONAL

CARF Accreditation Report

for

University of Maryland Rehabilitation & Orthopaedic Institute

Three-Year Accreditation

CARF International Headquarters
6951 E. Southpoint Road
Tucson, AZ 85756-9407, USA

www.carf.org

Contents

About CARF

CARF is an independent, nonprofit accreditor of health and human services, enhancing the lives of persons served worldwide.

The accreditation process applies CARF's internationally recognized standards during a site survey conducted by peer surveyors. Accreditation, however, is an ongoing process that distinguishes a provider's service delivery and signals to the public that the provider is committed to continuous performance improvement, responsive to feedback, and accountable to the community and its other stakeholders.

CARF accreditation promotes providers' demonstration of value and Quality Across the Lifespan® of millions of persons served through application of rigorous organizational and program standards organized around the ASPIRE to Excellence® continuous quality improvement framework. CARF accreditation has been the recognized benchmark of quality health and human services for more than 50 years.

For more information or to contact CARF, please visit www.carf.org/contact-us.

Organization

University of Maryland Rehabilitation & Orthopaedic Institute
2200 Kernan Drive
Baltimore, MD 21207

Organizational Leadership

Julie Nemens, RN, MSN, Chief Administrative Officer
Lori Patria, MS, OTR/L, Director of Therapy Services

Survey Number

167941

Survey Date(s)

March 13, 2023–March 14, 2023

Surveyor(s)

James A. Lomastro, PhD, Administrative
Dorothy Corbin Terry, MEd, CCC-SLP, CCM, Program
Darcy Erickson, OTR/L, MAOL, ATP, Program
Laurie R. Leach, PhD, ABN, Program
Dawn M. Lucasey, PT, DPT, CLSSBB, Program
Page Riggs, OTR/L, MRMC, Program

Program(s)/Service(s) Surveyed

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Amputation Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Spinal Cord Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Spinal Cord Specialty Program (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Amputation Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Brain Injury Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Brain Injury Specialty Program (Children and Adolescents)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Children and Adolescents)

Previous Survey

July 21, 2020
Three-Year Accreditation

Accreditation Decision

Three-Year Accreditation
Expiration: April 30, 2026

Executive Summary

This report contains the findings of CARF's site survey of University of Maryland Rehabilitation & Orthopaedic Institute conducted March 13, 2023–March 14, 2023. This report includes the following information:

- Documentation of the accreditation decision and the basis for the decision as determined by CARF's consideration of the survey findings.
- Identification of the specific program(s)/service(s) and location(s) to which this accreditation decision applies.
- Identification of the CARF surveyor(s) who conducted the survey and an overview of the CARF survey process and how conformance to the standards was determined.
- Feedback on the organization's strengths and recognition of any areas where the organization demonstrated exemplary conformance to the standards.
- Documentation of the specific sections of the CARF standards that were applied on the survey.
- Recommendations for improvement in any areas where the organization did not meet the minimum requirements to demonstrate full conformance to the standards.
- Any consultative suggestions documented by the surveyor(s) to help the organization improve its program(s)/service(s) and business operations.

Accreditation Decision

On balance, University of Maryland Rehabilitation & Orthopaedic Institute demonstrated substantial conformance to the standards. University of Maryland Rehabilitation & Orthopaedic Institute substantially provides a comprehensive continuum of care that includes a transition between inpatient and outpatient specialized services. It has an impressive array of specialty accredited programs. The organization has a strong commitment to delivering high-quality and reliable services. The organization has worked through three difficult years, responding well to the pandemic and offering rehabilitation services throughout the pandemic. It is commended for its comprehensive and extensive approach to patient family advisory councils. The organization has well-equipped and spacious physical facilities with outdoor areas and gardens. The leaders and personnel are committed, energetic, and highly motivated. Medical, nursing, and clinical leadership are outstanding and demonstrate a clear commitment to improvement and results. University of Maryland Rehabilitation & Orthopaedic Institute is open and receptive to suggestions and consultation. Committed and supportive leadership, physicians, and staff members provide services to patients in the Maryland area. The staff members are enthusiastic and professional, providing customized, comprehensive programming to meet the functional, social, and psychological needs of the persons served. The culture of the rehabilitation programs promotes learning, competency, health and safety, and personal responsibility. Its institutional and community connections foster leisure, home, and community services for the person served. Its staff members are committed to developing a collaborative relationship with the patients and focus on achieving positive outcomes. Opportunities for improvement are identified in training, wound care, analysis of trends, chart audits, and the collection of follow-up data and annual written analysis in the specialty programs. University of Maryland Rehabilitation & Orthopaedic Institute is likely to maintain and improve its current method of operation as it emerges from the impact of the COVID-19 pandemic and demonstrates a commitment to ongoing performance improvement.

University of Maryland Rehabilitation & Orthopaedic Institute appears likely to maintain and/or improve its current method of operation and demonstrates a commitment to ongoing quality improvement. University of Maryland Rehabilitation & Orthopaedic Institute is required to submit a post-survey Quality Improvement Plan (QIP) to CARF that addresses all recommendations identified in this report.

University of Maryland Rehabilitation & Orthopaedic Institute has earned a Three-Year Accreditation. The leadership team and staff are complimented and congratulated for this achievement. In order to maintain this accreditation, throughout the term of accreditation, the organization is required to:

- Submit annual reporting documents and other required information to CARF, as detailed in the Accreditation Policies and Procedures section in the standards manual.
- Maintain ongoing conformance to CARF's standards, satisfy all accreditation conditions, and comply with all accreditation policies and procedures, as they are published and made effective by CARF.

Survey Details

Survey Participants

The survey of University of Maryland Rehabilitation & Orthopaedic Institute was conducted by the following CARF surveyor(s):

- James A. Lomastro, PhD, Administrative
- Dorothy Corbin Terry, MEd, CCC-SLP, CCM, Program
- Darcy Erickson, OTR/L, MAOL, ATP, Program
- Laurie R. Leach, PhD, ABN, Program
- Dawn M. Lucasey, PT, DPT, CLSSBB, Program
- Page Riggs, OTR/L, MRMC, Program

CARF considers the involvement of persons served to be vital to the survey process. As part of the accreditation survey for all organizations, CARF surveyors interact with and conduct direct, confidential interviews with consenting current and former persons served in the program(s)/service(s) for which the organization is seeking accreditation. In addition, as applicable and available, interviews may be conducted with family members and/or representatives of the persons served such as guardians, advocates, or members of their support system.

Interviews are also conducted with individuals associated with the organization, as applicable, which may include:

- The organization's leadership, such as board members, executives, owners, and managers.
- Business unit resources, such as finance and human resources.
- Personnel who serve and directly interact with persons served in the program(s)/service(s) for which the organization is seeking accreditation.
- Other stakeholders, such as referral sources, payers, insurers, and fiscal intermediaries.
- Community constituents and governmental representatives.

Survey Activities

Achieving CARF accreditation involves demonstrating conformance to the applicable CARF standards, evidenced through observable practices, verifiable results over time, and comprehensive supporting documentation. The survey of University of Maryland Rehabilitation & Orthopaedic Institute and its program(s)/service(s) consisted of the following activities:

- Confidential interviews and direct interactions, as outlined in the previous section.
- Direct observation of the organization's operations and service delivery practices.
- Observation of the organization's location(s) where services are delivered.
- Review of organizational documents, which may include policies; plans; written procedures; promotional materials; governing documents, such as articles of incorporation and bylaws; financial statements; and other documents necessary to determine conformance to standards.
- Review of documents related to program/service design, delivery, outcomes, and improvement, such as program descriptions, records of services provided, documentation of reviews of program resources and services conducted, and program evaluations.
- Review of records of current and former persons served.

Program(s)/Service(s) Surveyed

The survey addressed by this report is specific to the following program(s)/service(s):

- Inpatient Rehabilitation Programs - Hospital (Adults)
- Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
- Inpatient Rehabilitation Programs - Hospital: Amputation Specialty Program (Adults)
- Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Adults)
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- Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Adults)
- Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Children and Adolescents)

A list of the organization's accredited program(s)/service(s) by location is included at the end of this report.

Representations and Constraints

The accreditation decision and survey findings contained in this report are based on an on-balance consideration of the information obtained by the surveyor(s) during the site survey. Any information that was unavailable, not presented, or outside the scope of the survey was not considered and, had it been considered, may have affected the contents of this report. If at any time CARF subsequently learns or has reason to believe that the organization did not participate in the accreditation process in good faith or that any information presented was not accurate, truthful, or complete, CARF may modify the accreditation decision, up to and including revocation of accreditation.

Survey Findings

This report provides a summary of the organization's strengths and identifies the sections of the CARF standards that were applied on the survey and the findings in each area. In conjunction with its evaluation of conformance to the specific program/service standards, CARF assessed conformance to its business practice standards, referred to as Section 1. ASPIRE to Excellence, which are designed to support the delivery of the program(s)/service(s) within a sound business operating framework to promote long-term success.

The specific standards applied from each section vary based on a variety of factors, including, but not limited to, the scope(s) of the program(s)/service(s), population(s) served, location(s), methods of service delivery, and survey type. Information about the specific standards applied on each survey is included in the standards manual and other instructions that may be provided by CARF.

Areas of Strength

CARF found that University of Maryland Rehabilitation & Orthopaedic Institute demonstrated the following strengths:

- University of Maryland Rehabilitation & Orthopaedic Institute shows strength in its steps to ensure sufficient capacity, reserves, and resources to weather the COVID-19 pandemic. The organization has developed a well-thought-out and detailed plan and approach to the issues precipitated by the COVID-19 pandemic. It rapidly adapted to the COVID-19 pandemic, participating as part of a larger system and benefiting from it. Although the surge of cases disrupted in-person programs and services, it pursued a deliberate path toward keeping its services open that did not jeopardize its patients' or staff members' well-being and safety. It has a well-developed and clear plan for addressing visitors, providing them access without risking their care. The organization readily acquired the necessary resources to support that endeavor. The organization strove to ensure that staff members and its patients were vaccinated and offered extended messaging and hours to ensure that it reached full vaccination for all staff members. The organization is commended for its efforts to recognize and treat the COVID-19 positive patient by extending inpatient rehabilitation services for COVID-19 positive patients. The organization was commended for its efforts to treat COVID-19 pandemic positive patients, including innovative staffing and sharing resources across the continuum to support nursing and therapy needs. The unit maintained, as much as possible, its service and outpatient rehabilitation services. The organization helped with the flow of patients entering the hospital and creating space for seriously ill patients.
- The organization is commended for its visitor policy to support a balance among the rights of patients, accessibility of significant others, and safety. The staff members also went above and beyond their duty to provide patients with accompaniment at the COVID-19 pandemic's beginning to ensure that no patient was isolated.

- Leadership articulates a vision and mission for the life for each patient its programs serve. The rehabilitation staff members, program leaders, program medical directors, and others support and enhance this effort. There is an extraordinary commitment to sustaining access to care. They are committed to producing a positive experience for the patients and value orientation to improve quality, accountability, integrity, and satisfaction across all services. They provide outcomes from the care delivery process for patients, their families, support networks, personnel, and all other stakeholders. The organization demonstrates a strong commitment to all patients and sincere respect for their rights, as evident in well-developed processes and interactions.
- The inpatient units feature spacious rooms, and some include ceiling tracking systems to provide safe lifting and movement from the bed area to the bathing area and toward doorways. There is a great deal of treatment space. The inpatient units have all up-to-date furniture, beds, and equipment.
- Health, safety, and infection control priorities align with the organization's strategic imperatives. The work is characterized by enthusiasm for doing whatever is best for each patient or stakeholder the program serves. Resources are secured to improve operational effectiveness and efficiency and the growth and development of personnel. Of particular note is the organization's collection and analysis of near misses.
- The organization has a well-developed approach to cultural diversity. It has sought to promote patients with diverse backgrounds and managers representative of the staff members.
- Many organizations struggle with providing psychological services. The organization has a well-developed and extensive psychological service and recognizes the impact of trauma on many of its patients and the psychological issues that follow.
- Although many rehabilitation facilities reduce recreational services, University of Maryland Rehabilitation & Orthopaedic Institute is strongly committed to recreational services. It has provided sufficient staff members, resources, and space for its programs. Its dedication to recreational therapy is shown as a therapeutic tool for the patient to express themselves. It also shows strength in its music program, allowing patients to use several therapeutic modalities.
- The organization truly values its personnel. This concern is demonstrated in many ways, but is easily notable through the volume of patients when vacancies occur and many staff members' longevity. The organization is strongly committed to staff member development in its HR development team.
- The organization shows strength in following up on its staff members' surveys, and this follow-up has resulted in changes to workforce processes.
- The organization's PFAC has a well-documented history of providing the patient served with a presence and voice to traditional healthcare committees and processes. Through its PFAC, the organization has included patients in many aspects of the administrative and clinical operations. With its actions, it is beginning to invert the process and put the patients at the top, followed by the direct care staff and management. Through the organization's PFAC, it recognizes that patients are ultimately responsible for creating the outcomes of the care delivered and the satisfaction of the patients and that they benefit from being realized, included, and involved. The organization is especially commended for including PFAC members in its performance improvement process and meetings.
- The organization is commended for its willingness to invest in new technology as an important means to pave the way for future rehabilitation services and interventions. The organization is recognized for its focus on research, taking on developing and delivering important contributions to future rehabilitation knowledge, services, and interventions.
- The organization shows strength in its accelerated recovery program during the COVID-19 pandemic, responding to the needs of its related facilities and patients needing service. Several patients in the acute unit were able to access rehabilitation services who would not otherwise have received them.
- The organization shows strength in recognizing food insecurity, especially among persons served who are aging, people with disabilities, and those with limited incomes.

- The organization has a nice physical space that facilitates the recovery process. Of note, this includes an outdoor space that encourages socialization and connection with a family member, including the availability of journaling for family members. Additionally, there were safe outdoor spaces for patients that would allow all patients to share in the experience, but minimizes risk to patient safety for those with cognitive difficulties.
- The brain injury (BI) program is well connected with research opportunities to enhance evidence-based research that benefits the BI community. The in-house research offices are physically located near the rehabilitation program. In addition, the medical leadership team actively pursues research opportunities.
- Housing options are available for families adjacent to the rehabilitation facility, which is inviting and easily accessible. This reinforces the value the rehabilitation team places on including families and support systems in the rehabilitation process.
- The BI leadership team is a notable strength with its enthusiasm for the program, high degree of collaboration across the inpatient and outpatient program settings, and broad breadth of knowledge.
- The environment utilizes indoor space effectively and expands to outdoor space for mobility, including variable terrain healing gardens with various surfaces and elevations as an excellent way to use the outdoor space that is functional for patients in wheelchairs or those who ambulate. It allows patients and families to test their skills in various environments with support from therapy and nursing to increase confidence and skills for discharge. The organization also stores journals under the benches and encourages patients, families, visitors, and other stakeholders to write their thoughts to support and inspire others. The organization is repurposing the old therapy pool space for updated and expanded therapy gym space on the main level.
- The organization's admissions team includes nursing, occupational therapy, and speech language pathology representatives to assess patients for program admission. This creates a holistic look at the patient and opportunities to improve the process from various perspectives.
- The wound care team recognizes and addresses wounds within the organization and specific units. It has updated processes, provided additional education and training to the interdisciplinary team, and collaborated with its quality specialist to track its data. It is committed to continuous improvement and addressing the needs of even the most complex patients.
- The amputee specialty program providers, therapists, and nurses are very involved in coordinating care at all phases of care for patients and families. Patients voiced high levels of satisfaction with inpatient care, including timely support by nursing staff members, education tailored to their situation and needs, and support of their families for discharge planning and aftercare. They highly complimented providers, therapists, and prosthetists in the outpatient clinic.
- There are open channels of communication among all team members over all varieties of disciplines. Team members are in close physical proximity throughout the day; during patient treatment; and during documentation activities, daily rounds, huddles, and team conferences. The organization utilizes both formal and informal methods of communication for persons served, including family conferences and numerous information boards throughout the rehabilitation programs for stakeholder, such as performance outcomes, stakeholder feedback, staff committee updates, and patient education and safety. It is evident that team members demonstrate mutual respect and value for what each member brings to benefit the program.
- The comprehensive integrated inpatient rehabilitation program benefits from membership in the larger system of care, in which team members are provided with opportunities for professional development and specialization within their field of practice and opportunities for leadership development. Within the program, leadership and staff discuss clinical and patient outcomes and treatment approaches and assess strengths and weaknesses and necessary equipment or educational needs. The program gathers feedback from personnel regarding topics for education and preferred format across disciplines, resulting in better support for existing staff members and new hires through consistency of training methods and outcomes.

- Current and former patients report that the inpatient rehabilitation program has a strong commitment to providing quality therapy services to the patients. The team members of University of Maryland Rehabilitation & Orthopaedic Institute are caring, knowledgeable, positive, and encouraging. They demonstrate excellent teamwork, are passionate about providing high-quality care, and often go out of their way to meet the needs of the patients. In addition to recognizing clinical staff from the treatment teams, patients commented about the care demonstrated by the environmental services team and the excellent quality of meals offered by the organization.
- Members of the admission and case management teams and navigator program display many strengths in their tenure as members of the program, strong patient advocacy skills for a population with diverse rehabilitation and community needs, and proactive communication to facilitate excellent patient-centered care. This is a small team that wears multiple hats, and all members know each other's roles and needs, enabling each to deliver necessary information proactively. They support each other, share resources, are extremely responsive, and demonstrate respect for each other and all members of the rehabilitation team.
- As part of patient and family education, the patient navigation program provides a discharge planning class to teach patients and their caregivers self-management techniques as they transition back into their communities. Patient navigators follow patients telephonically post discharge, focusing on reducing readmissions and patient-centered, value-based care.
- The organization uses a process improvement methodology to identify, measure, process, re-think, and validate (IMPRV) gathered information. The IMPRV program is an innovative approach to quality management, developed to meet University of Maryland Rehabilitation & Orthopaedic Institute's unique needs, combining continuous improvement with business engagement, producing solid programmatic results, as evidenced through distinct progress improvement. One example of this process in action is the Throughput project, which focuses on admission and discharge timeframes. Late-in-the-day and Friday discharges resulted in safety concerns and decreased patient satisfaction. As a result of the IMPRV process, staff members have worked with patients and families to discharge patients earlier in the day and throughout the week, allowing families to better engage community resources on day of discharge, and contact program resources if needs arise. Strategies to reduce barriers to discharge include a "Meds to Beds" program in which the pharmacy technician delivers discharge medications to the patient's room before discharge, allowing the patient and family to review the medications with the primary nurse prior to discharge.
- The program seeks out opportunities for staff to participate in research activities. Recent projects have included a research poster in conjunction with the University of Indianapolis and the University of Maryland Eastern Shore and two recently accepted studies, "Subjective Visual Vertical among Persons with Pusher Syndrome and Left Versus Right Cerebrovascular Accident" and "Effect of VR Environment Immersion on Community Participation and Physical Performance among Persons with Traumatic Brain Injury." Staff members seek out new methods and technologies to prepare patients for reintegration into the community environment.
- The organization has invested in a wide variety of specialty equipment which advances care delivery and supports clinical interventions for professional staff in designing individualized care plans.
- Patients in the stroke specialty program expressed high satisfaction with the services received and remarked often of the collaboration of the team and the care they received.
- The stroke specialty program is committed to enhancing the educational opportunities for team members by hosting outside speakers to come onsite to share the most up-to-date clinical practices.
- The organization provides a dedicated private meditation space for the patients.
- There are numerous support groups offered by the organization that provide and encourage peer interactions, education, and support.
- The organization effectively incorporates volunteers to offer additional activities as an adjunct to the rehabilitation program. Scheduled activities include Sunday Bingo, Yappy Hour, and pet visits.

- The organization has incorporated a diabetic educator within the program who provides patients with a specialized resource for the management and prevention of further disability.
- The organization offers the family/support system with lodging on campus at the Hackerman-Patz House, even if they are not on caseload.
- The organization has incorporated programs, such as "Meds to Beds," rehabilitation navigators, enhanced activities of daily living (ADL) program, and diabetic programming, that are having a positive impact on throughput by minimizing barriers to discharge, improving access to care, and preventing readmissions.
- The program has a special adaptive sporting program allowing patients to explore, trial, and find their way back to recreation and leisure while simultaneously having a positive presence in the entire community for all patients that might benefit from the inspiration of the "I can" mindset brought forth through events such as the adapted sports festival.
- The development and implementation of the "moving on" packet for patients discharged to a skilled nursing facility, with key information regarding current status, critical issues to maintain, the contact information of rehabilitation staff members, and links to educational videos is an innovative way of assisting with maintaining patient function and well-being and providing a nonthreatening form of community education and spinal cord injury education outreach to outlying facilities.
- Three years in a row, the outpatient spinal cord injury (SCI) team patient rating for the likelihood of recommending the program was over 96 percent, with a patient sampling of close to or around 400 patients each year. These scores are commendable and represent the voice of patients who echoed this in each conversation.
- Year over year, the inpatient spinal cord specialty program functional outcomes demonstrate an over-expected ratio exceeding 1.0 for self-care, mobility, and operational efficiency. This is a commendable demonstration of outcome performance that the team should celebrate and reinforces the quality and expertise within the clinical care team.
- Implementing an embedded certified occupational therapist assistant to assist with nursing and therapy collaboration and implementation of enhanced ADL completion and training is a unique model to achieve improved outcomes in tasks that are typically challenging to improve, including bowel and bladder function and lower body bathing and dressing.
- The technology invested in benefiting the SPI population is extensive and state of the art, demonstrating an organizational commitment to this program.
- The patients in the spinal cord specialty program are afforded exceptional educational opportunities, with two to three classes per week, covering an extensive array of topics in an atmosphere that fosters peer relationship development, joint learning, and long-term success. There is also an active support group and a peer mentor program that builds upon one another, providing persons served with abundant resources, augmenting formal psychosocial support.
- The spinal cord team completed a patient conference format that is patient-outcome focused, directing the initial portion of the meeting at reviewing events and outcomes, such as skin tears and incontinence episodes unitwide, ensuring the entire team can have relevant patient information promptly and is then able to quickly pivot to address patient needs. This format, prefacing the common patient-by-patient review, demonstrates the key issues for this group of clinicians and physicians and helps to provide exceptional care to each patient.

Opportunities for Quality Improvement

The CARF survey process identifies opportunities for continuous improvement, a core concept of "aspiring to excellence." This section of the report lists the sections of the CARF standards that were applied on the survey, including a description of the business practice area and/or the specific program(s)/service(s) surveyed and a summary of the key areas addressed in that section of the standards.

In this section of the report, a recommendation identifies any standard for which CARF determined that the organization did not meet the minimum requirements to demonstrate full conformance. All recommendations must be addressed in a QIP submitted to CARF.

In addition, consultation may be provided for areas of or specific standards where the surveyor(s) documented suggestions that the organization may consider to improve its business or service delivery practices. Note that consultation may be offered for areas of specific standards that do not have any recommendations. Such consultation does not indicate nonconformance to the standards; it is intended to offer ideas that the organization might find helpful in its ongoing quality improvement efforts. The organization is not required to address consultation.

When CARF surveyors visit an organization, their role is that of independent peer reviewers, and their goal is not only to gather and assess information to determine conformance to the standards, but also to engage in relevant and meaningful consultative dialogue. Not all consultation or suggestions discussed during the survey are noted in this report. The organization is encouraged to review any notes made during the survey and consider the consultation or suggestions that were discussed.

During the process of preparing for a CARF accreditation survey, an organization may conduct a detailed self-assessment and engage in deliberations and discussions within the organization as well as with external stakeholders as it considers ways to implement and use the standards to guide its quality improvement efforts. The organization is encouraged to review these discussions and deliberations as it considers ways to implement innovative changes and further advance its business and service delivery practices.

Section 1. ASPIRE to Excellence®

1.A. Leadership

Description

CARF-accredited organizations identify leadership that embraces the values of accountability and responsibility to the individual organization's stated mission. The leadership demonstrates corporate social responsibility.

Key Areas Addressed

- Leadership structure and responsibilities
- Person-centered philosophy
- Organizational guidance
- Leadership accessibility
- Cultural competency and diversity
- Corporate responsibility
- Organizational fundraising, if applicable

Recommendations

There are no recommendations in this area.

Consultation

- University of Maryland Rehabilitation & Orthopaedic Institute strives to be a high reliability organization. As a high reliability organization, it seeks to reduce harm and has experienced extended periods without serious accidents or catastrophes. Given the complexity and acuity of its patients, the organization has formally and informally implemented many aspects of a high reliability organization and is encouraged to continue doing so in the future. The organization has many talents and is committed to the patients at all levels, and the resiliency of its staff members through the COVID-19 pandemic is noteworthy. The organization is encouraged to continue efforts in this journey and pass down the process of becoming a highly reliable organization to all management, supervisors, and staff levels.

1.C. Strategic Planning

Description

CARF-accredited organizations establish a foundation for success through strategic planning focused on taking advantage of strengths and opportunities and addressing weaknesses and threats.

Key Areas Addressed

■ Environmental considerations
■ Strategic plan development, implementation, and periodic review

Recommendations

There are no recommendations in this area.

Consultation

- The organization shows strength in having several private rooms. Although it recognizes that there are many factors involved and given the issues associated with the COVID-19 pandemic and other infectious diseases and the difficulty of cohorting like patients, the availability of all private rooms in the comprehensive integrated inpatient rehabilitation unit and particularly in specialty units affords persons served with privacy and dignity. It fosters an environment that promotes personal care and independence and has become the best practice for rehabilitation and residential facilities. While rehabilitation facilities may not become fully "homelike," the organization is encouraged to refer to the Veterans Administration manual on small homes as a guide toward ensuring the rehabilitation and other resident situations are made conductive toward recovery through a reworking of the environment, furniture, and other physical aspects of the units.

1.D. Input from Persons Served and Other Stakeholders

Description

CARF-accredited organizations continually focus on the expectations of the persons served and other stakeholders. The standards in this subsection direct the organization's focus to soliciting, collecting, analyzing, and using input from all stakeholders to create services that meet or exceed the expectations of the persons served, the community, and other stakeholders.

Key Areas Addressed

■ Collection of input from persons served, personnel, and other stakeholders
■ Integration of input into business practices and planning

Recommendations

There are no recommendations in this area.

1.E. Legal Requirements

Description

CARF-accredited organizations comply with all legal and regulatory requirements.

Key Areas Addressed

- Compliance with obligations
- Response to legal action
- Confidentiality and security of records

Recommendations

There are no recommendations in this area.

1.F. Financial Planning and Management

Description

CARF-accredited organizations strive to be financially responsible and solvent, conducting fiscal management in a manner that supports their mission, values, and performance objectives. Fiscal practices adhere to established accounting principles and business practices. Fiscal management covers daily operational cost management and incorporates plans for long-term solvency.

Key Areas Addressed

- Budgets
- Review of financial results and relevant factors
- Fiscal policies and procedures
- Reviews of bills for services and fee structures, if applicable
- Review/audit of financial statements
- Safeguarding funds of persons served, if applicable

Recommendations

There are no recommendations in this area.

1.G. Risk Management

Description

CARF-accredited organizations engage in a coordinated set of activities designed to control threats to their people, property, income, goodwill, and ability to accomplish goals.

Key Areas Addressed

- Risk management plan implementation and periodic review
- Adequate insurance coverage
- Media relations and social media procedures
- Reviews of contract services

Recommendations

There are no recommendations in this area.

1.H. Health and Safety

Description

CARF-accredited organizations maintain healthy, safe, and clean environments that support quality services and minimize risk of harm to persons served, personnel, and other stakeholders.

Key Areas Addressed

- Healthy and safe environment
- Competency-based training on health and safety procedures and practices
- Emergency and evacuation procedures
- Access to first aid and emergency information
- Critical incidents
- Infections and communicable diseases
- Health and safety inspections

Recommendations

There are no recommendations in this area.

Consultation

- The organization has also made strides in developing integrative health methods, techniques, and approaches to augment the positive clinical outcomes of its programs. Many organizations are integrating holistic health and alternative approaches into more traditional approaches. The programs could consider identifying key staff members that may be interested in these approaches and consider creating a special interest work group that include staff members with these interests to explore options, research evidence-based practices, and develop protocols.

1.I. Workforce Development and Management

Description

CARF-accredited organizations demonstrate that they value their human resources and focus on aligning and linking human resources processes, procedures, and initiatives with the strategic objectives of the organization. Organizational effectiveness depends on the organization's ability to develop and manage the knowledge, skills, abilities, and behavioral expectations of its workforce. The organization describes its workforce, which is often composed of a diverse blend of human resources. Effective workforce development and management promote engagement and organizational sustainability and foster an environment that promotes the provision of services that center on enhancing the lives of persons served.

Key Areas Addressed

- Composition of workforce
- Ongoing workforce planning
- Verification of backgrounds/credentials/fitness for duty
- Workforce engagement and development
- Performance appraisals
- Succession planning

Recommendations

There are no recommendations in this area.

Consultation

- It is suggested that the organization encourage many of its nurses to seek certification as a Certified Rehabilitation Registered Nurse (CRRN®). This certification has been moved to an online and remote option, which reduces the amount of travel and expense associated with achieving this certification.

1.J. Technology

Description

Guided by leadership and a shared vision, CARF-accredited organizations are committed to exploring and, within their resources, acquiring and implementing technology systems and solutions that will support and enhance:

- Business processes and practices.
- Privacy and security of protected information.
- Service delivery.
- Performance management and improvement.
- Satisfaction of persons served, personnel, and other stakeholders.

Key Areas Addressed

- Ongoing assessment of technology and data use, including input from stakeholders
- Technology and system plan implementation and periodic review
- Technology policies and procedures

Recommendations

There are no recommendations in this area.

1.K. Rights of Persons Served

Description

CARF-accredited organizations protect and promote the rights of all persons served. This commitment guides the delivery of services and ongoing interactions with the persons served.

Key Areas Addressed

- Policies that promote rights of persons served
- Communication of rights to persons served
- Formal complaints by persons served

Recommendations

There are no recommendations in this area.

1.L. Accessibility

Description

CARF-accredited organizations promote accessibility and the removal of barriers for the persons served and other stakeholders.

Key Areas Addressed

- Assessment of accessibility needs and identification of barriers
- Accessibility plan implementation and periodic review
- Requests for reasonable accommodations

Recommendations

There are no recommendations in this area.

Consultation

- Given the increasing prevalence of bariatric individuals in the general population, it is suggested that at least one room be set up that is fully equipped and geared toward bariatric patients. Further, it is suggested that the weight limit of all equipment used by patients be inventoried and made available to the staff members.

1.M. Performance Measurement and Management

Description

CARF-accredited organizations demonstrate a culture of accountability by developing and implementing performance measurement and management plans that produce information an organization can act on to improve results for the persons served, other stakeholders, and the organization itself.

The foundation for successful performance measurement and management includes:

- Leadership accountability and support.
- Mission-driven measurement.
- A focus on results achieved for the persons served.
- Meaningful engagement of stakeholders.
- An understanding of extenuating and influencing factors that may impact performance.
- A workforce that is knowledgeable about and engaged in performance measurement and management.
- An investment in resources to implement performance measurement and management.
- Measurement and management of business functions to sustain and enhance the organization.

Key Areas Addressed

- Leadership accountability for performance measurement and management
- Identification of gaps and opportunities related to performance measurement and management
- Input from stakeholders
- Performance measurement and management plan
- Identification of objectives and performance indicators for service delivery
- Identification of objectives and performance indicators for priority business functions
- Personnel training on performance measurement and management

Recommendations

There are no recommendations in this area.

1.N. Performance Improvement

Description

CARF-accredited organizations demonstrate a culture of performance improvement through their commitment to proactive and ongoing review, analysis, reflection on their results in both service delivery and business functions, and transparency. The results of performance analysis are used to identify and implement data-driven actions to

improve the quality of programs and services and to inform decision making. Performance information that is accurate and understandable to the target audience is shared with persons served, personnel, and other stakeholders in accordance with their interests and needs.

Key Areas Addressed

- Analysis of service delivery performance
- Analysis of business function performance
- Identification of areas needing performance improvement
- Implementation of action plans
- Use of performance information to improve program/service quality and make decisions
- Communication of performance information

Recommendations

There are no recommendations in this area.

Section 2. The Rehabilitation and Service Process for the Persons Served

Description

The fundamental responsibilities of the organization are to effect positive change in functional ability and independence and self-reliance across environments, while protecting and promoting the rights of the persons served. The persons served should be treated with dignity and respect at all times. All personnel are able to demonstrate their awareness of the rights of the persons served as well as their own rights. The rehabilitation and service process is delivered by an integrated team that includes the person served. The process focuses on clarity of information, efficient use of resources, reduction of redundancy in service delivery, achievement of predicted outcomes, and reintegration of the person served into the person's community of choice.

2.A. Program/Service Structure for all Medical Rehabilitation Programs

Description

A fundamental responsibility of the organization is to provide a comprehensive program structure. The staffing is designed to maximize opportunities for the persons served to obtain and participate in the services provided.

Key Areas Addressed

- Scope of the program and services
- Admission and transition/exit criteria
- Team communication
- Provision of services to any persons who require ventilatory assistance
- Provision of services related to skin integrity and wound care, when applicable

Recommendations

2.A.9.
It is recommended that each program/service implement procedures that address unanticipated service modification, reduction, or exits/transition precipitated by funding or other resource issues.

2.A.11.b.(1)
2.A.11.b.(2)
2.A.11.b.(3)
2.A.11.b.(5)
It is recommended that the organization provide documented personnel training at orientation and regular intervals that includes information on the psychological and social/cultural issues of the patients, legal requirements affecting the organization or the personnel, and suicide prevention.

2.A.14.a.
2.A.14.b.
2.A.14.c.
2.A.14.d.
2.A.14.e.(1)
2.A.14.e.(2)
2.A.14.e.(3)
2.A.14.e.(4)
2.A.14.e.(5)(a)
2.A.14.e.(5)(b)
2.A.14.e.(5)(c)
Although the organization demonstrates an outpatient collection of denials and interrupted services it did not include in its data collection service referral determined to be ineligible. Furthermore, the data, while analyzed addressing trends, actions for improvement, results of improvement, and necessary education and training, it completed this analysis on a triannual basis, reviewing the 2020, 2021, and 2022 in aggregate. It is recommended that the organization complete a written analysis to be provided to or conducted by leadership at least annually of all denials, service referrals determined to be ineligible, and interrupted services that addresses causes; trends; actions for improvement; results of performance improvement plans; and necessary education and training of personnel, payers and regulatory agencies. The outpatient department might work with leadership to streamline this process through an automated report created by the IT team members to decease the manual labor component of this data extraction, allowing key leadership time to be better spent on analysis of results and program improvement.

2.A.22.b.
It is recommended that, if a wound is present, the interdisciplinary team for each patient should implement written protocols that address when the wound care needed is outside of the scope of the program and referrals to or coordination with appropriate wound care specialists. The wound care team identified could address most of the wound care needs within the program, but there are wounds that do worsen or dehisce that need to return to acute care for management or surgical intervention. The organization could update the written protocol to reflect when patients need to leave the organization for wounds and how referrals or discharge recommendations are made.

2.A.26.b.(1)(a)
2.A.26.b.(1)(b)
2.A.26.b.(1)(c)
2.A.26.b.(2)
2.A.26.b.(3)
2.A.26.b.(4)
2.A.26.b.(5)(a)
2.A.26.b.(5)(b)
2.A.26.b.(5)(c)
The program at least annually conducts a written analysis that includes performance in relationship to established targets for wounds present at admission to the program that improved during the program, those wounds present at admission that worsened during the program, and new wounds that developed during the program. The results and targets are compared to previous year data by program. However, the written analysis does not include trends,

actions for improvement, and results of performance improvement plans specific to the programs that ideally correlate to data tracked on wounds. It is recommended that the organization's written analysis for performance in relationship to established targets for wounds present at admission to the program that improved during the program, wounds present at admission to the program that worsened during the program, and new wounds that developed during the program include trends; actions for improvement; results of performance improvement plans; and necessary education and training of patients, families/support systems, and personnel. The organization could consider setting targets other than previous year by type of wound, interventions available, and impact of interventions or practice changes on wounds in the program and trend that data for sustainable outcomes. Organizing data by type of wound (i.e., surgical incision, nonvascular, vascular, or incontinence dermatitis) could help quantify the number of wounds requiring more extensive intervention and/or team resources and outcomes of those interventions. This could create possibilities for other quality improvement projects or initiatives at the organizational and program level. Specific to the amputee specialty program, the organization could consider tracking surgical incisions related to amputation separately from other post-operative incisions relative to higher risks for further wounds and/or amputations to the ipsilateral and contralateral sides with this population.

Consultation

- The scope of services is reviewed annually and updated as necessary. To facilitate tracking of changes on an annual basis, the organization may consider adding the scope within PolicyStat so that dates of reviews and updates may be electronically tracked.
- The organization has a wound care checklist for RNs who are Wound Ostomy Continence Nurses (WOCN) certified for new employee orientation. This checklist also has a column for annual training in all areas. The wound care team reports that this checklist is used for new orientation only and that ongoing competency and education is obtained via other trainings, online programs, and courses. It is suggested that the wound care checklist be updated to reflect initial orientation only.

2.B. The Rehabilitation and Service Process for the Persons Served

Key Areas Addressed

- Scope of the program services
- Appropriate placement in and movement through the continuum of services
- Admission and ongoing assessments
- Information provided to persons served for decision making
- Team composition
- Team responsibilities and communication
- Medical director/physician providing medical input qualifications and responsibilities
- Discharge/transition planning and recommendations
- Family/support system involvement
- Education and training of persons served and families/support systems
- Sharing of outcomes information with the persons served
- Physical plant
- Behavior management
- Records of the persons served

Recommendations

2.B.46.a.
2.B.46.b.(1)
2.B.46.b.(2)
2.B.46.b.(3)
2.B.46.c.(1)(a)
2.B.46.c.(1)(b)
2.B.46.c.(1)(c)
2.B.46.c.(2)
2.B.46.c.(3)
2.B.46.c.(4)
2.B.46.c.(5)

The program provided documented evidence of annual chart audits for outpatient therapy; however, no evidence was provided indicating a written analysis was conducted on a representative sample of records for the inpatient program. Furthermore, the data collected by the outpatient program was presented as a triannual analysis. It is recommended that the program conduct a written analysis of a representative sample of records of the patients at least annually that includes documentation completed in accordance with the organization's policies; regulatory requirements, if applicable; and CARF documentation requirements. The written analysis should include performance in relationship to established targets for documentation in accordance with the organization's policies; regulatory requirements, if applicable; and CARF documentation requirements and include identification of trends, actions for improvement, results of performance improvement plans, and necessary education and training of personnel. For the existing outpatient data, and future inpatient data, the program might consider not only a percentage result, but the number of charts reviewed, allowing a clear demonstration that the volume of audits was an adequate representative sample of patients. For example, 500 patients might warrant 50 reviewed for a 10 percent capture.

Consultation

- The inpatient unit features spacious private rooms and some include ceiling tracking systems to provide safe lifting and movement from the bed area to the bathing area and toward doorways. The organization is encouraged to have all rooms equipped with ceiling lifts to promote rehabilitation and reduce staff injuries.
- The inpatient program might want to consider reviewing the VA manual on small homes as a guide toward ensuring that the rehabilitation and other patient situations are made conductive toward recovery through a reworking of the environment, furniture, and other physical aspects of the units.

2.E. The Rehabilitation and Service Process for Children and Adolescents Served

Key Areas Addressed

- Provision of services to any children/adolescents
- Family involvement throughout program
- Developmentally, culturally, and age-appropriate programs
- Competencies of personnel
- Education and training of the children/adolescents served and their families/support systems
- Communication with the school system

Recommendations

2.E.1.b.
Although information related to age range and numbers of patients is shared with the public, prospective patients and their families/support systems, and other relevant stakeholders, the number of patients is not shared annually. It is recommended that the organization share information with the public, prospective patients and their families/support systems, and other relevant stakeholders regarding the number of patients annually by age group. Verbiage related to age range that is shared in the scope of services mentions age and weight combinations, but the programs admit no patients under the age of 14. The scope includes all potential age ranges based on provider credentialing and ability to serve those ages. For patients, it is suggested that the program outcome data that is shared on each program's snapshot report indicate that the age range was changed from zero to 17 to 14-17.

Consultation

- The program implements policies and written procedures that address the opportunity for families to remain with patients 24/7. The verbiage is applicable, but not specific to the patient's population. The program may consider updating the language of the policies and written procedures to specifically address patients.
- Each patient is surveyed to measure experience of services received on a case-by-case basis to ensure age- and developmentally appropriate issues are addressed. If greater numbers of patients are served over time, the program may consider use of a standard format that is age- and developmentally appropriate in order to facilitate analysis of this data across patients.
- The education and training program for the family/support system of each patient is developed on an individual basis for that family/support system and addresses all aspects of the standard. If greater numbers of patients are served over time, the program may consider use of a standard education and training program for the family/support system of patients.

2.F. Service Delivery Using Information and Communication Technologies

Description

Depending on the type of program, a variety of terminology may be used to describe the use of information and communication technologies to deliver services; e.g., telepractice, telehealth, telemental health, telerehabilitation, telespeech, etc. Based on the individual plan for the person served, the use of information and communication technologies allows providers to see, hear, and/or interact with persons served, family/support system members, and other providers in remote settings.

The provision of services via information and communication technologies may:

■ Include services such as assessment, individual planning, monitoring, prevention, intervention, follow-up, supervision, education, consultation, and counseling.
■ Involve a variety of professionals such as case managers/service coordinators, social workers, psychologists, speech-language pathologists, occupational therapists, physical therapists, physicians, nurses, rehabilitation engineers, assistive technologists, and teachers.
■ Encompass settings such as:
- Hospitals, clinics, professional offices, and other organization-based settings.
- Schools, work sites, libraries, community centers, and other community settings.
- Congregate living, individual homes, and other residential settings.

The use of technology for strictly informational purposes, such as having a website that provides information about the programs and services available, is not considered providing services via the use of information and communication technologies.

Key Areas Addressed

- Written procedures for the use of information and communication technologies (ICT) in service delivery
- Personnel training on how to deliver services via ICT and the equipment used
- Instruction and training for persons served, family/support system members, and others
- Provision of information related to ICT
- Maintenance of ICT equipment
- Emergency procedures that address unique aspects of service delivery via ICT

Recommendations

There are no recommendations in this area.

Section 3. Program Standards

3.A. Comprehensive Integrated Inpatient Rehabilitation Program

Description

A Comprehensive Integrated Inpatient Rehabilitation Program is a program of coordinated and integrated medical and rehabilitation services that is provided 24 hours a day and endorses the active participation and preferences of the person served throughout the entire program. The preadmission assessment of the person served determines the program and setting that will best meet the needs of the person served. The person served, in collaboration with the interdisciplinary team members, identifies and addresses medical and rehabilitation needs. The individual resource needs and predicted outcomes of the person served drive the appropriate use of the rehabilitation continuum of services, the provision of care, the composition of the interdisciplinary team, and discharge to the community of choice.

The scope and intensity of care provided are based on a medical and rehabilitation preadmission assessment of the person served. An integrated interdisciplinary team approach is reflected throughout all activities. To ensure the transparency of information the program provides a disclosure statement to each person served that addresses the scope and intensity of care that will be provided.

A Comprehensive Integrated Inpatient Rehabilitation Program clearly identifies the scope and value of the medical and rehabilitation services provided. Dependent on the medical stability and acuity of the person served, a Comprehensive Integrated Inpatient Rehabilitation Program may be provided in a hospital, skilled nursing facility, long-term care hospital, acute hospital (Canada), or hospital with transitional rehabilitation beds (Canada). Through a written scope of services, each program defines the services provided, intensity of services, frequency of services, variety of services, availability of services, and personnel skills and competencies. Information about the scope of services and outcomes achieved is shared by the program with stakeholders.

Key Areas Addressed

- Preadmission assessment
- Privileging process
- Appropriate placement in the continuum of services
- Secondary prevention
- Rehabilitation nursing services
- Rehabilitation physician/medical services and management
- Program-specific information-gathering requirements
- Information gathering regarding durability of outcomes

Recommendations

3.A.15.a.(1)
3.A.15.a.(2)
3.A.15.a.(3)
3.A.15.b.(1)(a)
3.A.15.b.(1)(b)
3.A.15.b.(1)(c)
3.A.15.b.(2)
3.A.15.b.(3)
3.A.15.b.(4)
3.A.15.b.(5)(a)
3.A.15.b.(5)(b)
3.A.15.b.(5)(c)

Although the inpatient rehabilitation unit gathers information related to unplanned transfers to acute medical facilities, discharges to long-term care, and expiration, this is done for all programs in aggregate. The analysis available is not inclusive of all data points for three years and does not include all programs of service. It is recommended that the comprehensive integrated inpatient rehabilitation program gather information on each patient, including information on unplanned transfers to acute medical care facilities, discharges to long-term care, and expiration and complete a written analysis at least annually that addresses performance in relationship to established targets for unplanned transfers to acute medical facilities, discharges to long-term care, and expiration. The written analysis should identify trends; actions for improvement; results of performance improvement plans; and any necessary education and training of personnel, payers, and regulatory organizations.

3.A.16.a.
3.A.16.b.(1)
3.A.16.b.(2)
3.A.16.b.(3)
3.A.16.b.(4)
3.A.16.c.(1)(a)
3.A.16.c.(1)(b)
3.A.16.c.(1)(c)
3.A.16.c.(1)(d)
3.A.16.c.(2)
3.A.16.c.(3)
3.A.16.c.(4)
3.A.16.c.(5)(a)
3.A.16.c.(5)(b)
3.A.16.c.(5)(c)

The inpatient programs began collecting data through Medtel Communications questionnaires in 2022 to obtain data related to the durability of outcomes achieved with built in trending graphs. One year of data was presented, but no analysis has been completed by the organization validating internal targets; actions for improvement; results of performance improvement plans; and the necessary education and training of patients, families/support systems, and healthcare providers. It is recommended that, to access the durability of outcomes achieved, the comprehensive integrated inpatient rehabilitation program define its timeframe(s) for collecting long-term, follow-up information on the patients and systematically gather information on the patients, including information on activity, environment, health status, and participation. At least annually, the program should conduct a written analysis that addresses performance in relationship to established targets for activity, environment, health status, and participation and address trends; actions for improvement; results of performance improvement plans; and necessary education and training of patients, families/support systems, and healthcare providers.

Consultation

- The organization may consider supporting staff efforts to obtain the credential of CRRN®, allowing those individuals to validate their level of knowledge and commitment to patient care and the organization to demonstrate commitment to staff education and provision of quality care and services by continuing to increase the percentage of nurses with CRRN® designations on the rehabilitation units.

3.B. Outpatient Medical Rehabilitation Program

Description

An Outpatient Medical Rehabilitation Program is an individualized, coordinated, outcomes-focused program that promotes early intervention and optimizes the activities and participation of the persons served. The program, through its scope statement, defines the characteristics of the persons it serves. An assessment process initiates the individualized treatment approach for each person served, which includes making medical support available based on need. The program includes direct service provision, education, and consultations to achieve the predicted outcomes of the persons served. Information about the scope and value of services is shared with the persons served, the general public, and other relevant stakeholders.

The strategies utilized to achieve the predicted outcomes of each person served determine whether the individual program is single discipline or an interdisciplinary service. A Single Discipline Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served who require services by a professional with a health-related degree who can address the assessed needs of the person served. An Interdisciplinary Outpatient Medical Rehabilitation Program focuses on meeting the needs of persons served that are most effectively addressed through a coordinated service approach by more than one professional with a health-related degree who can address the assessed needs of the person served.

The settings for Outpatient Medical Rehabilitation Programs include, but are not limited to, health systems, hospitals, freestanding outpatient rehabilitation centers, day hospitals, private practices, and other community settings.

Key Areas Addressed

- Program-specific information-gathering requirements
- Personnel requirements
- Team composition
- Types and provision of services
- Analysis of no-shows, cancellations, and dropouts

Recommendations

3.B.4.a.
Although the organization demonstrates an outpatient collection of data related to dropouts, cancellations, and no shows with analysis addressing trends, actions for improvement, results of improvement and necessary education and training, it appears to be completed on a triannual basis, reviewing the 2020, 2021, and 2022 in aggregate. It is recommended that the written analysis of no-show, dropouts, and cancellations for each outpatient medical rehabilitation program be conducted at least annually. As previously noted, the outpatient department might work with leadership to streamline this process through automated report features with the IT team to decease the manual labor component of this data extraction, allowing key leadership time to be better spent on analysis of results and program improvement.

Section 4. Specialty Program Designation Standards

4.B. Amputation Specialty Program

Description

A person-centered Amputation Specialty Program utilizes a continuum of care with a holistic interdisciplinary team approach. Interventions address the needs and desires of the person served and family/support systems and include, but are not limited to, medical, rehabilitation, behavioral, psychosocial, vocational, avocational, and educational needs; prosthetic, orthotic, and pedorthic services; equipment; self-management of healthcare; preventive strategies; identification and use of peer support; and techniques to facilitate empowerment. The program supports and establishes connections to the local and national community that enhance the quality of the person's everyday life. The person served actively participates as a member of the interdisciplinary team to develop and understand the services provided and the impact on functional abilities.

The Amputation Specialty Program focuses on strategies of collaboration to impact perioperative care, prevention, minimizing impairment, maximizing independent function, and maximizing the quality of life of the person served. Through the use of performance indicators, the program measures the results achieved for the persons served across the continuum offered.

An Amputation Specialty Program may be provided in a variety of settings, including hospitals, healthcare systems, outpatient clinics, community-based programs, and residential services.

Key Areas Addressed

- Intervention services provided for persons served and their families/support systems
- Prevention of further limb loss and complications
- Continuum of services
- Health assessments
- Education of the persons served and their families/support systems
- Discharge/transition recommendations
- Data collection regarding the effectiveness of the services provided

Recommendations

4.B.9.a.
4.B.9.b.
4.B.9.c.
The organization should have documented evidence of training of peer supporters on current practices in peer support services, including, at a minimum, the role of peer supporters, boundaries, and communication skills. The organization utilizes the Amputee Coalition for education and training of peer mentors in its program, but does not have updated certificates of ongoing training. The organization has plans to restart its peer mentor training program soon and anticipates a more formalized training program to complete training elements in person and electronically to ensure peer mentors are certified before meeting with patients.

4.B.16.b.(2)
4.B.16.b.(3)
4.B.16.b.(4)
The organization does gather information on the number of patients who experience additional amputation from admission to discharge in the amputation specialty program involving both the residual and contralateral limb and those who developed new foot ulcers, if applicable, and does have established targets for each area. The organization should at least annually conduct a written analysis that includes trends, actions for improvement, and results of performance improvement plans.

4.B.17.a.(1)
4.B.17.a.(2)(a)
4.B.17.a.(2)(b)
4.B.17.a.(3)
4.B.17.b.(1)(a)
4.B.17.b.(1)(b)(i)
4.B.17.b.(1)(b)(ii)
4.B.17.b.(1)(c)
4.B.17.b.(2)
4.B.17.b.(3)
4.B.17.b.(4)
4.B.17.b.(5)(a)
4.B.17.b.(5)(b)
4.B.17.b.(5)(c)
It is recommended that the amputation specialty program gather information on each patient at follow-up, including information on the use of the prosthesis after discharge, the number of patients who experience additional amputation after discharge from the amputation specialty program involving the residual and contralateral limb, and the number of patients who developed new foot ulcers after discharge from the amputation specialty program, if applicable. The amputation specialty program should at least annually conduct a written analysis that includes performance in relationship to established targets for the use of the prosthesis after discharge, the number of patients who experience additional amputation after discharge from the amputation specialty program involving the residual and contralateral limb and the number of patients who developed new foot ulcers after discharge from the amputation specialty program and include trends; actions for improvement; results of performance improvement plans; and necessary education and training of patients, families/support systems, and personnel. The organization may need to explore methods of tracking this data in the outpatient program consistently. Targets could be based on national data, regional data, or even program-specific numbers from previous years that are meaningful to improvements in the program itself.

4.C. Brain Injury Specialty Program

Description

A Brain Injury Specialty Program delivers services that focus on the unique medical, physical, cognitive, communication, psychosocial, behavioral, vocational, educational, accessibility, and leisure/recreational needs of persons with acquired brain injury. The program integrates services to:

- Minimize the impact of impairments and secondary complications.
- Reduce activity limitations.
- Maximize participation, including wellness, quality of life, and inclusion in the community.
- Decrease environmental barriers.
- Promote self-advocacy.

A Brain Injury Specialty Program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. It provides access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized program for persons with acquired brain injury. A Brain Injury Specialty Program utilizes current research and evidence to provide effective rehabilitation and supports future improvements by advocating for or participating in brain injury research.

A Brain Injury Specialty Program partners with the persons served, families/support systems, and providers from emergency through community-based services to foster an integrated system of services that optimizes recovery, adjustment, inclusion, participation, and prevention. A Brain Injury Specialty Program engages and partners with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a brain injury to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large.

Key Areas Addressed

- Continuum of services
- Intervention services provided for persons served and their families/support systems
- Facilitation of advocacy for the persons served
- Personal preferences of persons served
- Initial and ongoing assessments of persons served
- Discharge/transition planning
- Prevention of complications and re-injury
- Program-specific information-gathering requirements
- Education for persons served and their families/support systems
- Knowledge and application of clinical research to treatment practices

Recommendations

4.C.33.a.(1)(a)
4.C.33.a.(1)(b)
4.C.33.a.(1)(c)
4.C.33.a.(1)(d)(i)
4.C.33.a.(1)(d)(ii)
4.C.33.a.(2)(a)
4.C.33.a.(2)(b)
4.C.33.a.(2)(c)
4.C.33.b.(1)(a)(i)
4.C.33.b.(1)(a)(ii)
4.C.33.b.(1)(a)(iii)
4.C.33.b.(1)(a)(iv)
4.C.33.b.(1)(a)(v)
4.C.33.b.(1)(b)(i)
4.C.33.b.(1)(b)(ii)
4.C.33.b.(1)(b)(iii)
4.C.33.b.(2)
4.C.33.b.(3)
4.C.33.b.(4)
4.C.33.b.(5)(a)

4.C.33.b.(5)(b)
4.C.33.b.(5)(c)
4.C.33.b.(5)(d)
The BI specialty program has gaps in data for 2020 and 2021, and elements for this standard were not found. Additionally, while the data for 2022 has all the elements from patients and support systems, the program has not gathered this information from other stakeholders. It is recommended that the BI specialty program consistently gather information on experience of services received and other feedback, including clinical practices/behaviors; the degree of inclusion of the patients in its programs; outcomes achieved; and information received about the program, including accuracy of information and usefulness of information from patients, families/support systems, and other relevant stakeholders. At least annually, the BI specialty program should conduct a written analysis that addresses performance in relationship to established targets for experience of services received and other feedback regarding clinical practices/behaviors; the degree of inclusion of the persons served in their programs; outcomes achieved; and accuracy of information received about the program and usefulness of information received about the program from persons served, families/support systems, and other relevant stakeholders. The written analysis should address trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, healthcare providers, and personnel. As part of gathering information from stakeholders, the organization is encouraged to utilize this opportunity to not just gather information, but to also share information with stakeholders about patient outcomes as well.

Consultation

- Although the BI leadership and staff members can certainly verbalize well the scope of interventions for both inpatient and outpatient services, the written scopes for the inpatient versus outpatient program vary, with the latter much more general in nature. It is encouraged that the program broadens the inpatient treatment scope to incorporate outpatient treatment services, or the organization could write a separate scope for outpatient services specifically for patients with BI.
- While sexually inappropriate behavior is addressed well in the program, the program may wish to consider more robust policy or processes for sexually inappropriate behavior as the role of cognitive impairment may often determine how to best manage it (such as occurs with visitor coming into the facility) and a process or policy that distinguishes between behavior that is intentional verses when the person served is unable to control behavior that may be a treatment focus.
- Although wellness opportunities are provided to patients, the program is encouraged to broaden its definition of wellness to include a focus on lifelong habits that could help promote recovery and sustain durability of outcomes. For example, focusing on how patients could develop good self-care routines for diet, exercise, socialization, and more.

4.E. Spinal Cord Specialty Program

Description

A person-centered spinal cord specialty program utilizes a holistic, culturally aware, interdisciplinary team approach to address the unique rehabilitation needs of persons who have been diagnosed with spinal cord dysfunction, whether due to trauma or disease. A spinal cord specialty program may be provided in a variety of settings, including inpatient, outpatient, home and community, residential, and vocational settings. Personnel demonstrate competencies and the application of evidence-based practices to deliver services that address the preventive, restorative, supportive, and lifelong rehabilitation needs of the persons served.

The spinal cord specialty program focuses on strategies to optimize outcomes in an effort to prevent impairments or minimize the impact thereof, reduce activity limitations, and maximize participation for the persons served. The program communicates and collaborates with all appropriate healthcare providers and other relevant stakeholders to deliver coordinated care and promote appropriate transitions in the continuum of care.

The program is guided by the individual preferences, strengths, and needs of the persons served and their families/support systems. Throughout the program the person's perception of and adjustment to disability are considered and addressed. A spinal cord specialty program assists the persons served to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available and encompasses care that advocates for full inclusion to enhance the lives of the persons served within their families/support systems, communities, and life roles.

The program demonstrates the commitment, capabilities, and resources to maintain itself as a specialized spinal cord program. The spinal cord specialty program formally links with key components of care that address the lifelong needs of the persons served. A spinal cord specialty program advocates on behalf of persons served to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A spinal cord specialty program translates current research evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in spinal cord research.

Key Areas Addressed

- Scope of services
- Identified needs of the persons served
- Peer support services
- Health and wellness activities
- Leadership support of advancing the field of spinal cord rehabilitation
- Organized education program
- Community education and advocacy
- Consideration of life-long follow-up care
- Role as a resource for other spinal cord programs
- Evidence of long-term positive outcomes
- Knowledge and application of clinical research to treatment practices

Recommendations

4.E.21.a.(1)
4.E.21.a.(2)
4.E.21.a.(3)
4.E.21.a.(4)
4.E.21.a.(5)
4.E.21.b.(1)(a)
4.E.21.b.(1)(b)
4.E.21.b.(1)(c)
4.E.21.b.(1)(d)
4.E.21.b.(1)(e)
4.E.21.b.(2)
4.E.21.b.(3)
4.E.21.b.(4)
4.E.21.b.(5)(a)
4.E.21.b.(5)(b)
4.E.21.b.(5)(c)
4.E.21.b.(5)(d)

Although data is collected regarding rehospitalizations, adjustment to disability health promotion, independence and autonomy, and a return to productive activity, the data is specific to the inpatient program only. Furthermore, the data is not analyzed for trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, healthcare providers, and others as appropriate. It is recommended that the spinal cord specialty programs gather follow-up information on a representative sample of the patients on rehospitalizations, adjustment to disability, health promotion,

independence and autonomy, and return to productive activity. At least annually, the spinal cord specialty programs should conduct a written analysis that addresses performance in relationship to established targets for rehospitalizations, adjustment to disability, health promotion, independence and autonomy, and return to productive activity, that addresses trends; actions for improvement; results of performance improvement plans; and necessary education and training of patients, families/support systems, healthcare providers, and others, as appropriate.

4.E.27.a.
4.E.27.b.
4.E.27.c.
4.E.27.d.
4.E.27.e.
4.E.27.f.
4.E.27.g.
4.E.27.h.
4.E.27.i.

Although the program has knowledgeable staff members with expertise in the care of SCI rehabilitation, the inpatient and outpatient spinal cord specialty programs are urged to ensure that there is documented competency-based education provided to personnel that includes, but is not limited to, medical/physiological sequelae, function, psychosocial issues, transitions across the lifespan, resource management, health promotion and wellness, resources for independent living and community integration, prevention related to potential risks and secondary health conditions, and safety for patients in the environments in which they participate. The program might consider using existing presentations, expanding upon them to include all criteria noted, and implementing a process by which review of this information is established. This might as simple as a form that indicates the staff members have read and understand the information contained.

Consultation

- The program is commended for an extensive implementation of peer opportunities, which were evident as a part of the overall program culture. The program demonstrated evidence of training; however, it might consider enhancing its documentation tracking system to include date of initial certification and any ongoing training or updates. The program might also implement a risk management system related to peer involvement that includes the current persons served signing a consent for visit when one on one and a HIPPA release if medical information is to be shared in advance by the clinical team.
- The spinal cord program might consider enhanced utilization of the discharge nurse navigator to assist with the population of patients discharging to nursing home/skilled care as an intermediate step prior to home. This population is at high risk to fall through the cracks with issues that might be proactively managed upon discharge to home, versus discovery at annual follow-up or during outpatient therapy services. This could be particularly important for this diagnostic group due to the volume of highly complex patients served, many of whom require post-acute placement prior to discharge home.
- The program has a long history of investment into research progressing the field of rehabilitation. In light of shrinking funds and staffing and in an effort to ensure this incredible legacy continues, the program might consider how endowment programs or other resources could be used to reinvigorate and sustain research capabilities within the organization for many years to come. This might include resources for full investigational research projects or bedside clinician education and research programs.

4.F. Stroke Specialty Program

Description

A stroke specialty program, through application of the research available to clinical practice, delivers services that focus on the unique needs of persons who have sustained a stroke, including:

- Minimizing impairments and secondary complications.
- Reducing activity limitations.
- Maximizing participation and quality of life.
- Decreasing environmental barriers.
- Preventing recurrent stroke.

The program recognizes the individuality, preferences, strengths, and needs of the persons served and their families/support systems. A stroke specialty program assists the persons served and their families/support systems to manage their own health, encourages their appropriate use of healthcare systems and services, and supports their efforts to promote personal health and wellness and improve quality of life throughout their life span. The program provides ongoing access to information, services, and resources available to enhance the lives of the persons served within their families/support systems, communities, and life roles.

A stroke specialty program partners with the persons served, families/support systems, and providers within and outside of rehabilitation throughout phases of care from emergency through community-based services. A stroke specialty program fosters an integrated system of care that optimizes prevention, recovery, adaptation, and participation.

A stroke specialty program contributes to the development of stroke systems of care by partnering with providers within and outside of rehabilitation to increase access to services by advocating for persons who have sustained a stroke to regulators, legislators, educational institutions, research funding organizations, payers, and the community at large. A stroke specialty program utilizes current research and evidence to provide effective rehabilitation and supports future improvements in care by advocating for or participating in stroke research.

Key Areas Addressed

- Intervention services provided for persons served and their families/support systems
- Prevention of recurrent stroke and the complications of stroke
- Reducing activity limitations and decreasing environmental barriers
- Continuum of services
- Health assessments and promotion of wellness
- Education for persons served and their families/support systems
- Maximizing participation and quality of life
- Discharge/transition recommendations
- Data collection and analysis regarding the effectiveness of the program
- Evidence of long-term positive outcomes

Recommendations

4.F.20.a.(1)
4.F.20.a.(2)
4.F.20.a.(3)
4.F.20.a.(4)
4.F.20.a.(5)
4.F.20.a.(6)
4.F.20.b.(1)(a)
4.F.20.b.(1)(b)
4.F.20.b.(1)(c)
4.F.20.b.(1)(d)
4.F.20.b.(1)(e)
4.F.20.b.(1)(f)
4.F.20.b.(2)
4.F.20.b.(3)
4.F.20.b.(4)
4.F.20.b.(5)(a)
4.F.20.b.(5)(b)
4.F.20.b.(5)(c)

It is recommended that the stroke specialty program gather follow-up information on a representative sample of the patients, including information on aspiration pneumonia, falls, falls with injuries, other injuries, re-hospitalizations, and unplanned medical visits/encounter. At least annually, the stroke specialty program should conduct a written analysis that addresses performance in relationship to established targets for follow-up information regarding aspiration pneumonia, falls, falls with injuries, other injuries, re-hospitalizations, and unplanned medical visits/encounters that addresses trends; actions for improvement; results of performance improvement plans; and necessary education and training of persons served, families/support systems, and healthcare providers.

Consultation

- The organization may consider transitioning to a centralized electronic scheduling platform, which could enhance the systematic approach used to maximizing the intensity of services by providing transparency and efficient utilization of program resources.
- The organization may consider modifying the performance indicators collection methods for measuring the percentage of patients who, at the time of discharge, are in compliance with evidence-based guidelines. In addition, it may want to consider incorporating evidence-based guidelines into stroke education groups and/or discipline-specific sessions, as this might enhance the program outcomes.

Program(s)/Service(s) by Location

University of Maryland Rehabilitation & Orthopaedic Institute

2200 Kernan Drive
Baltimore, MD 21207

Inpatient Rehabilitation Programs - Hospital (Adults)
Inpatient Rehabilitation Programs - Hospital (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Amputation Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Brain Injury Specialty Program (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Spinal Cord Specialty Program (Adults)
Inpatient Rehabilitation Programs - Hospital: Spinal Cord Specialty Program (Children and Adolescents)
Inpatient Rehabilitation Programs - Hospital: Stroke Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Amputation Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Brain Injury Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Brain Injury Specialty Program (Children and Adolescents)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Adults)
Interdisciplinary Outpatient Medical Rehabilitation Programs: Spinal Cord Specialty Program (Children and Adolescents)

EXHIBIT 14

September 14, 2023

Julie Nemens
Chief Administrative Officer
James Lawrence Kernan Hospital, Inc.
2200 Kernan Drive
Baltimore, MD 21207

Joint Commission ID #: 6251
Program: Hospital Accreditation
Accreditation Activity: 60-day Evidence of Standards Compliance
Accreditation Activity Completed : 9/14/2023

Dear Ms. Nemens:

The Joint Commission is pleased to grant your organization an accreditation decision of Accredited for all services surveyed under the applicable manual(s) noted below:

Comprehensive Accreditation Manual for Hospitals

This accreditation cycle is effective beginning July 8, 2023 and is customarily valid for up to 36 months. Please note, The Joint Commission reserves the right to shorten the duration of the cycle.

Should you wish to promote your accreditation decision, please view the information listed under the'Publicity Kit' link located on your secure extranet site, The Joint Commission Connect.

The Joint Commission will update your accreditation decision on Quality Check®.

Congratulations on your achievement.

Sincerely,

Ken Grubbs, DNP, MBA, RN
Executive Vice President and Chief Nursing Officer
Division of Accreditation and Certification Operations