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August 30, 2019

VIA ELECTRONIC MAIL
AND HAND DELIVERY

Mr. Ben Steffen
Executive Director
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Exemption Notice of Acquisition of Bon Secours Hospital Baltimore, Inc., by LifeBridge Health, Inc.

Dear Mr. Steffen:

This is written on behalf of LifeBridge Health, Inc. ("LBH"), Sinai Hospital of Baltimore, Inc. ("Sinai Hospital"), and Northwest Hospital Center, Inc. (collectively, the "Joint Applicants") to (1) provide notice to the Maryland Health Care Commission ("MHCC") of their intent to reallocate inpatient behavioral health bed capacity and services, and to make certain related capital expenditures, within a merged asset system pursuant to a consolidation or merger of two or more health care facilities, and (2) request an exemption from certificate of need (CON) review for such reallocation and capital expenditures.

As described further below, the proposed reallocation of inpatient behavioral health bed capacity and services will be from Bon Secours Hospital Baltimore, Inc. ("Bon Secours Hospital") (which is to become a part of the LBH health system on or about November 1, 2019) to Sinai Hospital and Northwest Hospital, existing members of the LBH system. The related capital expenditures will be incurred by Sinai Hospital and Northwest Hospital in order to renovate existing space to accommodate the additional behavioral health beds coming from Bon Secours Hospital.

BACKGROUND

1. The Master Affiliation Agreement

On August 26, 2019, LBH notified the MHCC of LBH's intent to acquire Bon Secours Hospital on or about November 1, 2019. The acquisition will be pursuant to a Master Affiliation

Agreement dated August 19, 2019 (the "MAA") between LBH and Bon Secours Hospital, Bon Secours Baltimore Health Corporation (the current sole member of Bon Secours Hospital) and its sole member, Bon Secours Mercy Health Inc. Pursuant to the MAA, upon the consummation of the transaction, LBH will become the sole member of Bon Secours Hospital, and Bon Secours Hospital will join the LBH system, along with Sinai Hospital, Northwest Hospital, Carroll Hospital Center and Levindale Hebrew Geriatric Center and Hospital. An organizational chart of the LBH system post-closing (including Bon Secours Hospital) is attached as **Exhibit 1**.

2. The Plan To Reconfigure and Enhance Services to West Baltimore Under the MAA

In executing the MAA, the parties recognized that they share a common and unifying charitable mission: to provide high quality, affordable health care and health care-related services, expand access to health care services, and promote and improve the health care status of the communities they serve, including care of the poor and underserved. With that united mission, the MAA recognizes the parties' shared belief that they can develop a strategic relationship that will enhance and reconfigure health care delivery in West Baltimore, generating savings that can be used to modernize the healthcare facilities serving the West Baltimore community, and allow the commitment of resources to community investments that will address the social determinants of health, reduce health disparities, improve the delivery of healthcare in, and benefit the poor and underserved of, the West Baltimore community.

Through an enhancement and reconfiguration of health care delivery in West Baltimore, the transaction is intended to generate savings that can be used to modernize the health care facilities serving the Bon Secours Hospital community, as well as the commitment of resources to community investments aimed at addressing the social determinants of health.[1] Through these efforts, the aim is to reduce health disparities and improve the delivery of health care in West Baltimore.

The MAA outlines the reconfiguration of healthcare services expected to be undertaken by LBH following the acquisition, subject to such notices and/or applications to, and review and approvals by, the MHCC or other regulatory agencies as are required. The reconfiguration plan set forth in the MAA calls for inpatient medical and surgical care to be transitioned to Sinai Hospital (or other appropriate LBH facility) beginning immediately after closing, except for Maryland Department of Corrections inpatients who will continue to be cared for at Bon Secours Hospital pursuant to contract with MDOC. The reconfiguration plans thereafter have three major components. The component of the reconfiguration plans that is the subject of this exemption request involves the inpatient behavioral health services at Bon Secours Hospital. Specifically,

[1] The Health Services Cost Review Commission has approved a Staff Recommendation and entered into a Memorandum of Understanding with LBH to enable the savings to be reinvested in the community and in modernized facilities.

under the MAA, Bon Secours Hospital's inpatient behavioral health service and beds will be relocated to Sinai Hospital and Northwest Hospital. Before that can occur, renovations at Sinai Hospital and Northwest Hospital will be required in order to accommodate the relocation of behavioral health beds from Bon Secours Hospital. After the completion of the renovations, all inpatient behavioral health services will be transitioned from Bon Secours Hospital to those hospitals. (The inpatient behavioral health reconfiguration will be described further below.)

The second major component of the reconfiguration plans under the MAA is the construction by LBH of either a reconfigured replacement acute care hospital or a freestanding medical facility (FMF) to serve the Bon Secours Hospital community, which in either case will include an emergency department and related ambulatory services. Portions of the existing hospital building may be demolished by LBH consistent with the reconfiguration plans in this phase.

The third component, which will occur after the construction of the reconfigured replacement hospital or FMF, is the establishment by LBH of a new, approximately 40,000-square foot resource center to serve the Bon Secours Hospital community. The resource center will either be new construction on or near the existing Bon Secours Hospital campus, or in a repurposed existing building in the community to be acquired by LBH for this purpose. The resource center is expected to include healthy food initiatives, job training programs, school mentoring programs and population health initiatives.

In addition to the above investments by LBH to reconfigure and enhance health care delivery in West Baltimore, LBH will also be making community investments aimed at addressing the social determinants of health. Bon Secours Hospital and its affiliates operate various community services in West Baltimore. These include low income and senior housing and Community Works, including the Family Support Center, the Women's Resource Center career development services, re-entry to the community after prison and screening and outreach services. Under the MAA. LBH will make a $25 Million contribution towards these community services over a six year period to be used for community services in West Baltimore.

Bon Secours Hospital's membership in the LBH system and these investments in the Bon Secours Hospital campus and community by LBH will enable significant improvements in access to health care services in the community and to generate improvements in health outcomes. For example, in the existing outpatient clinics and even for patients of the emergency department, Bon Secours Hospital does not currently have access to ENT physicians, neurologists, pulmonologists, or consistent coverage for vascular access for outpatient renal dialysis patients. Nor does Bon Secours Hospital currently have a gastroenterologist for GI cases. As part of the LBH system, however, Bon Secours Hospital patients will have access to those physicians onsite as well as more advance treatments.

Further, this improvement in access will enable better and more consistent follow up care. Currently, if a patient coming to the emergency department needs a neurologist, the patient must be sent to another hospital's emergency department which could be end up being anywhere in the City. It will be difficult for that patient to develop a consistent relationship with a provider, and follow-up visits with providers from other facilities is extremely hard for a patient with no transportation. Not only will LBH provide access to this and other specialties in a system environment, but will also improve the opportunity of those patients for necessary follow up care by providing transportation services for those patients and families. Joining the LBH system will enable a continuum of care that Bon does not have access to today.

Moreover, Bon Secours Hospital patients will benefit from being part of the LBH system in access to post-acute, long term care, and urgent care facilities that are part of the LBH system. Becoming part of the LBH system will also bring new technologies to Bon Secours Hospital that it does not currently have that can improve access to health care, including telehealth, teletriage and telepsych access services.

3. The Inpatient Behavioral Health Reconfiguration

As described above, a major component of the reconfiguration and enhancement of services at Bon Secours Hospital under the MAA is the transition of its inpatient behavioral health service to be relocated to Sinai Hospital and Northwest Hospital. Specifically, the MAA calls for the inpatient behavioral health service and beds at Bon Secours Hospital to be transitioned to Sinai Hospital and Northwest Hospital, to become part of those hospitals' existing inpatient behavioral health programs and the locations where Bon Secours Hospital's behavioral health patients in need of an inpatient admission will be served.

In order to accommodate the beds necessary to serve Bon Secours Hospital's behavioral health inpatients, renovations at Sinai Hospital and Northwest Hospital will be required, since neither hospital has existing space available for this purpose. Most of the 36 beds (24) are planned to be located at Sinai Hospital, where the associated renovations will cost approximately $5 Million (as described further below). The remaining 12 beds (for which no space is available at Sinai Hospital) are planned to be located at Northwest Hospital, where the associated renovations will cost approximately $2 Million (as also described further below).

To ensure that all the reconfiguration and enhancement of services called for under the MAA occur in a timely manner, these renovations will need to commence immediately following closing on November 1, 2019, since they are estimated to require approximately one year to complete. The transition of Bon Secours Hospital's inpatient behavioral health program to Sinai

Hospital and Northwest Hospital is a linchpin of the remainder of reconfiguration and enhancement of services called for under the MAA.

The reconfiguration of the Bon Secours Hospital's behavioral health program relates only to its inpatient beds. Bon Secours Hospital operates a wide range of community based behavioral health services, including a specialized behavioral health case management program, a psychiatric rehabilitation program, behavioral health homes, a residential recovery program, a mobile treatment team, peer recovery housing, as well as various substance use methadone and suboxone programs. Under the MAA, LBH committed to addressing the provision of all behavioral health services currently provided by Bon Secours Hospital, including these services based in and serving the Bon Secours Hospital community. Only the inpatient component of Bon Secours Hospital's behavioral health services will be transitioned to Sinai and Northwest hospitals.

4. Community Outreach Regarding the Reconfiguration and Enhancement of Bon Secours Hospital Services

The Joint Applicants plan to engage in community outreach in focused town halls to discuss the reconfiguration plans after closing. The town halls will include renderings of the new facilities and will highlight the benefits to the community that will result from the reconfiguration of services. As described above, these benefits include (among others) a new state of the art emergency department in a new reconfigured hospital or FMF, increased access to specialists and treatment modalities, and new technologies including telehealth, teletriage and telepsych access. The Joint Applicants plan to seek input from the community on detailed programming related to: healthy food initiatives, job training programs, school mentoring programs and population health needs. This plan will kick-off after closing of the transaction. Additionally, a leadership team from LifeBridge Health will be attending existing community meetings to meet and learn about the current programs and the needs of the community.

EXEMPTION REQUEST

1. Statutory and Regulatory Framework

The MHCC statute and regulations recognize several exemptions from CON review for projects that would otherwise be subject to such review, but are undertaken pursuant to a "consolidation or merger" of two or more health care facilities. Under the Acute Care Chapter of the State Health Plan, "consolidation" means "a merger such that one or more acute inpatient services are eliminated or centralized at one or more of the hospitals of the merged organization." COMAR 10.24.10.06B(8). "Merger" means "the combining of two or more independent hospitals under a permanent, legally binding arrangement or reorganization so as to result in the reapportionment and reconfiguration of beds or services among the health care facilities of a merged or consolidated organization that operates more than one health care facility." COMAR 10.24.10.06B(20). Under Health-General Article §19-120(a)(2), "consolidation" and "merger" are defined to "include increases and decreases in bed capacity or services among the components of an organization that operates more than one health care facility."

While some merged asset system exemptions are based on advance notice to the MHCC alone, others are based on certain criteria (the "Exemption Criteria") that the MHCC must find exist in order to grant the exemption. The Exemption Criteria generally require the MHCC to determine whether the project (1) is not inconsistent with the State Health Plan, (2) will result in the delivery of more efficient and effective health care services; and (3) is in the public interest.

The merger or consolidation of two or more hospitals is exempt from the CON requirement provided that 45 days' prior written notice is given to the MHCC. COMAR 10.24.01.04.

Changes in bed capacity are exempt from the CON requirement under Health-General §19-120(h)(3), which provides that an increase or decrease of bed capacity pursuant to a consolidation or merger is exempt from the CON requirement if at least 45 days' notice is given to the MHCC, and the MHCC finds that the change is pursuant to the consolidation or merger of two or more health care facilities such that it satisfies the Exemption Criteria. See also COMAR 10.24.01.04A(3). However, in a county with three or more hospitals (such as Baltimore City and Baltimore County), an increase or decrease in bed capacity between hospitals in a merged asset system located in the same health service area does not require a CON as long as (1) it does not occur earlier than 45 days after a notice of intent is filed with the MHCC, (2) the change does not create a new health care service through the relocation of beds from one county to another, and (3) the change does not involve comprehensive or extended care beds. Health-General Article §19-120(i).

Similarly, a change in the type or scope of a health care service pursuant to a consolidation or merger is exempt from the CON requirement if 45 days' notice is given before increasing or decreasing the volume of one or more health care services is provided to the MHCC, and the MHCC finds that the Exemption Criteria are satisfied and notifies the health care facility within 45 days after receiving notice. Health-General Article §19-120(j)(2)(iv); COMAR 10.24.01.04A(4).

Likewise, while a capital expenditure that results in a "substantial increase" in hospital bed capacity is generally subject to the CON requirement, such a project is exempt from CON review if 45 days' notice is given to the MHCC before making the expenditure, and the MHCC finds that the Exemption Criteria are satisfied and notifies the health care facility within 45 days after receiving notice. Health-General Article §19-120(k)(1)(i)3.; (6)(v); COMAR 10.24.01.04A(5).[2]

2. Grounds for Exemption from CON Requirement

LBH is an existing merged asset system of hospitals and other health care facilities, including Sinai Hospital, Northwest Hospital, Carroll Hospital Center and Levindale Hebrew Geriatric Center and Hospital. Bon Secours Hospital will become part of the LBH merged asset system when the transaction closes on or around November 1, 2019. Like the other hospitals in the LBH system, Bon Secours Hospital will maintain its separate corporate existence, with LBH as its sole member, making Bon Secours part of a combination of "two or more independent hospitals in a permanent, legally binding arrangement" as provided in the definition of "merger" in COMAR 10.24.10.06(2).

Further, the specific project for which approval is sought in this exemption request – the reconfiguration of the inpatient behavioral health service at Bon Secours Hospital and the transition of its inpatient behavioral health service and beds to Sinai Hospital and Northwest Hospital – involves elements of both consolidation and merger as defined in the Acute Care Chapter. It involves the "reapportionment and reconfiguration of beds or services among the health care facilities" within the LBH system, as provided in the definition of "merger", and "one or more acute inpatient services are eliminated or centralized at one or more of the hospitals", as provided in the definition of "consolidation." It also involves "increases and decreases in bed capacity or services among the components of an organization that operates more than one health care facility" as provided in Health-General Article §19-120(a)(2). Accordingly, the project and

[2] The bed capacity being created at Sinai Hospital and Northwest with the renovations is, in both cases, less than 10% of its overall bed capacity.

requested changes in beds and services are eligible for an exemption as being pursuant to a consolidation or merger of two or more health care facilities.

COMAR 10.24.01.04B sets forth the specific requirements and standards for a notice of intent to seek exemption from CON review pursuant to a merger or consolidation. Each is addressed below.

(1) Name or Names of each affected health care facility:

(a) Sinai Hospital
(b) Northwest Hospital
(c) Bon Secours Hospital

(2) The location of each health care facility:

(a) Sinai Hospital: 2401 West Belvedere Avenue, Baltimore MD 21215
(b) Northwest Hospital: 5401 Old Court Road, Randallstown MD 21133
(c) Bon Secours Hospital: 2000 West Baltimore Street, Baltimore MD 21223

(3) A general description of the proposed project including, in the case of mergers and consolidations, any proposed:

(a) Conversion, expansion, relocation or reduction of one or more health care services.

This project involves the reconfiguration of the inpatient behavioral health service and beds of Bon Secours Hospital within the LBH system. The inpatient behavioral health service currently provided at Bon Secours Hospital will be relocated in its entirety to Sinai Hospital and Northwest Hospital (and thus no longer provided at Bon Secours Hospital) after the necessary renovations to accommodate the additional bed capacity are completed. Both Sinai Hospital and Northwest Hospital currently provide inpatient behavioral health services (in 24-bed and 37-bed units, respectively) which will be expanded as a result of this project.

This relocation or reconfiguration of existing medical services is eligible for an exemption under Health-General Article §19-120(j)(2)(iv); COMAR 10.24.01.04A(4).

(b) Renovation of existing facilities

At Sinai Hospital, an existing 13,000 square foot patient care unit currently utilized for an inpatient hospice unit will be renovated into a 24-bed behavioral health unit which will contain 6 private and 9 semi-private rooms. See drawings attached as **Exhibit 2**. (The hospice program will be relocated to a vacant medical surgical floor at Sinai Hospital). The total cost of the renovations at Sinai Hospital will be approximately $5 Million.

At Northwest Hospital, an existing 6,500 square foot patient care unit currently used for medical surgical surge capacity during high census periods will be converted into a 12 bed behavioral health unit. All the rooms will be private rooms. See drawings attached as **Exhibit 3**. The total cost of the renovations at Northwest Hospital will be approximately $2 Million.

To the extent these capital expenditures are covered by Health-General Article §19-120(k)(1)(i)3., they are eligible for an exemption under Health-General Article §19-120(k)(6)(v); COMAR 10.24.01.04A(5).

(c) New construction

No new construction is associated with this project.

(d) Relocation or reconfiguration of existing medical services

As described above, this project involves the reconfiguration of the inpatient behavioral health service and beds of Bon Secours Hospital within the LBH system. The existing inpatient behavioral health service at Bon Secours Hospital will be relocated in its entirety to Sinai Hospital and Northwest Hospital (and thus no longer provided at Bon Secours Hospital) after the necessary renovations to accommodate the additional bed capacity are completed. Both Sinai Hospital and Northwest Hospital currently provide inpatient behavioral health services (in 24-bed and 37-bed units, respectively) which will be expanded as a result of this project.

This relocation or reconfiguration of existing medical services is eligible for an exemption under Health-General Article §19-120(j)(2)(iv); COMAR 10.24.01.04A(4).

(e) Change in bed capacity at each affected facility

As a result of this project, the bed capacity at Bon Secours Hospital will decrease by 36 beds, the bed capacity at Sinai Hospital will increase by 24 beds, and the bed capacity at Northwest Hospital will increase by 12 beds.

The Joint Applicants recognize that they are seeking to relocate more beds from Bon Secours Hospital than the number of beds allocated to behavioral health on its license for FY20. This is because the allocation of 27 beds to inpatient behavioral health under the FY20 license is inadequate based on the average daily census that Bon Secours Hospital has been experiencing over the recent few months. As shown on **Exhibit 4**, Bon Secours Hospital has had an ADC in its behavioral health unit of approximately 28.2 during the period of January through July, 2019. Applying the 140% licensed bed calculation to this ADC would equate to 39.5 beds. The Joint Applicants are not requesting the full 39 beds, allowing for some level of attrition of patients (estimated at 5%) who may decide to go to other hospitals.[3] With the 36 beds requested to be relocated, an ADC of 28.2 reduced 5% for attrition (26.8) equates to 74% occupancy, which is higher than the occupancy percentage upon which the 140% of ADC licensed bed calculation is based (71%). On the other hand, at 27 beds (the allocation under the current license), the ADC that Bon Secours Hospital has been experiencing less 5% for attrition would mean the beds would be utilized at 99% occupancy, an unrealistically high occupancy level. Because a behavioral health unit cannot function at this level of occupancy, relocating only 27 beds would jeopardize LBH's ability to ensure that all Bon Secours Hospital patients needing a behavioral health admission can be accommodated at either Sinai Hospital or Northwest Hospital, as required by the MAA.

At 24 beds as planned, the space at Sinai Hospital can accommodate 6 private rooms. The maximum number of beds that the space can accommodate is 27 beds, but this would mean that there could only be 3 private rooms (the minimum ADA requirement) which would restrict throughput in admissions based on gender and other admission constraints. As described above, the Joint Applicants believe that relocating only 27 beds would jeopardize LBH's ability to accommodate all Bon Secours Hospital patients needing a behavioral health admission based on the 28.2 ADC it has been experiencing since January, but if only 3 private rooms available, the likelihood of not being able to accommodate Bon Secours Hospital patients is much greater.

[3] The Joint Applicants project minimal attrition. The strong demand for inpatient behavioral health services in the community combined with the very strong presence the Joint Applicants will maintain in the community as well as the maintenance of the emergency department both in the existing and the new facility to be constructed are expected to lead to minimal attrition.

Further, at 12 beds, the new space planned for Northwest Hospital maximizes the use of the space and is cost effective in light of the significant requirements associated with the design and construction of inpatient psychiatric units (including making it a secure unit and special requirements for fixtures like anti-ligature requirements) and from a staffing perspective. As the number of beds that are allowed to be constructed is reduced, the cost effectiveness of the unit diminishes and the unit eventually becomes cost ineffective.

Lastly, it should be noted that the existing behavioral health units at Sinai Hospital and Northwest Hospital do not have excess capacity to accommodate the new volume from Bon Secours Hospital patients. In FY19, Sinai Hospital's 24-bed unit had an ADC of 21 (88% occupancy), and Northwest Hospital's 39-bed unit had an ADC of 30 (77% occupancy).

Baltimore City and Baltimore County have more than three hospitals each and both Sinai Hospital and Northwest Hospital have existing inpatient behavioral health programs. Accordingly, this change in bed capacity among hospitals in a merged asset systems is eligible for exemption under Health-General Article §19-120(i). See also Health-General Article §19-120(h)(3) and COMAR 10.24.01.04A(3).

(4) The scheduled date of the project's completion.

The renovations at Sinai Hospital and Northwest Hospital to accommodate the behavioral health beds from Bon Secours Hospital will be complete approximately one year after construction commences. Assuming MHCC approval of the exemption within 45 days of this filing, renovations would be complete in approximately November, 2020.

(5) Identification of any outstanding public body obligations

There are no outstanding public body obligations of Bon Secours Hospital, LBH, or Sinai Hospital or Northwest Hospital.

(6) Information demonstrating the project:

(a) Is consistent with the State Health Plan

Exhibit 5 addresses each of the applicable sections of the State Health Plan Chapter governing psychiatric services. As demonstrated in Exhibit 5, this

project is consistent with the State Health Plan chapter governing psychiatric services.

(b) Will result in more efficient and effective delivery of health care services

The reconfiguration of inpatient behavioral health services at Bon Secours Hospital through the relocation of the service to Sinai Hospital and Northwest Hospital will result in more efficient and effective delivery of inpatient behavioral health services. As the regulatory definitions of "merger" and "consolidation" in the State Health Plan inherently recognize, centralizing health care services at fewer facilities within a merged asset system enable fixed cost savings and economies of scale. Here, the consolidation of inpatient behavioral health services at Sinai Hospital and Northwest Hospital rather than maintaining three such programs will generate efficiencies through eliminating the fixed costs of the Bon Secours Hospital program and economies of scale in the operation of the inpatient behavioral health programs at Sinai Hospital and Northwest Hospital, the fixed costs of which will be able to be spread across a larger number of beds and patients. With Sinai Hospital and Northwest Hospital only a minimal distance from Bon Secours Hospital (5 miles and 10 miles respectively), these efficiencies can be achieved without disrupting patient care.

Further, the reconfiguration of behavioral health services must be considered in the context of aging physical plant in which Bon Secours Hospital's program is located and the entirety of the reconfiguration plan under the MAA. That plan calls for significant investment by LBH in order to address the significant physical plant issues in the Bon Secours Hospital building, by replacing it with modernized health care facilities providing high quality, affordable health care and health care-related services. The plan includes the construction of either a reconfigured replacement acute care hospital that would have a small inpatient component or an FMF, including in either case a new state of the art emergency department and ambulatory services designed specifically around promoting and improving the health care status of the West Baltimore community.

Maintaining inpatient behavioral health at Bon Secours Hospital would be inconsistent with the overall reconfiguration of services under the MAA. Inpatient behavioral health could not be part of an FMF, so it would have to become a freestanding psychiatric hospital and would be subject to the Federal IMD exclusion (under which Federal financial participation in Medicaid admissions is prohibited) unless the bed complement was reduced to only 16 beds. At 16 beds, operating a freestanding psychiatric hospital would be

inefficient as compared to relocating the service to Sinai Hospital and Northwest Hospital, and it would not meet the needs of the Bon Secours Hospital community in light of the census that Bon Secours Hospital has been experiencing as described above. A freestanding psychiatric hospital would also be less effective because co-location with full service acute medical facilities is preferable for safe inpatient care of medically complex psychiatric patients. Free-standing psychiatric facilities are limited in the ability to provide support for patients with moderate to severe chronic illness and often decline admissions on this basis. Psychiatric patients in this service area often require access to medical and surgical consultation services.

Further, retaining inpatient behavioral health service at Bon Secours Hospital with the number of beds necessary to serve the community based on the census of those beds (as described above) would also be at odds with constructing a reconfigured replacement acute care hospital with only a small inpatient component, and the program would also lose the connection to a fuller service acute care general hospital with the benefits described above.

Accordingly, whether an FMF or a replacement reconfigured acute care hospital is constructed on the Bon Secours Hospital campus, relocating the inpatient behavioral health to Sinai Hospital and Northwest Hospital is a more effective alternative.

Additionally, the relocation of Bon Secours Hospital's inpatient behavioral health program to Sinai Hospital and Northwest Hospital will result in more effective and efficient delivery of behavioral health services based on recruitment and retention of staff. Bon Secours Hospital has had challenges in recruiting and retaining staff at the hospital, and has had to rely on third party staffing services to fill positions to a greater extent than Sinai Hospital and Northwest Hospital.

(c) Is in the public interest

The relocation of the inpatient behavioral health program from Bon Secours Hospital to Sinai Hospital and Northwest Hospital is, even standing alone, in the public interest because it will provide for the inpatient behavioral health care needs of the Bon Secours Hospital community to be met in modern, state of the art inpatient units at Sinai Hospital and Northwest Hospital with access to a wider array of supportive acute care hospital resources and services, while maintaining

critical community-based outpatient behavioral health programs in the Bon Secours Hospital community.

However, when considered in light of the overall reconfiguration of services under the MAA, the public benefit is even more compelling. As described above, that reconfiguration will bring about significant investment by LBH to create a modern health care campus providing high quality, affordable health care and health care-related services improving access to care and tailored to the needs of its community. Further, the savings resulting from the reconfiguration of services under the MAA described above will be reinvested in the community to further address health care needs and the social determinants of health, reduce health disparities, improve the delivery of healthcare in, and benefit the poor and underserved of, the West Baltimore community. The reconfiguration of the behavioral health service at Bon Secours Hospital is a central – and indispensable – component of the overall reconfiguration of services under the MAA that will bring about these significant benefits to the public.

Based on the foregoing, we respectfully request a determination by the MHCC that the reconfiguration of behavioral health services at Bon Secours Hospital within the LBH system as described above is exempt from the CON requirement.

Additionally, because of the time sensitivity of commencing the renovations at Sinai Hospital and Northwest Hospital as soon as possible following the closing of the transaction on November 1, we would appreciate this matter being considered at the MHCC's October, 2019 monthly meeting. We understand, of course, that an exemption granted by the MHCC at the October meeting would not be effective until (and would contingent on) the acquisition of Bon Secours Hospital by LBH as described in the August 26, 2019 notice of acquisition.

Should you need any additional information in order to evaluate this request, please let me know.

Very truly yours,

Marta D. Harting

Marta D. Harting

MDH:rlh
cc: Renee Webster, Office of Health Care Quality

AFFIRMATIONS

LIFEBRIDGE
HEALTH.

Sinai Hospital
Northwest Hospital
Carroll Hospital
Levindale Hebrew Geriatric Center and Hospital

AFFIRMATION

I hereby declare and affirm under penalties of perjury that the facts stated in the foregoing Exemption Request dated August 30, 2019 and filed on behalf of LifeBridge Health, Inc., Sinai Hospital, Inc., Northwest Hospital, Inc. and Bon Secours Hospital Baltimore, Inc., are true and correct to the best of my knowledge, information and belief.

D.H

Printed name: DAWN HURLEY

Title: AVP, Behavioral Health

Date: 8-28-19

AFFIRMATION

I hereby declare and affirm under penalties of perjury that the facts stated in the foregoing Exemption Request dated August 30, 2019 and filed on behalf of LifeBridge Health, Inc., Sinai Hospital, Inc., Northwest Hospital, Inc. and Bon Secours Hospital Baltimore, Inc., are true and correct to the best of my knowledge, information and belief.

Rebecca A. Altman

Printed name:

Title: Interim Executive Director

Date: 8/28/2019

AFFIRMATION

I hereby declare and affirm under penalties of perjury that the facts stated in the foregoing Exemption Request dated August 30, 2019 and filed on behalf of LifeBridge Health, Inc., Sinai Hospital, Inc., Northwest Hospital, Inc. and Bon Secours Hospital Baltimore, Inc., are true and correct to the best of my knowledge, information and belief.

Printed name: Maurice Spielman

Title: Corp. Dir. Design & Construction

Date: 8/28/19

AFFIRMATION

I hereby declare and affirm under penalties of perjury that the facts stated in the foregoing Exemption Request dated August 30, 2019 and filed on behalf of LifeBridge Health, Inc., Sinai Hospital, Inc., Northwest Hospital, Inc. and Bon Secours Hospital Baltimore, Inc., are true and correct to the best of my knowledge, information and belief.

Printed name: Kevin Kelbly

Title: VP of Finance

Date: August 30, 2019

EXHIBIT 1

CONFIDENTIAL

LifeBridge Health, Inc.
Organizational Chart
Upon Closing Of
Bon Secours Hospital Baltimore Acquisition

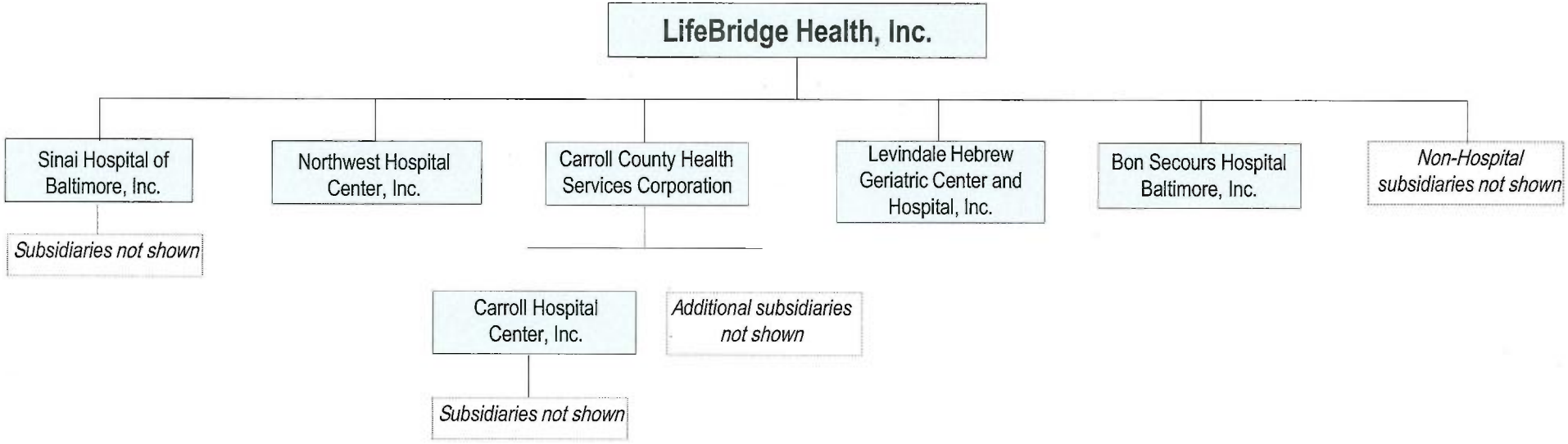

EXHIBIT 2


NOT IN CONTRACT
RISK ZONE LEGEND
High Risk Zone
Medium Risk Zone
Low Risk Zone
Building Support Space

EXHIBIT 3

FLOOR PLAN (MINIMAL CONST.) 4D

NWHC 4D RENOVATION

5401 OLD COURT ROAD, RANDALLSTOWN, MARYLAND 21133

CONCEPT SHEET | hord | coplan | macht

3/16" = 1'-0" | 08/26/2019

EXHIBIT 4

Bon Secours Hospital Behavioral Health Unit Average Daily Census (January through July, 2019)

Month	Patient Days	Days Reported	ADC
January	861	31	27.8
February	843	28	30.1
March	903	31	29.1
April	836	30	27.9
May	902	31	29.1
June	742	30	24.7
July	889	31	28.7
Overall	5,986	212	28.2

EXHIBIT 5

Standard AP 3a

Inpatient acute psychiatric programs must provide an array of services. At a minimum, these specialized services must include: chemotherapy, individual psychotherapy, group therapy, family therapy, social services, and adjunctive therapies, such as occupational and recreational therapies.

Applicant Response:

The psychiatric units at Sinai Hospital and Northwest Hospital provide an array of services as required by this standard. The services are tailored to meet each patient's needs and may include but are not limited too: Individual and group therapy, family therapy, case management and expressive therapies. These modalities are designed to assist patients in the development of interpersonal skills within a group setting, restoration of family functioning and provision of any other specialized areas that the individualized diagnostic and treatment process reveals as indicated for the patient and family. The programs are accredited by the Joint Commission on Accreditation of Healthcare Organizations.

Standard AP 3b

In addition to the services mandated in Standard 3a, inpatient child and adolescent acute psychiatric services must be provided by a multidisciplinary treatment team which provides services that address daily living skills, psychoeducational and/or vocational development, opportunity to develop interpersonal skills within a group setting, restoration of family functioning and any other specialized areas that the individualized diagnostic and treatment process reveals is indicated for the patient and family. Applicants for a Certificate of Need for child and/or adolescent acute psychiatric beds must document that they will provide a separate physical environment consistent with the treatment needs of each age group.

Applicant Response:

This standard is not applicable because the proposed project does not include inpatient child or adolescent psychiatric services.

Standard AP 3c

All acute general hospitals must provide psychiatric consultation services either directly or through contractual arrangements.

Applicant Response:

The psychiatric units at Sinai Hospital and Northwest Hospital provide psychiatric consultation services through fulltime and part time staff psychiatrists, a Psychiatric Nurse Practitioner and /or Licensed Clinical Social Workers.

Standard AP 4a

A Certificate of Need for child, adolescent or adult acute psychiatric beds shall be issued separately for each age category. Conversion of psychiatric beds from one of these services to another shall require a separate Certificate of Need.

treated in general pediatric beds.

Applicant Response:

This standard is not applicable.

Standard AP 11
Private psychiatric hospitals applying for a Certificate of Need for acute psychiatric beds must document that the age-adjusted average total cost for an acute (≤ 30 days) psychiatric admission is no more than the age-adjusted average total cost per acute psychiatric admission in acute general psychiatric units in the local health planning area.

Applicant Response:

As shown in **Attachment G**, in 2018, the average age adjusted charges for a psychiatric admission in acute general hospital-based psychiatric units in Central Maryland based on Sinai Hospital's case mix was $13,186. Sinai Hospital's actual charge per case was $8,634.

As shown in **Attachment H**, in 2018, the average age adjusted charges for a psychiatric admission in acute general hospital-based psychiatric units in Central Maryland based on Northwest Hospital's case mix was $12,614. Northwest Hospital's actual charge per case was $7,444.

Quality

Standard AP 12a
Acute inpatient psychiatric services must be under the clinical supervision of a qualified psychiatrist.

Applicant Response:

All psychiatric care at Sinai Hospital and Northwest Hospital is directed by a board-certified psychiatrist which is the head of a multidisciplinary team of mental health professionals. All staff psychiatrists are evaluated by the Chair of the LifeBridge Health Psychiatric Department.

Standard AP 12b
Staffing of acute inpatient psychiatric programs should include therapists for patients without a private therapist and aftercare coordinators to facilitate referrals and further treatment. Staffing should cover a seven-day per week treatment program.

Applicant Response:

Patients admitted to the psychiatric unit and Sinai Hospital or Northwest Hospital receive therapeutic programming which provides active treatment in compliance with standards of practice, 7 days a week. The individual's case manager is responsible for coordinating aftercare planning to promote continuity of care. In addition to making appointments and referrals to outpatient providers, the case manager ensures that an aftercare plan with recommendations is transmitted to the patient's next level care provider.

Standard AP 12c
Child and/or adolescent acute psychiatric units must include staff who have experience and training in child and/or adolescent acute psychiatric care, respectively.

Applicant Response:

This standard is not applicable because the proposed project does not include inpatient child or adolescent psychiatric services.

Continuity

Standard AP 13
Facilities providing acute psychiatric care shall have written policies governing discharge planning and referrals between the program and a full range of other services including inpatient, outpatient, long-term care, aftercare treatment programs, and alternative treatment programs. These policies shall be available for review by appropriate licensing and certifying bodies.

Applicant response:

Sinai Hospital and Northwest Hospital have discharge planning and referral policies to ensure the patient's aftercare needs are met through a variety of services including, outpatient, partial hospitalization and other alternative programs. These policies are available for review by licensing and certifying bodies.

Acceptability

Standard AP 14
Certificate of Need applications for either new or expanded programs must include letters of acknowledgement from all of the following:

(i) the local and state mental health advisory council(s);
(ii) the local community mental health center(s);
(iii) the Department of Health and Mental Hygiene; and
(iv) the city/county mental health department(s).

Letters from other consumer organizations are encouraged.

Applicant Response: This standard is not applicable because a certificate of need is not being sought.

ATTACHMENT A

SINAI HOSPITAL OF BALTIMORE
INPATIENT PSYCHIATRY POLICY AND PROCEDURE

SUBJECT: Admission, Treatment Plans, and Discharge Criteria

SCOPE: Inpatient Psychiatry

PURPOSE:

I. To provide crisis management consistent with short-term hospitalization and cost-effective clinical care.

II. To provide effective improvement in the client and enable him to return to the community.

III. To establish a consumer-oriented process to promptly meet the needs of the patient in need of hospitalization.

POLICY:

The Inpatient Division consists of a 24-bed inpatient unit located on the first floor of the Mount Pleasant Building. The inpatient unit is geared to short-term treatment tailored to the clinical needs of the individual patient without regard to race, religion, color, creed, or nationality.

I. **ADMISSION CRITERIA TO MOUNT PLEASANT 1 INPATIENT PSYCHIATRIC UNIT:**

A. Patient must have a primary psychiatric diagnosis.

B. Patient may have a mental disorder, is medically stable, (any active medical condition could be treated in an outpatient setting if patient were not to be admitted to the inpatient psychiatric unit), and discharge planning has been started. For patients requiring things such as central lines, heparin locks, blood products, and infectious diseases requiring isolation the following should be considered:

1. Availability of supplies to manage patient

2. Availability of adequate staffing to manage patient

3. Ability to provide necessary observation to keep patient safe e.g. due to ease of access and severity of patient illness, close observation may be indicated for patient's with something such as a central line

C. There is a reasonable expectation that acute short-term inpatient treatment will be successful in improving the patient's condition—i.e., within 5 days or less.

D. Patients with a recent history of disruption to the Inpatient Unit and chronic noncompliance with treatment *may be* considered inappropriate for admission.

E. Patients originally admitted to the Inpatient Unit who are later discharged to another LifeBridge Hospital service for an acute medical or surgical problem will be eligible to return to the Inpatient Unit if they meet acute inpatient criteria.

F. Special Considerations

1. If no seclusion rooms are available and the patient needs seclusion, that patient will be denied admission.

2. If an appropriate room in the facility is not available, the patient may be denied admission—i.e. special care bed.

G. Patients who have active police warrants for their arrest may be refused admission.

H. All patients with private insurance or an HMO should have their insurance contacted for pre-authorization prior to admission. This however, will not preclude admission.

I. Patient will be 18 years or older; there will be no discrimination as to sex, race, creed, religion or national origin.

J. Patients will be admitted as voluntary patients or as involuntary patients upon certification by two physicians (or one M.D. and one Ph.D. psychologist).

II. ADMISSION PROCEDURES

A. Emergency Admissions. There are three means for admitting patients on an emergency basis at night, on weekends and holidays.

1. The psychiatrist on-call to the Sinai or Northwest Emergency Room may evaluate the patient who has been admitted to the E.R. The patient must have a thorough medical screening by the medical staff prior to being transferred to the Psychiatric Inpatient Service. The admission note and initial orders are to be written by the Psychiatrist on call or entered into the computer.

2. Patients referred from an outside physician or agency should be referred to the psychiatrist on-call. If the patient is accepted for admission by the staff psychiatrist on-call to the unit, the patient may come through the Emergency Room and be admitted by the on-call psychiatrist.

3. Direct admissions can occur on MP1 if the patient is being referred from an emergency room or medical service and has been adequately screened by the referring facility. The request for a direct admission is received by the Charge Nurse or designee. The psychiatrist on-call to the Inpatient

Service must approve the admission if recommended by the Charge Nurse. The patient can then be admitted directly to the Inpatient Unit with the appropriate inpatient orders. All direct admission requests and disposition will be entered on the Direct Admission Referral Log.

B. In-House Discharge/Admission

1. Prior to readmission to the Inpatient Unit (after being treated on another service within the hospital), the patient will be evaluated by a psychiatrist who will ascertain availability of a bed by consulting with the Mount Pleasant Medical Director or his delegate. When medically cleared, the patient may be discharged from the other service and admitted to psychiatry. A copy of the patient's chart is sent with the patient including original history and physical, consultations, progress notes, laboratory and diagnostic test results, discharge summary, and physician's orders.

C. Admissions From The Sinai Emergency Room

1. Patients presenting to the Sinai E.R. will be evaluated by the Crisis Intervention Specialist in consultation with the on-call psychiatrist. If recommended for admission to MPI, the MPI psychiatrist on-call will be contacted to approve the admission. The usual procedure of admitting a patient to MPI will then be followed. This includes the completion of the history and evaluation, and electronic entry of admissions orders to the Inpatient Unit by the on-call psychiatrist.

III. THE ADMISSION ORDERS

A. Admitting diagnosis

B. Allergies

C. Diet

D. Lab Work

E. Vital Sign Frequency

F. Level of Responsibility

G. Visitors (indicate any restrictions)

H. Phone (indicate any restrictions)

I. Medications (include an appropriate PRN medication if the patient is psychotic or agitated—both PO and IM).

J. Any other special tests such as EEG, CT scan and others—the doctor is to fill out the appropriate request form.

K. Admission status, e.g. involuntary/voluntary status

L. Medical history and physical, and consults based on patient's needs

IV. Treatment Plans

A. Each patient admitted to the unit will have a Comprehensive Behavioral Assessment (CBA) by a psychiatrist and an Initial Nursing Database completed within the first 24 hours of admission. An Interdisciplinary problem list will be implemented upon admission. Goals will be reviewed and updated during each team meeting and coordinated with discharge planning and follow-up care. Reassessments of problems and goals will be documented in the progress notes. Problems that are resolved will be recorded on the Interdisciplinary Problem list.

B. Assessments and reassessments should include at least a history of emotional and behavioral issues and substance abuse; treatment modalities; current emotional and behavioral functioning; a mental status examination; maladaptive or problem behaviors; and a psychosocial assessment. Based on the patient's age and individual needs, the assessment will also include a history of physical or sexual abuse, sexual history, childhood history, medical health care issues, visual-motor functioning, level of functioning related to self care.

C. Psychological testing will be conducted on an as needed basis. However, in consideration of the MP1 short length of stay and crisis-oriented nature of services, testing such as projectives, intellectual, personality and neuropsychological is most appropriately conducted in an outpatient setting when the patient is more stable. Appropriate referrals for such testing will be made at the time of discharge.

V. Discharge Criteria

A. The patient's condition or status is such that they can be safely treated on an outpatient basis.

B. The patient is no longer an acute suicide or homicide risk, nor at risk of placing themselves or others in any danger.

C. The Global Assessment of Functioning score does not justify in-hospital treatment.

D. In-hospital treatment is no longer beneficial.

E. Patients are expected to be an active participant in their treatment. If they are able (but unwilling) to comply with expected participation, they may be discharged.

F. Patients, who are malingering, as determined by interdisciplinary staff consensus, may be discharged.

G. Patients determined to be in need of forensic services.

VI. Admission Exceptions

A. Admission referrals deemed inappropriate by the Charge Nurse will be escalated to the Nurse Manager or designee.

B. The Nurse Manager or designee will confer with the Medical Director.

C. If no agreement is reached regarding the disposition of the patient, the Director of Psychiatry and Nursing Director for Psychiatry will come to consensus as to the appropriateness of the admission referral.

Original Date: November, 1985

Revisions: February, 1988
February, 1990
February, 1997
September, 1999
January, 2009
October, 2011
October, 2014
October, 2017

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References:

ANA, (2014). *Psychiatric-Mental Health Nursing: Scope and Standards of Practice.* Silver Spring, MD. Nursebooks.org.

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Maryland Nurse Practice Act: Annotated Code of Maryland, Health Occupations Article, Title 8 (2017), Board of Nursing, Baltimore MD

Cross References: Department of Psychiatry Policy and Procedures Manual
Inpatient Discharge Planning
Inpatient Psychiatry Responsibility Levels
Inpatient Psychiatry Suicide Precautions

ATTACHMENT B

Northwest Hospital

Department of Psychiatry Policy Manual	Policy Name: Admission, Treatment Plan and Discharge Criteria Facility: Northwest Hospital Department: Inpatient Psychiatry Effective Date: July 1, 2011 Revised Date: February 18, 2013, July 2017 Next Review Date: July 2020

Purpose:

To establish admission criteria for patients referred for admission to the inpatient psychiatry unit

To provide guidance to staff regarding the admission process for patients referred from a variety of settings

Responsibility:

Physician and Registered Nurse, Nurse Practitioner, Crisis Intervention Specialist

Policy:

The Inpatient Behavioral Health Unit at Northwest Hospital is located in two sections of the fourth floor, a 23-bed inpatient unit identified as BHU and a 14-bed inpatient unit called 4-C. Both units are to be referred to as BHU (Behavioral Health Unit). The inpatient unit is geared towards a short-term treatment tailored to the clinical needs of the individual patient without regard to race, religion, color, creed, or nationality. Patients are admitted to the inpatient psychiatric unit based on criteria established by the Department of Psychiatry, in accordance with established standards of care in the community, and in compliance with standards of The Joint Commission, State of Maryland regulations, and Center for Medicare and Medicaid Services (CMS) regulations.

Procedures:

I. Admission Criteria to the Behavioral Health Unit:

A. The patient must be 18 years of age or older

B. Patients admitted to the BHU must have a primary Axis I diagnosis of a psychiatric disorder.

C. Patients with a primary diagnosis of alcohol/substance abuse cannot be admitted

D. The patient demonstrates risk of imminent harm to self or others

E. The patient demonstrates a lack of response to recent attempts at outpatient psychiatry to include day hospital and intensive outpatient treatment with medication management and/or with psychotherapy.

F. The patient demonstrates lack of insight, or inability to adequately care for his/her physical needs or adhere to a prescribed medical treatment plan such that there is potential for serious harm to self.

G. The patient is medically stable. Patients requiring continuous IV therapy, blood products, and/or chemotherapy, for example would not be candidates for an inpatient psychiatric admission because of their medical and safety needs.

H. For patients requiring a central venous catheter, the decision will be made on a case- by – case basis, determined by the patient's behavior and the patient's ability not to cause harm to themselves.

I. If for example, a patient is receiving IV medications through a porta cath or PICC line, Midline or has complex wound care needs; the following should be considered:

1. Availability of qualified staff to manage the patient

2. The need for isolation in excess of anything more than standard precautions (This may be a reason for non-admittance to the BHU/4-C)

J. Patients who are under the guardianship of agencies such as (DSS) Department of Social Services or (APS) Adult Protective Services may only be admitted on an involuntary basis, unless a court order is obtained permitting the agency to admit the patient voluntarily.

K. If seclusion is determined to be clinically indicated and no seclusion rooms are available, the patient will be denied admission at that time for safety of the patient and others

II. <u>Admission to BHU/4-C</u>

A. There are four means for admitting patients on:

1. Patients presenting to the Northwest Emergency Department will be evaluated by the Crisis Intervention Specialist (licensed clinical counselor, social worker, or psychiatric clinical nurse specialist), in consultation with the on-call psychiatrist, after receiving a Medical Screening Exam. If recommended for admission to the BHU, the psychiatrist on-call will be required to approve the admission. The usual procedure for admitting a patient to the BHU is followed. This includes the completion of the history and evaluation, and electronic entry of admission orders to the BHU by the on-call

psychiatrist. In addition, the physician and non-physician Comprehensive Behavioral Assessment (CBA) is completed prior to admission. A physician Assistant completed a physical assessment within 25-hours of the patient admission to BHU.

a) If the patient has an extended stay in the Emergency Department after admission to the BHU due to bed availability, the psychiatrist or nurse practitioner must write orders for ongoing routine and PRN psychotropic medication administration until the patient is transported to the BHU/4-C

b) Orders for STAT or NOW medications must be given prior to admission to the BHU; patients then can be transported no less than 30 minutes after medications have been administered.

2. Patients referred from an outside physician office or organization must first be screened and medically cleared in the Emergency Department. After the patient is medically cleared, an evaluation must be completed by a psychiatrist or nurse practitioner will admit the patient during off-hours of weekend after the patient is determined to be appropriate for admission

a) Prior to admission/readmission to the BHU (after being treated on another service within the hospital), the patient will be evaluated by a psychiatrist or nurse practitioner who will ascertain availability of a bed by consulting with the Behavioral Health Medical Director or designee. When medically cleared, the patient may be discharged from the other service and admitted if the patient meets admission criteria for an inpatient psychiatric admission. An abstract of the patient's chart is sent with the patient including:

1) The admissions demographic form that includes the patient's emergency contact

2) Original history and physical

3) Consultations

4) Progress notes

5) Laboratory and diagnostic test results

6) Discharge summary

7) Physician's order, etc.

B. <u>Admission Procedure</u>

1. The BHU nurse must review patient information in PowerChart. Prior to the patient transferring, the BHU nurse will receive an updated verbal report from the sending nurse. This report will include the patient's current psychiatric and physical status.

2. Restraints should be removed if the patient responds well to medication management if the patient is to be transported while in restraints then the Behavioral Health receiving nurse must be notified, and a minimum of two security guards will escort the Emergency Department companion and the patient to the BHU. Note: the preference is to avoid transporting patients while they are in restraints from the Emergency Department to the BHU.

3. A 30-minute interval between each patient admission is preferred to maintain the safety of patients and staff/

4. Patients who are in "Twice as Tough Restraints" cannot be transported to BHU until stabilized.

5. All patients are screened (via want) while in the Emergency Department and again when they arrive on BHU; contraband such as scarves, knives, sharp metal objects, necklaces, and shoelaces are to be turned into security prior to arriving on the unit.

6. Each patient admitted to the unit will have a Comprehensive Behavioral Assessment (CBS) by a psychiatrist or nurse practitioner and an Initial Nursing Database (Behavioral Health Admission Database) completed within the first 24 hours of admission. The admitting nurse will implement an Interdisciplinary Plan of Care (IPOC) upon admission. Patient goals will be reviewed during each team meeting and coordinated with discharge planning and follow-up care. Reassessments of problems and goals will be documented in the progress notes and Interdisciplinary Plan of Care.

7. Assessments include:

    a) A history of emotional and behavioral issues

    b) Substance abuse history

    c) Treatment modalities

    d) Current emotional and behavioral functioning

    e) A mental status examination

    f) Maladaptive or problem behaviors

    g) History of physical or sexual abuse

h) Sexual history

i) Childhood history

j) Medical health care issues

k) Visual-motor functioning

l) Level of functioning related to self-care

m) A psychosocial assessment

8. Psychological testing will be conducted on an as needed basis on the inpatient unit. However, in consideration of the Behavioral Health Unit's short length of stay and crisis-oriented nature of services, testing such as projectives testing, intellectual, personality and neuropsychological are appropriately conducted in an outpatient setting when the patient is more stable. Appropriate referrals for such sequential neurological testing will be made at the time of discharge.

C. The Admission Orders

1. Admitting diagnosis
2. Allergies
3. Diet
4. Lab Work
5. Vital Sign Frequency
6. Level of observation i.e., every 15 minute checks, continuous observation
7. Visitors (restrictions are indicated)
8. Telephone privileges (restrictions are indicated)
9. Medications (include any appropriate PRN mediation if the medication if the patient is psychotic or agitated- both PO and IM)
10. Any other special tests such as EEG, CT Scan, and others (after the doctor completes the appropriate request form)
11. Admission status, e.g. involuntary/voluntary
12. Medical history and physical, and consults based on patient's needs
13. Voluntary or involuntary forms must be signed by a physician(s) and admission orders by the referring psychiatrist must be present before a patient is admitted to the BHU.

III. Discharge Criteria

1. The patient's condition or status is such that they can be safely treated on an outpatient basis
2. The patient is no longer an acute suicide or homicide risk, nor at risk of placing themselves or others in imminent danger.
3. Patients may be discharged to the community if no current warrant is active

4. Patients determined to be in need of forensic services are discharged directly to the police once the police are notified and take custody. Notification of police is compliant and consistent with all HIPPA Regulations.

Original Date: July 1, 2011
Revised Date: August 10, 2012, February 18, 2013, July 17, 2017

Approvals:

Kevin Inman — Date
CNO, Vice President, Patient Care Services

Martin Chin M.D. — Date
Interim Chief of Psychiatry

ATTACHMENT C

Sinai Hospital of Baltimore
Quality, Risk Management, and Patient Safety Plan
2019

I. Introduction

a. Alignment with foundation statements:

The vision of LifeBridge Health is to be a nationally recognized, independent health system consistently providing outstanding quality, service, affordability and outcomes. More specifically, the vision of Sinai Hospital of Baltimore, a cornerstone of both acute inpatient and ambulatory care within the LifeBridge Health delivery network, states; Building upon its Jewish heritage, exceptional clinical strengths and history of service, Sinai will emerge as a unique institution in the Maryland health care marketplace and be a model for the nation by being a comprehensive health care provider.

The following plan outlines the structure, methods and approaches the leaders and staff at Sinai Hospital of Baltimore use to continuously evaluate and improve processes to achieve the vision of LifeBridge and Sinai leadership for exceptional quality, customer service, affordability and outcomes that are recognized within the Maryland health care market.

Sinai leaders recognize that strength in quality, risk management, and patient safety is dependent on an organizational culture that promotes commitment to excellence, honest conversations about improvement opportunities and reliance on sound data and information to prioritize improvement opportunities and measure progress. Leaders model and guide the culture of quality, risk management and patient safety at Sinai Hospital through the following organizational values: *Service, Performance, Innovation, Respect, Integrity* and *Teamwork*.

b. Objectives of the plan:

Leaders of Sinai Hospital of Baltimore strive to achieve the following objectives through the careful and intentional implementation of this quality, risk management and patient safety plan:

- Provide a framework for both hospital employees and members of the medical staff to engage in innovation and teamwork;
- Support formal and informal organizational learning that drives improved performance and outcomes that enhance quality of care, improve patient safety, and mitigate risk;
- Develop leaders' and staff's competency with methods and tools that support process evaluation and improvement;
- Ensure that Sinai Hospital steadily progresses along its journey toward high reliability and enterprise risk management (ERM); and
- Focus on the continuous enhancement of safety for all patients, staff and visitors

c. Alignment with LifeBridge Health and Sinai Hospital strategic imperatives:

For the purposes of this quality, risk management and patient safety plan, the term patient safety encompasses medical errors and adverse events as referenced in the CMS regulations.

Quality, Risk Management and Patient Safety Goals (subject to change pending HSCRC threshold and benchmarks)

Sinai Hospital of Baltimore leaders establish specific quality, risk management and patient safety goals at least annually based on the strategic imperatives articulated for LifeBridge Health and more specifically, Sinai Hospital. The following quality goals for calendar year 2018 are in alignment with the strategic plans and goals of LifeBridge Health and Sinai Hospital:

1. Exceed the Centers of Medicare and Medicaid goals and achieve scores that rank Sinai Hospital in the top 10% of all hospitals in Maryland and/or nationally (whichever is applicable): These goals represent the hospital FY 2018 System goals set by the Board of Directors for all LifeBridge entities.
    a) Meet or exceed the Maryland state threshold for inpatient mortality based on Risk Adjusted Survival Rate of 95.51%; the proposed HSCRC threshold for improvement.
    b) Eliminate preventable harm by reducing the Maryland Health Services Cost Review Commission's (HSCRC) Maryland Hospital-acquired Conditions, goal 0.45;
    c) Decrease the HSCRC readmission rate to 10.83 or less; Improvement is a cumulative 14.5% reduction and attainment starting at a readmit rate of 10.83%; proposed goal based on attainment target.
    d) Improve the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) overall score to 71.0% or greater goal set to achieve 1.2 percentage point increase from FY 17 performance

2. Quality Based Reimbursement Goals set by HSCRC – Safety Domain indicator goals.
    a) CAUTI – Achieve Threshold rate of 0.828.
    b) CLABSI – Achieve Threshold rate of 0.784.
    c) CDI – Achieve Threshold rate of 0.852.
    d) MRSA bacteremia – Achieve Threshold rate of 0.815.
    e) SSI Colon - Achieve Threshold rate of 0.781.
    f) SSI Hysterectomy - Achieve Threshold rate of 0.722.
    g) Elective Delivery before 39 weeks - Achieve Threshold rate of 0.00.

3. Hospital Compare CMS Star rating Hospital Goals Regarding Emergency Department Throughput Core Measures. Sinai is included in the Very High Category.
    a) ED 1b Median Time from Arrival to ED departure for Admitted ED patients goal to meet National Performance of 335 minutes
    b) ED 2b Admit Decision Time to ED Departure Time for Admitted patients goal to meet National Performance of 138 minutes
    c) OP 18b Median Time from ED Arrival to ED Departure for discharged ED patients goal to meet State Performance of 172 minutes
    d) OP 20 Median Time from ED Arrival to Provider Contact for ED patients goal to meet State Performance of 26 minutes

4. Use of the Rothman Index predictive analytics to identify the likelihood of certain future health outcomes in patients in the acute care setting. This allows for earlier interventions than most early warning systems currently in use.

Perahealth – Rothman Index Quality Indicators

a) Rapid Response – Increase in activation by 5% over CY 2016
b) Resuscitation – Decrease in Arrests by 5% over CY 2016
c) Transfer to a Higher level of care – Decrease Transfers by 5% over CY 2016
d) Sepsis Overall Mortality – Stay below MHA goal of 25%
e) Mortality – Achieve HSCRC threshold Survival rate
f) Readmissions – Achieve HSCRC threshold for Attainment
g) Maryland Hospital Acquired Conditions – Achieve HSCRC no penalty zone of 0.45
h) Length of Stay (LOS) – Decrease all payer LOS to 4.56

5. Implementation of proactive enterprise risk management (ERM) initiatives that develop a risk-aware culture ch focusing on projects and process changes to improve quality and patient safety. ERM implementation is an ongoing and iterative process that emphasizes an organization's ability to report, communicate, collaborate, and learn, being inclusive of the eight domains of ERM when addressing opportunities for improvement. The eight domains include:

a) Operational
b) Clinical/Patient Safety
c) Strategic
d) Financial
e) Human Capital
f) Legal/Regulatory
g) Technology
h) Hazard

II. Authority Structure

a. Leadership accountability

The Board of Directors is ultimately accountable for quality of care and patient safety at Sinai Hospital of Baltimore. Hospital executives and medical staff leaders are accountable to the Board of Directors for the quality and safety of care delivered by staff and licensed independent practitioners across the organization.

In conjunction with senior leadership and the leaders of the organized medical staff, the Board of Directors evaluates the hospital's performance in relation to its mission, vision, and strategic goals. The review of performance is ongoing and includes the specific goals for quality, risk mitigation and patient safety as outlined in this plan. Furthermore, the Board ensures that the Quality, Risk Management and Patient Safety Plan reflects the complexity of the organization and focuses the organization on outcomes and process improvements that will drive Sinai Hospital toward its stated future vision.

In collaboration, the Board of Directors, senior leadership and medical staff leadership:

- Determine the priorities for improvement and annual goals for quality improvement, risk mitigation and patient safety;
- Establish priorities for performance measurement and frequency of data collection and reporting;
- Role model behaviors that support a culture of improvement, risk awareness and patient safety, and strive to advance that culture across the organization; and

- Provide the structure and resources needed to support an effective quality, risk and patient safety improvement program across the organization.

In addition, it is the responsibility of the Sinai Hospital senior leadership and medical staff leadership to:

- Assure compliance with regulatory requirements;
- Set expectations for participation in quality improvement, patient safety, and risk mitigation activities across the organization, aligned with the current priorities for improvement;
- Engage participation from front-line staff regarding how we can improve our systems and processes;
- Personally participate in quality improvement, patient safety and risk mitigation activities, and engage staff in promoting patient safety;
- Review and report on key quality measures, safety indicators, and demonstrated inclusion of all ERM domains; and
- Periodically engage in an evaluation of the organization's culture to identify and remove barriers to a culture that promotes high reliability and a Just Culture environment

b. Quality Committee and Reporting Structure

The structure for designing, evaluating and improving processes associated with quality, risk mitigation and patient safety includes the following major hospital and medical staff committees.

Performance Oversight Committee (POC)

Membership: Board Members, Chief Quality Officer, Chiefs of Service, Hospital Executive Leadership, Sinai Community Care Medical Director. The committee is chaired by a Board Member.

Roles and Responsibilities:

The Board of Directors delegates oversight of the implementation of this Quality, Risk Management and Patient Safety Plan to the Performance Oversight Committee. This committee receives reports and evaluates the organization's progress toward goal achievement associated with strategic quality initiatives and metrics, including but not limited to the LifeBridge Quality Goals Dashboard and the Sinai hospital Executive Dashboard.

The Performance Oversight Committee supports achievement of Sinai Hospital quality goals and objectives by:

a) Establishing specific priorities for performance measurement and improvement on behalf of the Board of Directors;
b) Monitoring and evaluating progress toward the Sinai Hospital quality goals and priorities;
c) Holding hospital executives and medical staff leaders accountable for timely and measurable progress toward strategic improvement priorities;
d) Reprioritizing measurement and/or improvement activities when changes in the environment, regulatory requirements, customer requirements or observed performance dictate a shift in organizational priorities;
e) Delegating, when appropriate, oversight responsibility for quality and patient safety to the Quality Oversight Committee, Sinai Hospital leadership, the Medical Executive Committee, and the Nursing Outcomes Coordinating Council; and

f) Providing oversight and evaluation of risk mitigation strategies and actions taken in response to adverse patient outcomes and occurrences, including Sentinel Events.

Medical Executive Committee of the Medical Staff (MEC)

Membership: President and Chief Operating Officer, President of the Medical Executive Committee, Vice President of the Medical Executive Committee, President of the Medical Staff, Secretary, Treasurer, Department Chiefs of Staff, Elected and Administrative non-voting Members, and Committee Chairs.

Roles and Responsibilities:

The organized medical staff provides leadership in the activities associated with improving quality (including patient safety) of care, treatment, and services across the organization. The Medical Executive Committee is authorized through the Medical Staff Bylaws to provide leadership in performance improvement on behalf of the medical staff and holds the department chairs and section chiefs accountable for evaluating and improving the quality of care provided within their respective departments/services.

The medical staff is actively involved in the measurement, assessment, and improvement of the following:

a) Medical and behavioral assessment and treatment of patients;
b) Accurate, timely and legible completion of patient medical records;
c) Significant patient and medical errors
d) Population-specific use of medications, and adverse drug events;
e) Use of blood and blood components, and reported/confirmed transfusion reactions;
f) Operative or other procedures that place the patient at risk of disability or death;
g) Significant discrepancies between preoperative and postoperative diagnosis including pathological diagnoses;
h) Clinical practice patterns (including significant departures from established patterns of clinical practice), compliance with core measures, infection rates, and peer review findings;
i) Sentinel event and patient safety data; and
j) Application of autopsy criteria.

The MEC is directly accountable to the Board of Directors and makes regular reports to the Board of Directors on quality monitoring and improvement activities of the organized medical staff.

Quality Oversight Committee (QOC)

Membership: Representatives from the Clinical Departments of the Medical Staff, Patient Care Services, Ambulatory Quality, Quality/Patient Safety Department, Clinical and Nonclinical Support Departments, and Hospital Executive Leadership. The committee is chaired by the Chief Quality Officer.

Roles and Responsibilities:

Following the priorities and direction established through the Performance Oversight Committee, the Quality Oversight Committee offers hands-on, direct oversight to Sinai Hospital's Quality, Risk Management and Patient Safety initiatives. The Quality Oversight Committee supports the goals and objectives of the Quality, Risk Management and Patient Safety Plan by:

- Deploying and supporting multidisciplinary improvement teams inclusive of members across appropriate ERM domains tasked with achieving the strategic quality improvement goals and performance targets on the Executive Dashboard;
- Receiving and reviewing reports identifying and analyzing trends across the clinical and ancillary departments in the organization (including but not limited to department-specific Quality and Patient Safety metrics);
- Receiving and reviewing occurrence reports by identifying and analyzing trends as well as actions taken to mitigate future risk;
- Receiving and reviewing reports from the Multidisciplinary Committees providing guidance on indicator selection, encouraging small rapid tests of change, assessing the effectiveness of improvement efforts, and periodically verifying that improvement is sustained over time;
- Receiving and reviewing results and the implementation of corrective actions from event reviews;
- Identifying and facilitating removal of the obstacles to implementing improvement intiatives;
- When appropriate, integrating residents and the Graduate Medical Education (GME) programs into quality, risk mitigation and patient safety initiatives;
- Assuring compliance with regulatory and statutory requirements;
- At least annually evaluating the overall performance of the implementation of this Quality, Risk Management and Patient Safety Plan, and reviewing the findings and recommendations of that evaluation with the POC.

The QOC is ultimately accountable to the Board of Directors through the POC. QOC reports routinely to the Performance Oversight Committee. QOC relies on the accountability structures of Sinai Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Multidisciplinary Committees (MDC)

Membership: Representatives of the medical staff, diagnostics services, patient care services, ancillary staff, and executive staff, as appropriate and defined by the patient population of the clinical service area the MDC supports.

Roles and Responsibilities:

Multidisciplinary Committees (MDC's) are clinical service-based groups who meet regularly for the purpose of ensuring quality of care and patient safety for their respective patient populations. MDC's assess and improve the care provided to patients at Sinai by:

a) Aligning with and addressing the quality goals and improvement initiatives for Sinai Hospital as they apply to their respective patient populations;
b) Measuring important patient care processes and outcomes to identify improvement opportunities unique to their clinical service areas;
c) Gathering clinical evidence and best practices from other organizations and professional societies that can be adapted to Sinai Hospital and improve process and outcome measures;
d) Conducting proactive risk assessments to determine the need for process changes that will reduce potential for harm and increase high reliability;

e) Listening to the voice of the patient/family customer to determine the need for process changes that will impact quality, risk mitigation, patient safety and customer satisfaction;
f) Engaging staff in application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
g) Modeling and reinforcing a culture within their respective service lines that support performance improvement and patient safety;
h) Monitoring the impact of improvement initiatives to ensure that changes are implemented, and improvements are sustained over time; and
i) Emphasize dual relationship for unit level safety; staff and senior leadership.

The following MDC's are in place and functioning:

Procedural Services
Psychiatry Services
Emergency
Cardiovascular
Critical Care
Oncology
Acute Care
NeuroSciences
Orthopedics
Women and Childrens
Rehabilitation

MDC's are ultimately accountable to the Board of Directors through the POC. MDC's routinely report to the Quality Oversight Committee. MDC's rely on the accountability structures of Sinai Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Interdisciplinary Committees of Sinai Hospital and Medical Staff

The following interdisciplinary committees meet regularly and are charged with overseeing quality of care and patient safety within their areas of expertise and clinical practice:

a) Infection Prevention and Control Committee
b) LifeBridge Health Formulary Review Committee
c) Document Management Committee
d) Operating Room Committee
e) Blood and Tissue Management Committee
f) Cancer Committee
g) Continuing Medical Education Committee
h) Ethics Committee
i) Impaired Practitioner Committee
j) Library and Medical Informatics Committee
k) Nutrition Care Committee
l) Quality Oversight Committee
m) Professional Standards and Grievance Committee
n) Radiation Safety Committee

o) Staff Privileges and Credentials Committee
p) Trauma Committee
q) Code and RRT Committee

Each committee has an agenda driven by its unique charter and purpose. The interdisciplinary committees support the Quality, Risk Management and Patient Safety Plan by:

a) Aligning with and addressing the quality goals and improvement initiatives for Sinai Hospital as they apply to their respective areas of focus and expertise;
b) Measuring important patient care processes and outcomes to identify improvement opportunities within their respective areas of focus and expertise;
c) Gathering clinical evidence and best practices from other organizations and professional societies that can be adapted to Sinai Hospital and improve process and outcome measures;
d) Conducting proactive risk assessments to determine the need for process changes that will reduce potential for harm and increase high reliability;
e) Listening to the voice of the patient/family customer to determine the need for process changes that will impact quality, patient safety and customer satisfaction;
f) Engaging in the application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
g) Modeling and reinforcing a culture within their respective areas of focus that support quality improvement, risk mitigation and patient safety;
h) Monitoring the impact of improvement initiatives to ensure that changes are implemented, and improvements are sustained over time.

The interdisciplinary committees are ultimately accountable to the Board of Directors through the POC. These committees report routinely and/or minutes are shared to the Quality Oversight Committee and Medical Executive Committee. Interdisciplinary committees rely on the accountability structures of Sinai Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Resident Patient Safety Council

Membership: Chief Quality Officer, Director of Graduate Medical Education, Residents from Medical Staff Clinical Departments (Medicine, Surgery, Womens & Children, Ophthalmology, PM&R), AVP Quality & Patient Safety, Patient Safety Officer, Medication Safety Officer.

The Resident Patient Safety Council is a resident-centric council within the Graduate Medical Education Department committed to engaging residents in shaping Sinai Hospital's patient safety and quality improvement programs. The Council provides input by:

a) Development of the Quality Improvement, Risk Management and Patient Safety Curriculum, which includes annual resident quality improvement projects;
b) Facilitating communication of information from QOC to their respective departments;
c) Modeling and reinforcing a culture of safety within their respective departments which supports reporting of near-miss and actual events.

Nursing Research, Quality and Evidence Based Practice Council (NRQEBP) – Patient Care Services

Membership: The Assistant Vice President for Patient Care Services (advisor), clinical nurses serve as Chair and Co-Chair, and clinical nurses representing sister units throughout Sinai, one manager and one educator representative. Expert resources include the Clinical Nurse Specialists (CNS), Clinical Nurse Outcome Leaders (NOLs), other patient support department representatives and the Patient Safety Officer.

The NRQEBP Council is a house-wide council and part of the Shared Governance structure within Patient Care Services. This council is committed to utilization of evidence-based practice and focused on empirical outcomes. It deploys and oversees design and improvement of patient care processes and outcomes by:

a) Analyzing outcomes data (e.g., National Database of Nursing Quality Indicators) for trending and benchmarking;
b) Prioritizing and formulating improvement strategies as needed;
c) Aligning with and addressing the quality goals and improvement initiatives for Sinai Hospital as they apply to Patient Care Services;
d) Engaging staff in application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
e) Ensuring appropriate translation of evidence to identified practice issues;
f) Modeling and reinforcing a culture within the Patient Care Services division which supports quality improvement, risk mitigation, and patient safety;
g) Monitoring the impact of improvement initiatives to ensure changes are implemented and improvements are sustained over time;
h) Education, engagement and accountability of clinical nurses in performance improvement processes and nursing research.

The Nursing Research Quality and EBP Council is ultimately accountable to the Board of Directors through the POC. The Council reports routinely and/or minutes are shared to the Quality Oversight Committee. The Council relies on the accountability structures of Sinai Hospital and the medical staff to ensure improvement goals are achieved and sustained.

Outcomes Practice and Education Councils (OPEC)

Membership: Each OPEC is either unit-based or service-based and comprised of clinical nurses, the nurse manager, CNS, educator, and other interdisciplinary team members as needed.

At the unit level OPECs support the Quality and Patient Safety Program by:

a) Examining nursing practice issues, including variations within a unit or across Patient Care Services;
b) Applying the Rosswurm and Larrabee Model for evidence-based practice;
c) Identifying other resources necessary for the development and implementation of best practice;
d) Evaluating nurse-sensitive quality indicator data on a routine basis using the highest-level benchmarks available;
e) Prioritizing and creating clinical practice improvement plans;
f) Providing a framework for the Magnet appraisal process to assure compliance with the five categories of excellence required to maintain Magnet status designation; and
g) Conducting routine review of policies and procedures, standards, and protocols specific to the focus of nursing care in the unit or service line and assessing the factors that may impact the work environment

by implementing and evaluating action plans as necessary to maintain safe, productive, reliable, and effective methods of delivering patient care.

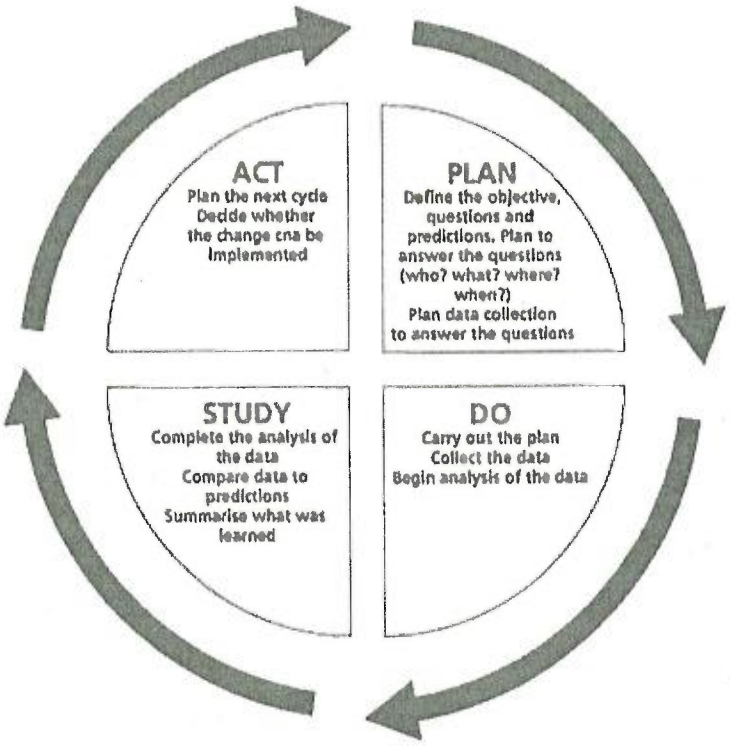
The Outcomes Practice and Education Councils are ultimately accountable to the Board of Directors through the accountability structure of Sinai Hospital and more specifically, the Patient Care Services Division.

III. Improvement Methodology/Model

Sinai Hospital applies the Institute for Healthcare Improvement's Plan-Do-Study- Act (PDSA) Model to encourage rapid-cycle change during the performance improvement process. The PDSA model involves the following steps:

a) Defining the overarching opportunity;
b) Identifying the specific objective(s);
c) Collecting and Measuring relevant data;
d) Analyzing performance;
e) Developing appropriate action plans;
f) Educating; and
g) Monitoring to assure the desired improvement is sustained.

The following diagram further illustrates this "tried and true" approach to process improvement.



This improvement model is adaptable and used in all settings and improvement initiatives. In addition, Sinai Hospital has staff and leaders who may bring other improvement methods to improvement initiatives in

which they are involved, depending on the team members' skills and experience in process design, analysis, and management.

While PDSA is the primary methodology used for PI, Sinai Hospital leaders and staff are trained and may participate in a variety of improvement activities that use other methodologies, including Lean (Eliminating waste in a process, Eliminating non-value-added steps, Improving process flow), Kaizen (Seek input from all levels of an organization, Improve processes that cross organizational boundaries, Standardize activities to eliminate waste), FMEA (Systematic identification and prioritization of possible failures in a process), Team STEPPS (Improve safety and performance through effective teamwork, RCA (identifying the root causes of faults or problems) or RCA^2(driving improvement in the process of reviewing events that cause or may cause serious harm, and in developing and implementing sustainable and measurable actions that prevent future harm to both patients and the workforce).

IV. Measurement and Analytics

a. Scope of measurement

Departments and services of Sinai Hospital of Baltimore engage in measurement of critical processes and outcomes associated with quality of care and patient safety. The scope of measurement activities encompasses all departments and service lines and the provision of care, treatment and services provided by both hospital staff and members of the medical staff.

The Board requires leadership and the medical staff to routinely gather and analyze data on important quality and patient safety processes and outcomes. Board-established frequencies for measurement across the organization are identified in Table 1 along with the description of the kinds of measures Sinai Hospital routinely reviews.

The Board requires clinical leaders to consider quality and patient safety performance measures based on the scope of care, treatment and services provided, as well as the patient populations served. Leaders of departments and clinical service lines recommend an appropriate set of performance measures that align with Board established quality/patient safety goals as applicable. Department and clinical service line measures are approved by the POC, acting on behalf of the Board.

The table on the following page illustrates the scope of measurement activity and lines of reporting across Sinai Hospital.

Table 1.0
Scope of Measurement at Sinai Hospital of Baltimore

Measurement Category	Description	Reports To	Board-Established Frequency
Executive Dashboard (Established by the POC on behalf of the Board)	Strategic measures aligned with LifeBridge and Sinai quality goals: • LifeBridge Quality Goals Dashboard • Sinai Hospital Executive Quality Dashboard	POC QOC Executive Team MEC	At least quarterly
Hospital Department	Each hospital department leader establishes pertinent measures of quality and patient safety reflective of the	QOC Executive	Monthly

Measures (Recommended by department leaders and approved by POC on behalf of the Board)	scope of services provided by the department and patient population served. Measures are prioritized and selected according to the following criteria: • Alignment with LifeBridge/Sinai priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone processes.	Team	
Medical Staff Measures (Recommended by department chairs and approved by the MEC and POC on behalf of the Board)	Each medical staff department leader establishes pertinent measures for ongoing professional practice evaluation within his/her department. OPPE measures typically reflect the clinical measures of the corresponding MDC that align with physician/AHP privileges.	POC MEC	At least semi-annually
Multi-Disciplinary Committee (MDC) Measures (Recommended by MDC leaders and approved by POC on behalf of the Board)	Each MDC establishes priorities for improvement and measurement that encompasses the scope of care and services, and patient population, of the MDC. Measures are prioritized and selected according to the following criteria: • Alignment with LifeBridge/Sinai priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone processes.	POC QOC Executive Team MEC	At least semi-annually

Measurement Category	Description	Reports To	Board-Established Frequency
Nursing Research Quality and Evidence Based Practice Council Measures (Recommended by the Council and approved by POC on behalf of the Board)	This Council of the Patient Care Services division maintains a dashboard of nurse-driven measures of quality and patient safety, including but not limited to the National Database of Nursing Quality Indicators. Other measures may be established according to the following criteria: • Alignment with LifeBridge/Sinai priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone processes.	POC QOC Executive Team	At least quarterly
Committees for Oversight of Important Functions within the Organization • Infection Prevention and Control • Pharmacy and Therapeutics	Each committee establishes and oversees the measurement and analysis of data representative of the function the committee was established to oversee and monitor. Measures are generally selected based on the following criteria: • Alignment with LifeBridge/Sinai priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone	POC QOC MEC Executive Team	Reflective of the committee's meeting cadence

• Blood Utilization and Review • Environment of Care/Safety (Recommended by each committee and approved by POC on behalf of the Board)	processes.		

V. Reporting of Medical Errors and Adverse Events

All Staff are empowered to practice in a safety-focused manner and are responsible for reporting any concerns regarding patient safety, including:

- Potential for an adverse event or medical error;
- Actual adverse event or medical error; or
- "Near miss" and Good Catch events or medical errors.

This expectation is introduced in new employee orientation and reinforced during ongoing education sessions for all LifeBridge and Sinai Hospital employees.

Sinai has established policies and procedures to guide management and staff through reporting of patient safety concerns and the proper response. These policies and procedures are maintained for easy reference in the Administrative or Patient Care Policy Manuals.

Sinai responds to patient safety concerns utilizing the concepts of a Just Culture. We are committed to a Just Culture in which employees are encouraged to come forward when they or others make mistakes, allowing the organization the opportunity to improve the care we deliver and prevent potential errors. Responses focus on system-wide issues that contribute to practice breakdown, and also examine the behavior and responsibilities of all staff. The Just Culture analysis is used to distinguish between human error, risk-taking behavior, and reckless behavior. This shifts the focus to quality of choices, not on undesired outcomes that may or may not result patient or organizational harm.

VI. Disclosure

Utilizing the principles of the AHRQ (Agency for Healthcare Research and Quality) CANDOR program (Communication and Optimal Resolution) process, patients and/or their families/representatives are informed of unanticipated and adverse outcomes of care. Initial disclosure of known facts occurs as soon as possible by the designated spokesperson which is most often the provider responsible for care or their Chief of Service.

For serious unanticipated adverse outcomes, or those that result in significant disability or death, a thorough investigation will be conducted, and the results of that investigation will be shared by leadership with the patient/family/representatives as appropriate. Any action items developed to prevent reoccurrence of the event will also be shared as appropriate.

VII. Annual Review of the Effectiveness of Quality, Risk Management and Patient Safety

The governing body continually evaluates the Sinai Hospital's performance in relation to its mission, vision, and goals. A component of the Board's evaluation of hospital performance is a structured evaluation of the effectiveness of the execution of this Quality, Risk Management and Patient Safety Plan.

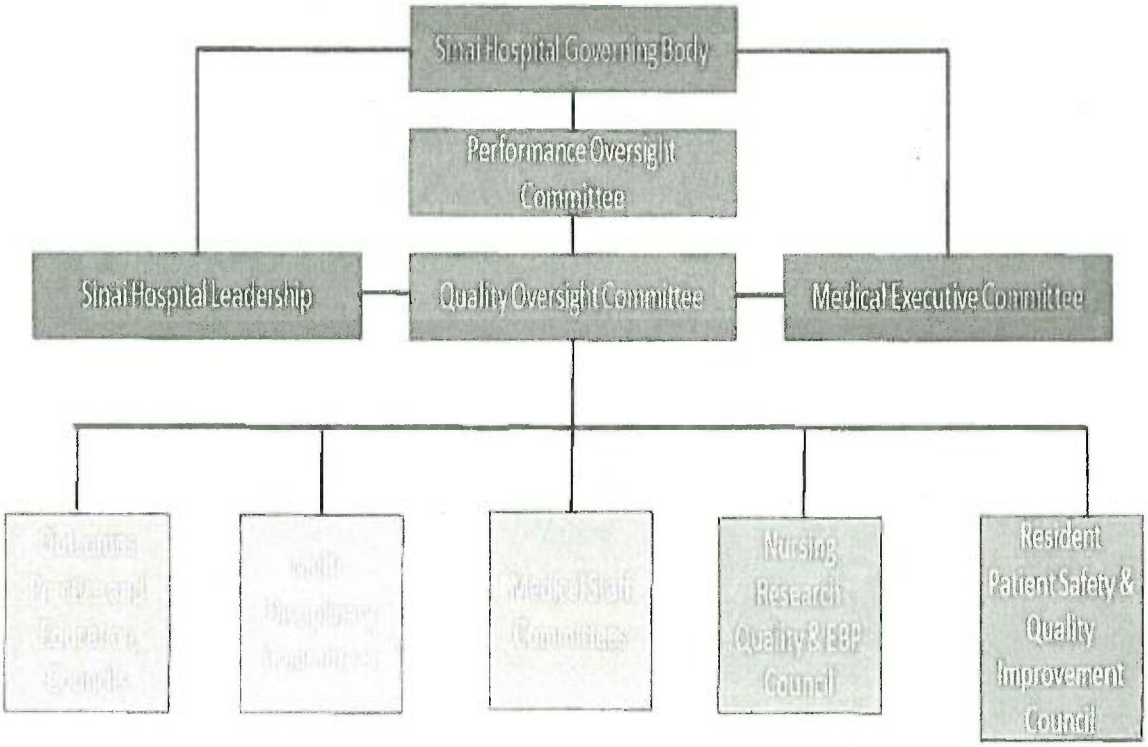
Annually, the Quality Oversight Committee coordinates an evaluation of all aspects of the Quality, Risk Management and Patient Safety Plan by gathering input from each of the MDC's and other quality committees/structures regarding:

- Measurable results of improvement initiatives;
- Perceived/real value of the performance measures that were reviewed and analyzed;
- Contribution to the LifeBridge and Sinai Hospital quality, risk management and patient safety goals;
- Appropriate inclusion of participants from the ERM domains
- Strengths to build upon in the way the committee/structure functions; and
- Opportunities to improve the way the committee/structure functions.

The Quality and Patient Safety Department synthesizes this information for a formal discussion and evaluation of the implementation of the Quality, Risk Management and Patient Safety Plan at the Quality Oversight Committee. The results of that evaluation are then brought to the Performance Oversight Committee for discussion and completion of the annual evaluation. The Quality and Patient Safety Plan is then updated to reflect any modifications recommended and/or approved by the Performance Oversight Committee.

The final step in the annual evaluation of the execution of the Quality, Risk Management and Patient Safety Plan is the formal approval of the updated plan. The Quality, Risk Management and Patient Safety Plan is reviewed and approved by the Quality Oversight Committee, the Performance Oversight Committee, Medical Staff acting through the Medical Executive Committee, and by the Sinai Hospital Administration.

Quality and Patient Safety Structure



LifeBridge Health Quality Goals

Sinai Hospital Quality Dashboard

QOC Review and Approval: March 22, 2019

MEC Review and Approval: April 8, 2019

POC Review and Approval:

ATTACHMENT D

NORTHWEST HOSPITAL

Quality, Patient Safety & Performance Improvement

2019 Annual Plan

NORTHWEST HOSPITAL
A LifeBridge Health Center

Table of Contents

Northwest Hospital
Quality, Patient Safety, & Performance Improvement Plan
2019

I. Introduction

a. Alignment with foundation statements:

Our mission, vision, and values are the standards upon which we were founded and continue to be the driving force behind all we do. The vision of LifeBridge Health is *to be a nationally recognized, independent health system consistently providing outstanding quality, service, affordability and outcomes*. More specifically, the vision of Northwest Hospital, a cornerstone of both acute inpatient and ambulatory care within the LifeBridge Health delivery network, states; *Northwest Hospital will be recognized as a leader in customer care and clinical quality in the services we choose to offer by exceeding expectations of patients, physicians, employees and the community.*

The following plan outlines the structure, methods and approaches the leaders and staff at Northwest Hospital use to continuously evaluate and improve processes in order to achieve the vision of LifeBridge and Northwest Hospital leadership for exceptional quality, customer service, affordability and outcomes that are recognized within the Maryland health care market.

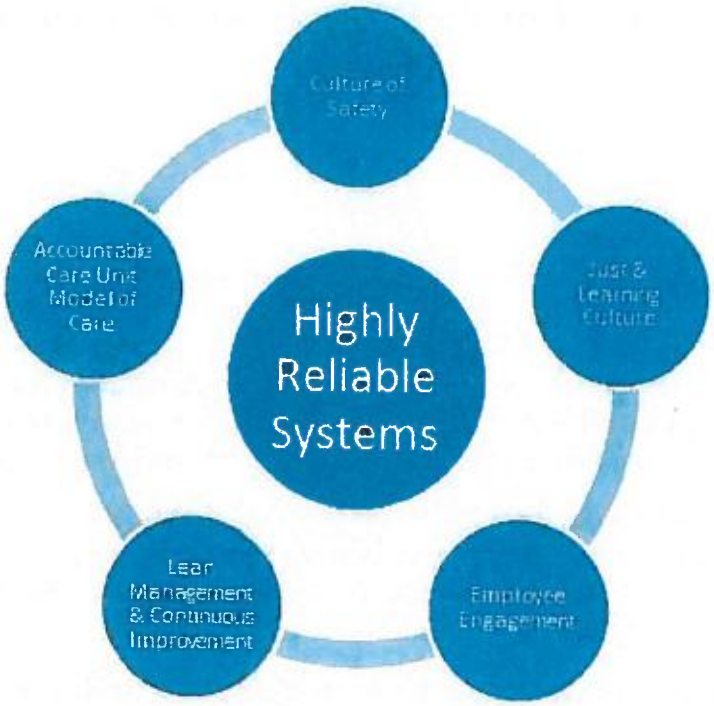
Northwest Hospital leaders recognize that strength in quality and patient safety is dependent on an organizational culture that promotes a commitment to excellence, honest conversations about improvement opportunities, multidisciplinary collaboration, reliance on sound data and information to prioritize improvement opportunities and measure progress, and a culture of shared accountability to outcomes and patient safety. Leaders model and promote a culture of quality and patient safety at Northwest Hospital through the following organizational values: *Service, Performance, Innovation, Respect, Integrity* and *Teamwork* (SPIRIT).

b. Objectives of the plan:

The Quality, Patient Safety & Performance Improvement Plan supports the systematic organization-wide approach to plan, design, measure, assess, and improve the organizational performance. Leaders of Northwest Hospital strive to achieve the following objectives through the careful and intentional implementation of this quality and patient safety plan:

- Provide a framework for both hospital employees and members of the medical staff to engage in innovation and teamwork to support the Northwest "Quest to be the Best"
- Attain optimal patient outcomes and patient and family experience;
- Support formal and informal organizational learning that drives improved performance and outcomes;
- Develop and share best practices;
- Develop leaders' and staff's competency with methods and tools that support process evaluation, performance improvement, and patient safety initiatives;
- Ensure that Northwest Hospital steadily progresses along its journey toward high reliability
- Provide cost effective quality of care with efficient use of resources and an exceptional patient experience
- Identify, reduce, and/or eliminate any hazards, risks, or avoidable harm associated with the provision of care and service at Northwest Hospital
- Support an engaged and safe workforce

On it journey towards high reliability, Northwest Hospital has strategically fostered an improved culture of safety, implemented the Accountable Care Unit model of care, adopted Lean Management performance improvement tools, started applying Just & Learning Culture principles, and focused on increasing employee engagement.



c. Alignment with LifeBridge Health and Northwest Hospital strategic imperatives:

For the purposes of this Quality, Patient Safety, & Performance Improvement Plan, the term patient safety encompasses medical errors and adverse events as referenced in the CMS regulations.

II. Quality and Patient Safety Goals

Northwest Hospital leaders establish specific quality and patient safety goals at least annually based on the strategic imperatives articulated for LifeBridge Health and more specifically, Northwest Hospital. The following quality goals for calendar year 2019 are in alignment with the strategic plans and FY19 goals of LifeBridge Health and Northwest Hospital:

1. Exceed the Centers of Medicare and Medicaid goals and achieve scores that rank Northwest Hospital in the top 10% of all hospitals in Maryland and/or nationally : These goals represent the hospital FY 2019 System goals set by the Board of Directors for all LifeBridge entities.
    a) Meet or exceed the Maryland state threshold for inpatient mortality based on Risk Adjusted Survival Rate of 95.62%; the proposed HSCRC threshold for improvement.
    b) Eliminate preventable harm by reducing the Maryland Health Services Cost Review Commission's (HSCRC) Maryland Hospital-acquired Conditions, goal > 0.45;
    c) Decrease the HSCRC readmission rate- HSCRC actual cumulative statewide target is 14.34% reduction from the base year and attainment starting at a readmit rate of 115%.
    d) Improve the Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) overall score to 66.2% or greater goal set to achieve 0.7% percentage point increase from FY 18 performance

2. Quality Based Reimbursement Goals set by HSCRC – Safety Domain indicator goals.
    a) CAUTI – Achieve Threshold rate of 0.828
    b) CLABSI – Achieve Threshold rate of 0.784
    c) CDI – Achieve Threshold rate of 0.852

d) MRSA bacteremia – Achieve Threshold rate of 0.851
e) SSI Colon - Achieve Threshold rate of 0.781
f) SSI Hysterectomy - Achieve Threshold rate of 0.722

3. Hospital Compare CMS Star-rating Hospital Goals Regarding Emergency Department Throughput Core Measures.
   a) ED 1b Median Time from Arrival to ED departure for Admitted ED patients goal to meet National Performance of 273 minutes
   b) ED 2b Admit Decision Time to ED Departure Time for Admitted patients goal to meet National Performance of 101 minutes
   c) OP 18b Median Time from ED Arrival to ED Departure for discharged ED patients goal to meet State Performance of 142 minutes
   d) OP 20 Median Time from ED Arrival to Provider Contact for ED patients goal to meet State Performance of 22 minutes

III. Authority Structure

a. Leadership accountability

The Board of Directors is ultimately accountable for quality of care and patient safety at Northwest Hospital. Hospital executives and medical staff leaders are accountable to the Board of Directors for the quality of care, treatment and services (including patient safety) provided by staff and licensed independent practitioners across the organization.

In conjunction with senior leadership and the leaders of the organized medical staff, the Board of Directors evaluates the hospital's performance in relation to its mission, vision, and strategic goals. The review of performance is on-going, and includes the specific goals for quality and patient safety as outlined in this plan. Furthermore, the Board ensures that the Quality and Patient Safety Plan reflects the complexity of the organization and focuses the organization on those outcome and process improvements that will drive Northwest Hospital toward its stated future vision.

In collaboration, the Board of Directors, senior leadership and medical staff leadership:

- Determine the priorities for improvement and annual goals for quality and patient safety;
- Establish priorities for performance measurement and frequency of data collection and reporting;
- Role model behaviors that support a culture of improvement and patient safety, and strive to advance that culture across the organization; and
- Provide the structure and resources needed to support an effective quality and patient safety improvement program across the organization.

In addition, it is the responsibility of the Northwest Hospital senior leadership and medical staff leadership to:

- Assure compliance with regulatory requirements;
- Set expectations for participation in performance improvement activities across the organization, aligned with the current priorities for improvement;
- Participate in patient safety and performance improvement activities and engage staff in promoting patient safety;
- Review and report on key quality measures and safety indicators; and
- Periodically engage in an evaluation of the organization's culture to identify and remove barriers to a culture that promotes quality and patient safety using Just & Learning Culture principles

b. Quality Committee and Reporting Structure

The structure for designing, evaluating and improving processes associated with quality and patient safety includes the following major hospital and medical staff committees.

Performance Oversight Committee (POC)

Membership: Board Members, Vice President of Medical Staff, Chief Quality Officer, Vice President of Medical Affairs, LBH Vice President of Quality, NWH Chief Nursing Officer, NWH Chief Operating Officer, NWH President.

Roles and Responsibilities:

The Board of Directors delegates oversight of the implementation of this Quality, Patient Safety, and Performance Improvement Plan to the Performance Oversight Committee. The committee is chaired by a Board Member. This committee receives reports and evaluates the organization's progress toward goal achievement associated with strategic quality initiatives and metrics, including but not limited to the LifeBridge Quality Goals Dashboard and the Northwest Hospital Executive Dashboard.

The Performance Oversight Committee supports achievement of Northwest Hospital quality goals and objectives by:

a) Establishing specific priorities for performance measurement and improvement on behalf of the Board of Directors;
b) Monitoring and evaluating progress toward the Northwest Hospital quality goals and priorities;
c) Holding hospital executives and medical staff leaders accountable for timely and measurable progress toward strategic improvement priorities;
d) Reprioritizing measurement and/or improvement activities when changes in the environment, regulatory requirements, customer requirements or observed performance dictate a shift in organizational priorities;
e) Delegating, when appropriate, oversight responsibility for quality and patient safety to the Quality Oversight Committee, Northwest Hospital leadership, the Medical Executive Committee, and the Nursing Outcomes Coordinating Council; and
f) Providing oversight and evaluation of risk reduction strategies and actions taken in response to adverse patient outcomes and occurrences, including Sentinel Events.

Medical Executive Committee of the Medical Staff (MEC)

Membership: NWH President, NWH Chief Operating Officer, VPMA, CNO, LBH VP of Quality, President of the MEC, Vice President of the MEC, Immediate Past President of MEC, Secretary/ Treasurer of MEC, Department Chiefs of Staff, & Elected and Administrative non-voting Members

Roles and Responsibilities:

The organized medical staff provides leadership in the activities associated with improving quality of care and patient safety, treatment, and services across the organization. The Medical Executive Committee is authorized through the Medical Staff Bylaws to provide leadership in performance improvement on behalf of the medical staff and holds the department chairs and division chiefs accountable for evaluating and improving the quality of care provided within their respective departments/services.

The medical staff leadership is actively involved in the measurement, assessment, and improvement of the following:

a) Medical and behavioral assessment and treatment of patients;
b) Accurate, timely and legible completion of patient medical records;
c) Significant patient and medical errors
d) Population-specific use of medications, and adverse drug events;

e) Use of blood and blood components, and reported/confirmed transfusion reactions;
f) Operative or other procedures that place the patient at risk of disability or death;
g) Significant discrepancies between preoperative and postoperative diagnosis including pathological diagnoses;
h) Clinical practice patterns (including significant departures from established patterns of clinical practice), compliance with core measures, infection rates, and peer review findings;
i) Sentinel event and patient safety data; and
j) Application of autopsy criteria.

The MEC is directly accountable to the Board of Directors, and makes regular reports to the Board of Directors on quality monitoring and improvement activities of the organized medical staff.

Quality Oversight Committee (QOC)

Membership: Representatives from the Clinical Departments of the Medical Staff, Patient Care Services, Ambulatory Departments, Quality/Patient Safety Department, Clinical and Nonclinical Support Departments, and Hospital Executive Leadership. The committee is chaired by the Vice President of MEC

Roles and Responsibilities:

Following the priorities and direction established through the Performance Oversight Committee, the Quality Oversight Committee offers hands-on, direct oversight of Northwest Hospital's Quality and Patient Safety initiatives. The Quality Oversight Committee supports the goals and objectives of the Quality, Patient Safety, & PI Plan by:

- Deploying and supporting multidisciplinary improvement teams tasked with achieving the strategic quality improvement goals and performance targets on the Executive Dashboard;
- Receiving and reviewing reports identifying and analyzing trends among the clinical and ancillary departments across the organization (including but not limited to department-specific Quality and Patient Safety metrics);
- Receiving and reviewing occurrence reports by identifying and analyzing trends as well as actions taken to mitigate future risk;
- Receiving and reviewing reports of the Multidisciplinary Committees providing guidance on indicator selection, encouraging small rapid tests of change, assessing the effectiveness of improvement efforts, and periodically verifying that improvement is sustained over time;
- Receiving and reviewing results and the implementation of corrective actions from administrative case reviews, focus case reviews and sentinel event reviews;
- Identifying and facilitating removal of the barriers to improvement;
- Assuring compliance with regulatory and statutory requirements;
- At least annually evaluating the overall performance of the implementation of this Quality, Patient Safety, and Performance Improvement Plan, and reviewing the findings and recommendations of that evaluation with the POC.

The QOC is ultimately accountable to the Board of Directors through the POC. QOC reports routinely to the Performance Oversight Committee. QOC relies on the accountability structures of Northwest Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Multidisciplinary Leadership Committees

Membership: Clinical Leadership, Administrative Leadership, Quality Leadership, & Executive Leadership.

Roles and Responsibilities:

Multidisciplinary Leadership Committees are clinical service-based groups who meet regularly for the purpose of ensuring quality of care and patient safety for their respective patient populations. The Committees assess and improve the care provided to patients at Northwest by:

a) Aligning with and addressing the quality goals and improvement initiatives for Northwest Hospital as they apply to their respective patient populations via Organizational Pillar goals;
b) Measuring important patient care processes and outcomes to identify improvement opportunities unique to their clinical service areas;
c) Gathering clinical evidence and best practices from other organizations that can be adapted to Northwest Hospital and improve process and outcome measures;
d) Conducting proactive risk assessments to determine the need for process changes that will reduce potential for harm and increase process reliability;
e) Listening to the voice of the patient/family customer to determine the need for process changes that will impact quality, patient safety and customer satisfaction;
f) Engaging staff in application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
g) Modeling and reinforcing a culture within their respective service lines that support performance improvement and patient safety;
h) Monitoring the impact of improvement initiatives to ensure that changes are implemented and improvements are sustained over time via Departmental Dashboards.

The following Multidisciplinary Leadership Committees are in place and functioning:

- Surgical Services
- Anesthesia Services
- Imaging Services
- Psychiatry Services
- Emergency Services
- Orthopedic Services
- Medical Departments (Hospitalist Services, Critical Care, Neurology, Infectious Disease, Cardiology, Hem/Onc, Rehabilitation, Neurology)

The Multidisciplinary Leadership Committees are ultimately accountable to the Board of Directors through the POC. They routinely report to the Quality Oversight Committee and rely on the accountability structures of Northwest Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Interdisciplinary Committees of Northwest Hospital and Medical Staff

The following interdisciplinary committees meet regularly and are charged with overseeing quality of care and patient safety within their areas of expertise and clinical practice:

a) Infection Prevention and Control Committee
b) Safety & Emergency Management Committee
c) Operational Excellence Committee
d) LifeBridge Health Formulary Review Committee (P&T)
e) Peri-Op Governance Council
f) Continuing Medical Education Committee
g) Ethics Committee
h) Nutrition Care Committee
i) Stroke Committee
j) STEMI Committee

k) Radiation Safety Committee
l) Staff Privileges and Credentials Committee
m) Medication Safety Committee
n) Utilization Review Committee

Each committee has an agenda driven by its unique charter and purpose. The interdisciplinary committees support the Quality, Patient Safety, and Performance Improvement Plan by:

a) Aligning with and addressing the quality goals and improvement initiatives for Northwest Hospital as they apply to their respective areas of focus and expertise;
b) Measuring important patient care processes and outcomes to identify improvement opportunities within their respective areas of focus and expertise;
c) Gathering clinical evidence and best practices from other organizations that can be adapted to Northwest Hospital and improve process and outcome measures;
d) Conducting proactive risk assessments to determine the need for process changes that will reduce potential for harm and increase process reliability;
e) Listening to the voice of the patient/family customer to determine the need for process changes that will impact quality, patient safety and customer satisfaction;
f) Engaging in the application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
g) Modeling and reinforcing a culture within their respective areas of focus that support performance improvement and patient safety;
h) Monitoring the impact of improvement initiatives to ensure that changes are implemented and improvements are sustained over time.

The interdisciplinary committees are ultimately accountable to the Board of Directors through the POC. These committees report routinely and/or minutes are shared to the Quality Oversight Committee and Medical Executive Committee. Interdisciplinary committees rely on the accountability structures of Northwest Hospital and the medical staff to ensure that improvement goals are achieved and sustained.

Nursing Shared Governance Model – Patient Care Services

The Northwest Hospital Nursing Shared Governance Model is comprised of five Nursing Councils. Shared Governance is a shared decision-making process led by staff nurses and assisted by interdisciplinary team members to organize and make formal decisions about the best clinical practices, professional growth and development of staff, staff engagement, and quality improvement. A culture of shared governance provides a sense of empowerment, ownership, and accountability by nursing staff to impact outcome measures related to patient care and success of the organization. Furthermore, a Shared Governance model leads to decreased lengths of stay, readmissions, and clinical practice errors and increased patient and employee satisfaction while yielding improved quality outcomes. Shared Governance provides a framework to organizationally support a culture of safety and clinical excellence.

Nursing Shared Governance Councils:

1) Nursing Leadership Council
2) Nursing Professional Practice Council
3) Nursing Quality Improvement & Patient Safety Council
4) Nursing Clinical Practice Council
5) Nursing Professional Development Council

Membership: The Assistant Vice President for Patient Care Services (advisor), clinical nurses serve as Chair and Co-Chair, and clinical nurses representing sister units throughout Northwest, one manager and one educator representative. Expert resources include the Clinical Nurse Specialists (CNS/ CNE), other patient support department representatives and the Patient Safety Officer.

The Councils are house-wide councils and part of the Shared Governance structure within Patient Care Services. The councils are committed to utilization of evidence based practice and focused on empirical outcomes. They deploy and oversee design and improvement of patient care processes and outcomes by:

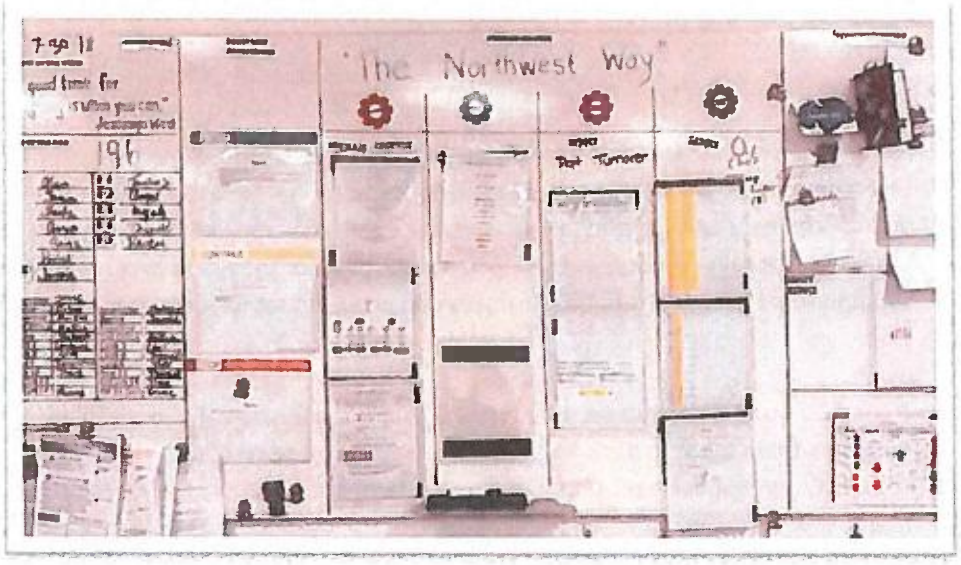
a) Analyzing outcomes data (e.g., National Database of Nursing Quality Indicators) for trending and benchmarking;
b) Prioritizing and formulating improvement strategies as needed;
c) Aligning with and addressing the quality goals and improvement initiatives for Northwest Hospital as they apply to Patient Care Services;
d) Engaging staff in application of process improvement methods, including small, rapid tests of change or pilots to validate improvement ideas;
e) Ensuring appropriate translation of evidence to identified practice issues;
f) Modeling and reinforcing a culture within the Patient Care Services division which supports performance improvement and patient safety;
g) Monitoring the impact of improvement initiatives to ensure changes are implemented and improvements are sustained over time;
h) Education, engagement and accountability of clinical nurses in performance improvement processes and nursing research.
i) Examining nursing practice issues, including variations within a unit or across Patient Care Services;
j) Identifying other resources necessary for the development and implementation of best practice;
k) Evaluating nurse-sensitive quality indicator data on a routine basis using various benchmarking sources;
l) Prioritizing and creating clinical practice improvement plans;
m) Conducting routine review of policies and procedures, standards, and protocols specific to the focus of nursing care in the unit or service line, and assessing the factors that may impact the work environment by implementing and evaluating action plans as necessary to maintain safe, productive, reliable, and effective methods of delivering patient care.

The Nursing Shared Governance Councils are ultimately accountable to the Board of Directors through the POC. The Councils reports routinely and/or minutes are shared to the Quality Oversight Committee. The Councils rely on the accountability structures of Northwest Hospital and the medical staff to ensure improvement goals are achieved and sustained.

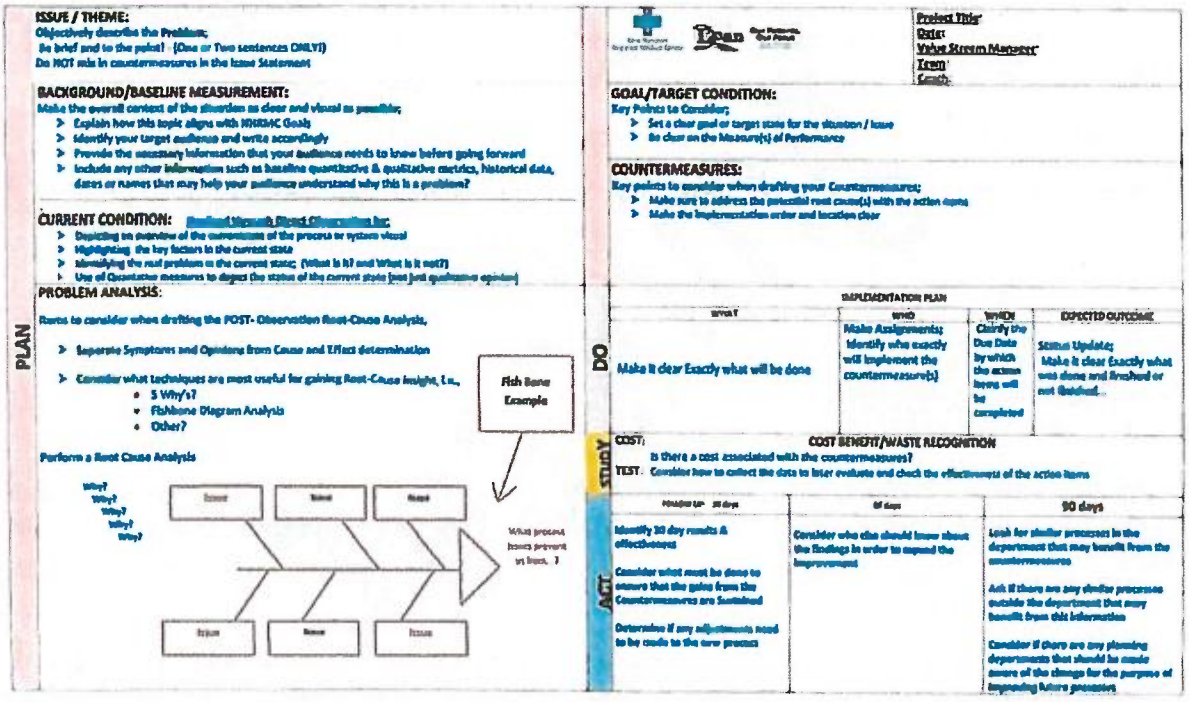
IV. Improvement Methodology/Model

LifeBridge Health has launched Operational Excellence (OPX), a system-wide process improvement management system that teaches employees strategies to make positive changes in their work areas using Lean Management Tools to improve efficiency, increase quality, decrease costs and, reduce frustrations and stress associated with process defects. OPX fosters a culture of continuous performance improvement and learning, allows for evidence-based reduction of system defects, and increases transparency through visual management systems. Lean Management tools that Northwest Hospital has adopted include Problem Solving Sheets, Standard Work, and unit/ department-specific visual management boards called Huddle Boards used to track performance measures (lagging and leading indicators) daily and to ensure on-going communication surrounding performance improvement initiatives. To maintain a daily focus on patient safety, the Safety Section of the huddle board is used to communicate safety concerns and to encourage reporting of and track department-specific adverse events and near misses.

Huddle Boards are used throughout NWH as a visual scorecard and means of fostering daily problem solving and by aligning daily work with the organization goals structured using Organizational Pillars- Safety, Culture, Service, and Value.



The following diagram illustrates how A3 Problem-Solving is used for process improvement to define the problem, analyze the problem to identify root cause(s), develop and implement action plans (counter measures), and evaluate results/data to ensure sustainability in alignment with the Plan-Do-Study-Act (PDSA) methodology.



This improvement model is adaptable and used in all settings and improvement initiatives. In addition, Northwest Hospital has staff and leaders who may bring other improvement methods to improvement initiatives in which they are involved, depending on the team members' skills and experience in process design, analysis, and management.

While Lean Management Tools are the primary methodology used for performance improvement, Northwest Hospital leaders and staff are also trained and may participate in a variety of improvement activities that use other methodologies, FMEA (Systematic identification and prioritization of possible failures in a process), Team STEPPS

(Improve safety and performance through effective teamwork), Root Cause Analysis: RCA (identifying the root causes of faults or problems) or RCA^2(driving improvement in the process of reviewing events that cause or may cause serious harm, and in developing and implementing sustainable and measurable actions that prevent future harm to both patients and the workforce).

Accountable Care Unit (ACU) Model of Care & Unit-Based ACU Teams

Recognizing the need for a construct that would replace the inherent silos of health care systems at a Hospital unit-based level, in 2014 NWH leveraged the Accountable Care Unit (ACU) model to foster a new culture of shared accountability and multidisciplinary collaboration to achieve the Triple Aim. First implemented by Emory in 2010, it was modeled for an academic hospital setting, but recognizing the value of the ACU model of care, NWH took the tenets and customized it to form an organizational structure and process that we felt could be adapted to any healthcare setting.

To achieve & sustain the ACU goals of shared accountability & multidisciplinary collaboration, Northwest Hospital (1) created forums for front line team input to their unit based ACU, (2) created multidisciplinary ACU team leadership (which included a Provider Champion for each unit to partner with the Nursing Leader), (3) started zoning providers and ancillary department staff including Infection Prevention, Quality/ Patient Safety, Pharmacy, and Clinical Practice/ Education Specialists to the ACU to encourage shared accountability to outcomes, (4) focused on unit based outcomes metrics , (5) created a structure for daily ACU multidisciplinary rounds that fosters team collaboration, and (6) ensured that ACU operations supported the vision of patient-centered care delivery via weekly multidisciplinary ACU Meetings.

Since 2014, NWH has used the structure of the ACU in our organization as a way to demonstrate to our teams the commitment to shared accountability and its ability to improve outcomes while increasing frontline team engagement. Each ACU Team is unit-based and comprised of a Provider Champion, the nurse manager, the assistant nurse manager, educator, quality/ patient safety and other interdisciplinary team members as needed.

The unit-based ACU Teams support the Quality and Patient Safety Program by:

a) Evaluating quality indicator data on a routine basis using a variety of benchmarking sources;
b) Prioritizing and creating clinical practice improvement plans;
c) Providing a process to assure compliance with core measures and best practice

V. Measurement and Analytics

a. Scope of measurement

Departments and services of Northwest Hospital engage in measurement of critical processes and outcomes associated with quality of care and patient safety. The scope of measurement activities encompasses all departments and service lines and the provision of care, treatment and services provided by both hospital staff and members of the medical staff.

The Board requires leadership and the medical staff to routinely gather and analyze data on important quality and patient safety processes and outcomes. Board-established frequencies for measurement across the organization are identified in Table 1 along with the description of the kinds of measures Northwest Hospital routinely reviews.

The Board requires clinical leaders to consider quality and patient safety performance measures based on the scope of care, treatment and services provided, as well as the patient populations served. Leaders of departments and clinical service lines recommend an appropriate set of performance measures that align with Board established quality/patient safety goals as applicable. Department and clinical service line measures are approved by the POC, acting on behalf of the Board.

The table on the following page illustrates the scope of measurement activity and lines of reporting across Northwest Hospital.

Table 1.0
Scope of Measurement at Northwest Hospital

Measurement Category	Description	Reports To	Board-Established Frequency
Executive Dashboard (Established by the POC on behalf of the Board)	Strategic measures aligned with LifeBridge and Northwest Hospital quality goals: • LifeBridge FY Quality Goals Dashboard • Northwest Hospital Executive Quality Dashboard	POC QOC Executive Team MEC	At least quarterly
Departmental Measures (Recommended by department leaders and approved by POC on behalf of the Board)	Each Multidisciplinary Leadership Committee establishes pertinent measures of quality and patient safety reflective of the scope of services provided by the department and patient population served. Measures are prioritized and selected according to the following criteria: • Alignment with LifeBridge/Northwest priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone processes. • Opportunities identified with FPPE & OPPE	QOC Executive Team	Monthly
Clinical Quality & Patient Safety Measures (Specific to individual Committees)	Each committee establishes and oversees the measurement and analysis of data representative of the function the committee was established to oversee and monitor. Measures are generally selected based on the following criteria: • Alignment with LifeBridge/Northwest priorities for improvement as applicable • Applicable regulatory requirements • High risk, high volume or problem prone processes.	POC QOC MEC Quality & PI Council	At least semi-annually

VI. Reporting of Medical Errors and Adverse Events

All Staff are empowered to practice in a safety-focused manner and are responsible for reporting any concerns regarding patient safety, including:

- Potential for an adverse event or medical error;
- Actual adverse event or medical error; or
- "Near miss" and Good Catch events or medical errors.

This expectation is introduced in new employee orientation and reinforced during ongoing education sessions for all LifeBridge and Northwest Hospital employees. Northwest Hospital has established policies and procedures to guide management and staff through reporting of patient safety concerns (including a list of examples of adverse events that should be reported) and the proper response.

Northwest Hospital responds to patient safety concerns utilizing the concepts of a Just & Learning Culture. Responses focus on system-wide issues that contribute to practice breakdown, and also examines the behavior and responsibilities of all staff. The Just Culture algorithm is used to distinguish between human error, risk-taking behavior, and reckless behavior. This shifts the focus to quality of choices v. undesired outcomes that may or may not result patient or organizational harm.

Patient Safety & Risk Management Activities:

Northwest Hospital fosters a culture of safety and aims to reduce and/or eliminate preventable harm to patients through a variety of on-going quality improvement, patient safety, and risk management and mitigation activities which are managed by the NWH Patient Safety Officer and include but are not limited to the following:

- Adverse Event & Near Miss Reporting via Midas Event Reporting System or 5-SAFE
- Prioritize near miss and adverse event response based on severity rating and how wide-spread the safety concern is
- Investigation of Events (including RCA)
- Analysis of event trends and levels of harm
- Peer Review
- Adverse Event Response Team & Disclosure Program
- Reporting to state agency as required by State of Maryland Regulations (COMAR)
- Sentinel Event Alert Process
- Patient Safety & Risk Management Education for all hospital employees
- Formal program for managing patient grievances
- Proactive Risk Assessments (FMEA, Gap Analysis)
- Management of Product Recalls & Alerts
- Periodic & Annual Reports to communicate lessons learned
- OPPE & FPPE Program
- Ethics Committee Meetings
- Culture of Patient Safety Survey
- Participation in State and National Collaboratives

- Management of Aggressive Behavior (MOAB) Training
- Monitoring of sustained performance improvement via dashboards
- Utilization of Just & Learning Culture algorithm
- Hospital-wide & department-specific quality indicator reviews
- State and National Benchmarking
- Providing on-going staff education on safe practices (NPSG, NQF, AHRQ, ISMP)
- Monitoring compliance with regulatory standards
- Recalls & Product Alerts Management
- Medical Device Reporting
- Maintaining on-going communication with Credentialing department

VII. Annual Review of the Effectiveness of Quality and Patient Safety

The governing body continually evaluates the Northwest Hospital's performance in relation to its mission, vision, and goals. A component of the Board's evaluation of hospital performance is a structured evaluation of the effectiveness of the execution of this Quality, Patient Safety, and Performance Improvement Plan.

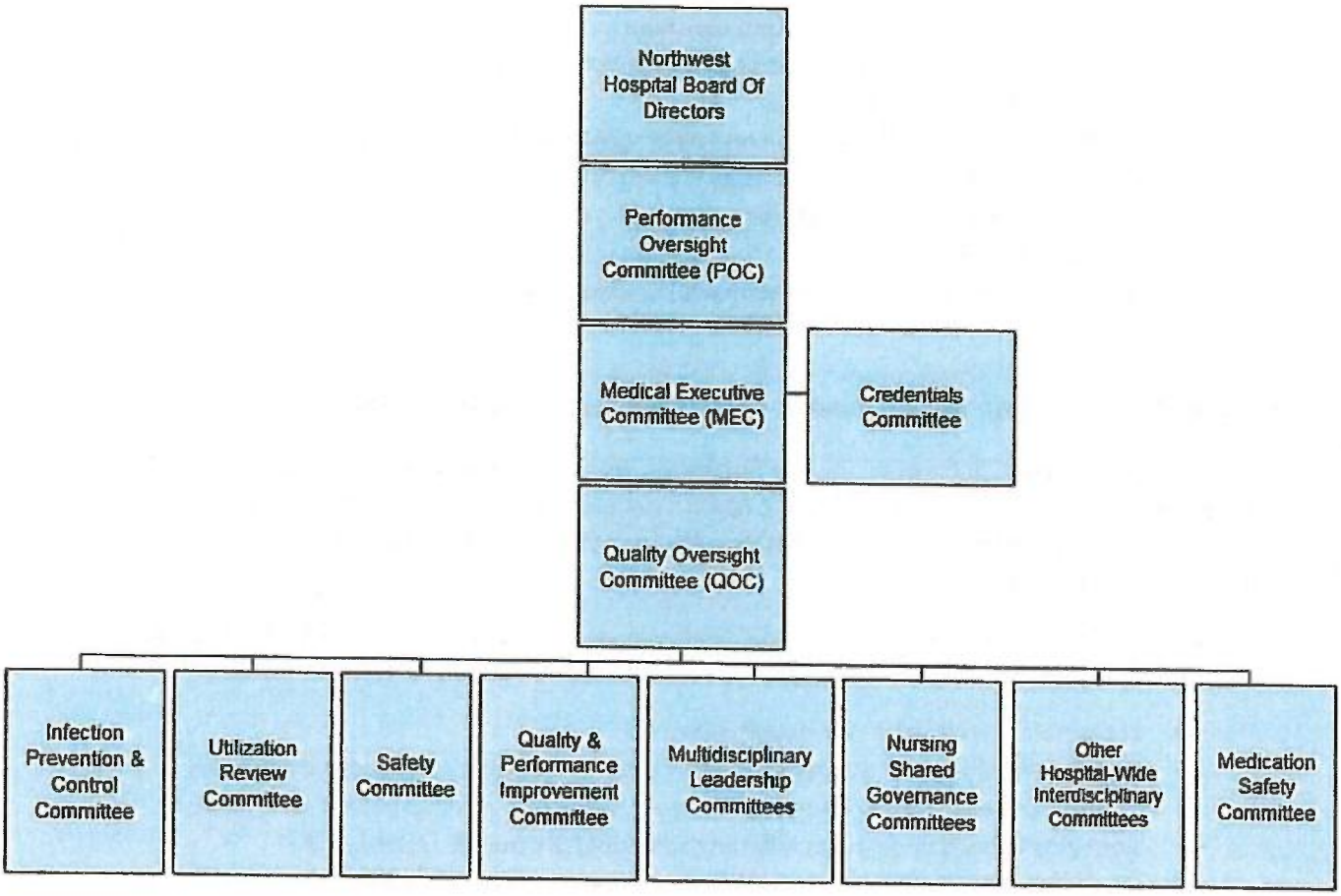
Annually, the Quality Oversight Committee coordinates an evaluation of all aspects of the Quality and Patient Safety Plan by gathering input from each of the quality committees/structures regarding:

- Measurable results of improvement initiatives;
- Perceived/real value of the performance measures that were reviewed and analyzed;
- Contribution to the LifeBridge and Northwest Hospital quality and patient safety goals;
- Strengths to build upon in the way the committee/structure functions; and
- Opportunities to improve the way the committee/structure functions.

The Quality & Patient Safety Department synthesizes this information for a formal discussion and evaluation of the implementation of the Quality and Patient Safety Plan at the Quality Oversight Committee. The results of that evaluation are then brought to the Performance Oversight Committee for discussion and completion of the annual evaluation. The Quality and Patient Safety Plan is then updated to reflect any modifications recommended and/or approved by the Performance Oversight Committee.

The final step in the annual evaluation of the execution of the Quality and Patient Safety Plan is the formal approval of the updated plan. The Quality and Patient Safety Plan is reviewed and approved by the Quality Oversight Committee, the Performance Oversight Committee, Medical Staff acting through the Medical Executive Committee, and by the Northwest Hospital Administration.

Northwest Hospital Quality & Patient Safety Structure



LifeBridge Health Quality Goals

Proposed LifeBridge FY19 Quality Goals Dashboard

Threshold 7, Target 8, Max 9

Mortality (Reported as a Survival Rate)	Definition	Component of HSCRC QBR Score	FY 19 Goal	Q1 FY2019	Q2 FY2019	Q3 FY2019	Q4 FY2019	FYTD
Sinai	Inpatient mortality within 80% of specific diagnosis groups. Risk Adjusted Survival rate now including patients receiving comfort care, end of life care or palliative care	State Achievement Threshold is 95 66% (to Achieve Attainment points) 15% of Quality Based Reimbursement (QBR) Financial Rate Adjustment: 2% at Risk, 2% Reward	HSCRC Threshold 95 62%					
Northwest								
Carroll								
Maryland Hospital Acquired Conditions (MHAC)	**Definition**	**HSCRC**	**FY 19 Goal**	**Q1 FY2019**	**Q2 FY2019**	**Q3 FY2019**	**Q4 FY2019**	**FYTD**
Sinai	Quality Measurement of 46 Potentially Preventable Hospital Acquired Conditions in patients in High Frequency diagnosis groups	Score Eligible for HSCRC No Penalty in the Scaling Methodology; No penalty zone at 0 45 - 0.55 (Penalty is up to 2% and reward up to 1% of inpatient revenue)	No penalty zone at 0 45					
Northwest								
Carroll								
Levindale								
Readmissions All Payer Risk Adjusted based on HSCRC incentive program definition	**Definition**	**HSCRC**	**FY 19 Goal**	**Q1 FY2019**	**Q2 FY2019**	**Q3 FY2019**	**Q4 FY2019**	**FYTD**
Sinai	Unplanned admission to any hospital within 30 days of an admission to our hospital	HSCRC actual cumulative statewide target -14 34% (Currently Scaled Maximim penalty up to 2% of inpatient revenue and reward up to 1% of inpatient revenue)	Risk Adjusted Readmission Rate of 11 5%					
Northwest								
Carroll								
Levindale								
Levindale Indicators	**Definition**	**Measurement Methodology**	**FY 19 Goal**	**Q1 FY2019**	**Q2 FY2019**	**Q3 FY2019**	**Q4 FY2019**	**FYTD**
Falls	Hospital and LTC combined facility Falls with moderate-severe injury	Rate of Hospital and LTC combined facility Falls with moderate-severe injury over patient days (over 1000 patient days)	0 20 (or 19 injuries)					

LifeBridge Patient Perception / Satisfaction FY18 Quality Goals Dashboard

Threshold 2, Target 3, Max 4

Patient Perception (Hospital Consumer Assessment of Healthcare Global Rating Domain	Definition	HSCRC	FY19 Goal 0.7% Point Improvement	Q1 FY 2019	Q2 FY 2019	Q3 FY 2019	Q4 FY 2019	FYTD
Sinai	Measurement of Patient Care Experience during an inpatient hospital stay Reported by the ***Overall Rating*** of the Hospital from Patient Perception Surveys submitted	FY 2018 Baseline performance of Overall % 9&10 Press Ganey database top 50% of improvers increased performance by 0 7% points year over year	70.25%					
Northwest			66.20%					
Carroll			66 03%					

Northwest Hospital Quality Dashboard

Northwest Hospital Executive Waiver Dashboard - January 2019

Quality Based Reimbursement (QBR) Measures (Goals as of 03/01/2018 HSCRC letter)

15% of Score	Mortality	Threshold	Benchmark	Jan-Dec 2017	Jan'18-Dec'18 Preliminary					
	Risk Adjusted Survival Rate	95.82%	97.06%	[illegible]	97.06%					
35% of Score	Catheter associated Urinary Tract Infection	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18	QBR RYTD
	Hospital Wide (as of Jan'15) rate per 1,000 urinary catheter days	0.828	0.00	0.00 (0 / 1551)	1.03 (2 / 1938)	0.57 (1 / 1765)	0.59 (1 / 1693)	3.11 (2 / 644)	1.75 (1 / 573)	0.86 (7 / 8154)
	Central Line associated Blood Stream Infection	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18	QBR RYTD
	Hospital Wide (as of Jan'15) rate per 1,000 central line days	0.784	0.00	1.32 (2 / 1515)	3.34 (5 / 1498)	0.00 (0 / 1759)	1.31 (2 / 1530)	3.45 (2 / 579)	0.00 (0 / 553)	1.48 (11 / 7434)
	Clostridium difficile Colitis	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18	QBR RYTD
	Healthcare Facility Onset Incidence rate per 1,000 patient days	0.852	0.001	0.26 (3 / 11349)	0.32 (4 / 12370)	0.44 (5 / 11239)	0.39 (4 / 10364)	0.26 (1 / 3830)	Pending	0.35 (17.00 / 49142)
	MRSA	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18	QBR RYTD
	Inpatient Bloodstream Infection incidence rate per 1,000 patient days	0.815	0.00	0.18 (2 / 11349)	0.32 (4 / 12370)	0.44 (5 / 11239)	0.39 (4 / 10334)	0.26 (1 / 3837)	0.27 (1 / 3694)	0.32 (17 / 52793)
	Surgical Site Infection (per 100 surgeries)	Threshold	Benchmark	CY'14 Q4	CY'18 Q1	CY'18 Q2	Jul-18	Aug-18	Sep-18	QBR RYTD
	Colon	0.781	0.00	23.08 (3 / 13)	5.88 (1 / 17)	9.09 (1 / 11)	Pending	Pending	Pending	12.20 (5 / 41)
	Abdominal Hysterectomy	0.722	0.00	0.00 (0 / 1)	0.00 (0 / 1)	0.00 (0 / 2)	Pending	Pending	Pending	0.00 (0 / 4)
50% of Score	HCAHPS Top Box Percentage	Threshold	Benchmark	CY'17 Q4 as of 3 8 18	CY'18 Q1 as of 6 12 18	CY'18 Q2 as of 11 8 18	CY'18 Q3 as of 12 4 18	Oct-18 as of 12 4 18	Nov-18 as of 01 15 19	QBR RYTD
	Rate Hospital 0-10	71.59%	85.12%	62.2%	69.4%	66.5%	58.5%	66.6%	66.7%	64.5%
	Communication with Nurses	79.08%	87.12%	75.8%	76.7%	81.5%	73.7%	79.8%	78.7%	77.3%
	Response of Hospital Staff	65.07%	60.14%	63.5%	64.5%	70.2%	63.8%	73.5%	67.4%	66.4%
	Communication with Doctors	80.41%	88.44%	77.2%	78.2%	77.4%	71.4%	71.4%	76.1%	75.5%
	Hospital Environment (Cleanliness & Quietness)	65.72%	79.42%	62.9%	63.5%	68.0%	60.5%	69.5%	63.9%	64.2%
	Communication about Medicines	63.30%	73.66%	65.3%	59.7%	62.6%	59.5%	61.1%	64.4%	61.5%
	Discharge Information	87.44%	92.11%	87.2%	84.6%	88.3%	85.9%	88.6%	85.9%	86.6%
	Care Transitions	51.14%	62.50%	43.6%	52.4%	56.5%	49.7%	49.5%	50.8%	51.0%
	Hospital Throughput	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18	QBR RYTD
	Reporting Rate is Missing									
	Median Time from ED Arrival to ED departure for admitted ED patients ED-1b	369	288	423	509	495	454	544	414	475
	Median Admit Decision to ED departure time for admitted ED patients ED-2b	111	119	118	155	159	132	147	112	139

HSCRC Waiver Initiatives

Up to 2% Penalty, 1% reward	Readmissions (HSCRC RRIP)	Goal	Jan-Dec 2017	May-18	Jun-18	Jul-18	Aug-18	Sep-18	Oct-18
	All Payer Risk adjusted based on HSCRC incentive program definition - Reduction of 9.3% over two year period.	14.34%	11.83%	9.54%	10.42%	10.86%	11.10%	8.83%	Pending
Up to 2% Penalty, 1% reward	Maryland Hospital Acquired Conditions (MHAC)	Goal	Jan-Dec 2017	Jan'18-Dec'18 Preliminary					
	HSCRC incentive program definition - Reduction of 6% per year. All scores are calendar YTD.	0.45	0.63	0.64					

Northwest Hospital Executive Quality Dashboard - January 2019

CMS Quality Indicator Rates

Sepsis Bundle	Internal Goal	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
Early Severe Sepsis and Septic Shock Management Bundle	80%	44% 42 | 95	33% 35 | 107	47% 43 | 92	40% 39 | 91	36% 10 | 28	44% 7 | 16

Inpatient JC (ORYX) Quality Indicator Rates

Immunization	Threshold	Benchmark	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
Influenza Vaccination Overall Rate IMM-2	95.16%	99.77%	96.9% 281 | 290	95.4% 272 | 285	Not Flu Season	Not Flu Season	98.0% 97 | 99	90.6% 29 | 32

Venous Thromboembolism	National Average	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18 Preliminary	Nov-18 Preliminary
Incidence of Preventable VTE VTE-6	4.0%	33% 1 | 3	0% 0 | 6	0% 0 | 10	0% 0 | 10	0% 0 | 3	0% 0 | 1

Outpatient JC (ORYX) Quality Indicator Rates

Outpatient Acute Myocardial Infarction (AMI)	National Rate	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18 Preliminary	Nov-18 Preliminary
Median Time to Transfer to Another Facility for Acute Coronary Intervention - Reporting Measure Only AMI patients with ST-segment elevation or LBBB on ECG performed closest to arrival and prior to transfer OP-3b	57 minutes	59 min (2)	90 min (3)	40 min (3)	35 min (1)	97 min (1)	Pending

Outpatient Aspirin/ ECG	National Rate	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3 Preliminary	Oct-18 Preliminary	Nov-18 Preliminary
Aspirin at Arrival OP-4	97.0%	90.0% 18 | 20	100% 14 | 14	Retired as of April 2018			
Median Time to Electrocardiogram (ECG) OP-5	7 minutes	17 min (20)	15 min (15)	10 min (22)	8 min (19)	14 min (8)	Pending

Outpatient Emergency Department Throughput	National Rate	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3 Preliminary	Oct-18 Preliminary	Nov-18 Preliminary
Median Time from ED Arrival to ED Departure for Discharged ED Patients OP-18b	175 minutes	244 min (87)	314 min (83)	305 min (87)	277 min (88)	254 min (31)	Pending
Door to Diagnostic Evaluation by Qualified Medical Personnel OP-20	33 minutes	65 min (98)	77 min (95)	Retired as of April 2018			

Outpatient Pain Management in the Emergency Department (ED)	National Rate	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
Median Time to Pain Management for Long Bone Fracture OP-21	54 minutes	29 min (30)	22 min (28)	Retired as of April 2018			

Stroke Patients Arriving Through the Emergency Department	National Rate	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3 Preliminary	Oct-18 Preliminary	Nov-18 Preliminary
Head CT or MRI Scan Results within 45 Minutes of ED Arrival OP-23	57.0%	33% 1 | 3	38% 3 | 8	29% 2 | 7	20% 1 | 5	0% 0 | 2	Pending

Outpatient Colonoscopy	Goal	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3 Preliminary	Oct-18 Preliminary	Nov-18 Preliminary
Endoscopy/ Polyp Surveillance: Appropriate Follow-up Interval for Normal Colonoscopy in Average Risk Patients OP-29	100%	88% 23 | 26	82% 9 | 11	53% 8 | 15	93% 14 | 15	86% 6 | 7	Pending
Endoscopy/Polyp Surveillance: Colonoscopy Interval for Patients with a History of Adenomatous Polyps - Avoidance of Inappropriate Use OP-30	100%	99% 72 | 73	94% 47 | 50	96% 66 | 69	100% 40 | 40	100% 12 | 12	Pending

Performance Measures

Falls	Internal Goal	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
IP Falls with Injury per 1,000 Patient Days	0.6	0.5 5 | 9468	1.1 11 | 10464	1.1 11 | 10413	0.9 8 | 9029	4.9 17 | 3483	0.3 1 | 3338

Pressure Ulcers	Internal Goal	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
Hospital Acquired Pressure Ulcers- All Hospital Reported Incidents	GOAL PENDING	25	25	29	37	10	10

Hand Hygiene	State Goal	Feb-18	Mar-18	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
30 DIRECT OBSERVATIONS PER PATIENT CARE UNIT	90%	87.8% 202 | 230	89.7% 217 | 242	88.1% 398 | 452	86.6% 645 | 745	85.3% 220 | 258	Pending

Surgical Site Infection (per 100 surgeries)	Internal Goal	CY'17 Q4	CY'18 Q1	CY'18 Q2	CY'18 Q3	Oct-18	Nov-18
HIPS	0	0.00 0 | 41	0.00 0 | 24	0.00 0 | 43	Pending	Pending	Pending
KNEES	0.037	0.00 0 | 114	0.82 1 | 122	1.68 2 | 119	Pending	Pending	Pending

ATTACHMENT E

Department of Psychiatry Dashboard - April 2018

Culture (People)

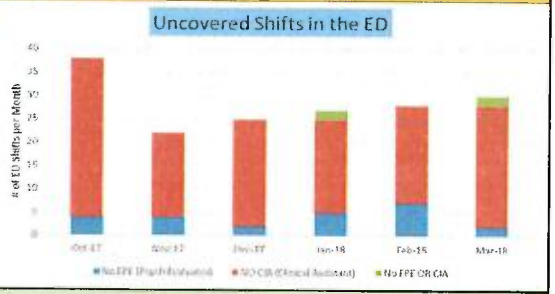
Data Source: Occupational Health

Staff Information

Data Source: Psych Administration

Combative Patient Staff Injuries on BHU/4C

Date of Injury	Injury Type - Location
11/1/2017	Strain - Lower Arm
11/27/2017	Contusion - Head
1/25/2018	Contusion - Head
1/29/2018	Contusion - Upper Arm
2/17/2018	Contusion - Finger(s)
2/20/2018	Contusion - Mouth
2/26/2018	Contusion - Head
3/6/2018	Strain - Wrist

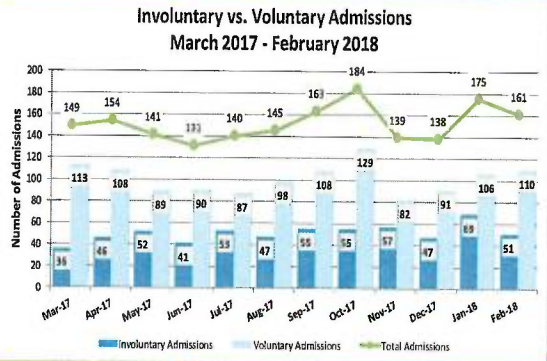


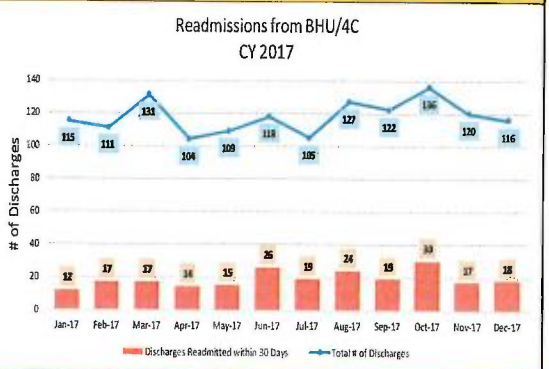
Quality and Patient Safety

Data Source: Cerner

Admissions

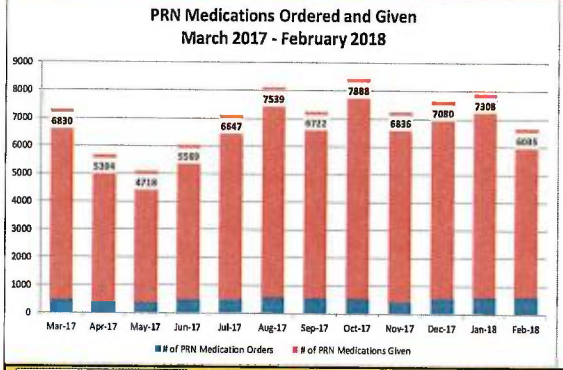
Data Source: Care Management





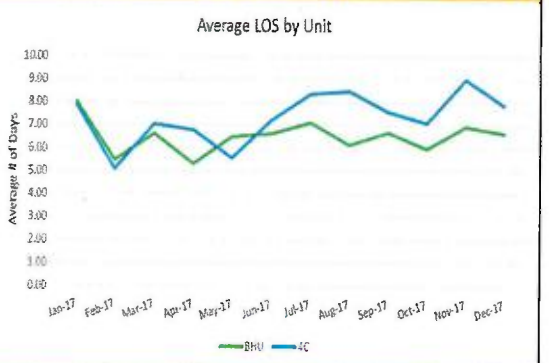
Data Source: Cerner

Medications



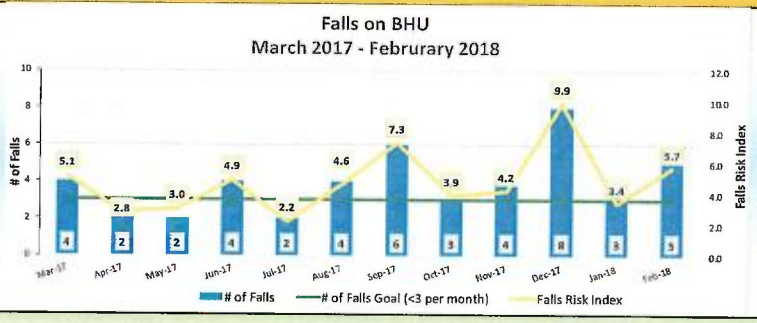
ALOS

Data Source: Care Management



Data Source: Midas

Falls



Service

Data Source: ED TAT Dashboard

Turn Around Times

ED Psych TAT	Sep-17	Oct-17	Nov-17	Dec-17	Jan-18	Feb-18
Median Time from ED Arrival to BHU Admission	17:30 (71)	22:53 (97)	15:57 (88)	16:10 (80)	18:43 (99)	21:15 (83)
Median Time from ED Arrival to Discharge	18:43 (116)	15:13 (180)	13:28 (157)	12:42 (127)	14:10 (125)	16:35 (137)
Median Time from ED Arrival to Transfer	29:07 (24)	35:39 (41)	31:30 (27)	29:38 (34)	31:23 (42)	31:15 (33)

Greviances

Data Source: Guest Relations

Data Pending

Value (Finance)

Under construction

ATTACHMENT F

Hospital Bad Debt and Uncompensated Care
2018

County	Hospital	Annual Filing Year	Gross Patient Revenues A	Bad Debt B	Charity Care C	Uncompensated Care Percentage D = (B+C)/A
Baltimore City	University of Maryland Medical Center	2018	$1,478,505	$41,982	$18,572	4.10%
Harford County	Harford Memorial Hospital	2018	105,944	5,362	1,903	6.86%
Baltimore City	Mercy Medical Center	2018	539,029	9,164	14,632	4.41%
Baltimore City	Johns Hopkins Hospital	2018	2,409,766	33,103	26,475	2.47%
Baltimore City	St. Agnes Hospital	2018	438,696	407	21,652	5.03%
Baltimore City	Sinai Hospital	2018	783,534	21,934	5,643	3.52%
Baltimore City	Bon Secours Hospital	2018	110,088	2,018	324	2.13%
Baltimore County	MedStar Franklin Square Hospital Center	2018	535,572	13,835	7,344	3.95%
Anne Arundel	Anne Arundel Medical Center	2018	632,981	13,778	3,924	2.80%
Baltimore City	MedStar Union Memorial Hospital	2018	440,415	9,482	6,328	3.59%
Baltimore City	Johns Hopkins Bayview Medical Center	2018	670,224	15,639	18,783	5.14%
Carroll County	Carroll Hospital Center	2018	234,994	3,459	416	1.65%
Baltimore City	MedStar Harbor Hospital Center	2018	194,522	4,469	3,821	4.26%
Baltimore CIty	UMMC Midtown Campus	2018	236,967	9,196	3,962	5.55%
Baltimore County	Northwest Hospital Center	2018	266,928	9,479	2,067	4.33%
Anne Arundel	UM Baltimore Washington Medical Center	2018	428,075	19,037	6,845	6.05%
Baltimore County	Greater Baltimore Medical Center	2018	463,553	8,787	1,642	2.25%
Howard County	Howard County General Hospital	2018	313,005	6,768	4,598	3.63%
Harford County	Upper Chesapeake Medical Center	2018	343,214	5,720	4,313	2.92%
Baltimore City	MedStar Good Samaritan Hospital	2018	275,754	6,514	4,954	4.16%
Baltimore County	UM St. Joseph Medical Center	2018	414,387	10,889	5,307	3.91%
Total for These Counties			**$11,316,152**	**$251,022**	**$163,506**	**3.66%**

Notes:
[1] Source: 2018 Annual Filings, RE Schedule (Regulated only)
{2] Gross patient revenues, bad debt, and charity care are all stated in thousands

ATTACHMENT G

Sinai Hospital Projected Charge per Case
Psychiatry & Substance Abuse

Age Group	Cases	Average Charge	CMI	Avg Charge @ CMI of 1.0	Sinai Cases	Sinai Cases @ Health Area Average
0-4	13	$14,858	0.6140	$24,198	-	$0
5-14	953	15,046	0.6330	23,767	1	23,767
15-44	12,185	10,537	0.6080	17,328	776	13,446,915
45-54	4,428	11,294	0.6093	18,535	289	5,356,676
55-64	3,395	13,288	0.6584	20,183	225	4,541,282
65-74	983	19,794	0.8076	24,510	62	1,519,620
75-84	438	21,596	0.9214	23,438	34	796,879
85+	270	13,394	0.9035	14,825	6	88,947
Total	**22,665**	**$11,938**	**0.6351**	**$18,797**	**1,393**	**$26,183,560**

Overall Average Charge @ CMI of 1.0000	**$18,797**
Projected CMI (1)	**0.7015**
Average Age Adjusted Charges at Local Health Planning Area	**$13,186**
Sinai Charge per Case (2)	**$8,634**

Source: CY 2018 HSCRC discharge abstract dataset for Psychiatry and Substance Abuse product lines

Note (1): Sinai's actual CMI associated with the above listed cases of 1,393

Note (2): Sinai's actual Charge per Case associated with the above listed cases of 1,393

ATTACHMENT H

Northwest Hospital Center Projected Charge per Case
Psychiatry & Substance Abuse

Age Group	Cases	Average Charge	CMI	Avg Charge @ CMI of 1.0	Northwest Cases	Northwest Cases @ Health Area Average
0-4	13	$14,858	0.6140	$24,198	-	$0
5-14	953	15,046	0.6330	23,767	-	-
15-44	12,185	10,537	0.6080	17,328	1,233	21,366,038
45-54	4,428	11,294	0.6093	18,535	312	5,782,985
55-64	3,395	13,288	0.6584	20,183	299	6,034,859
65-74	983	19,794	0.8076	24,510	71	1,740,210
75-84	438	21,596	0.9214	23,438	19	445,315
85+	270	13,394	0.9035	14,825	16	237,192
Total	**22,665**	**$11,938**	**0.6351**	**$18,797**	**1,950**	**$36,653,224**

Overall Average Charge @ CMI of 1.0000	**$18,797**
Projected CMI (1)	**0.6711**
Average Age Adjusted Charges at Local Health Planning Area	**$12,614**
Northwest Charge Per Case	**$7,444**

Source: CY 2018 HSCRC discharge abstract dataset for Psychiatry and Substance Abuse product lines

Note (1): Northwest's actual CMI associated with the above listed cases of 1,950

Note (2): Northwest's actual Charge per Case associated with the above listed cases of 1,950