



maryland  
**health services**  
cost review commission

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## Emergency Department Wait Time Reduction Commission

April 30, 2026

11am-1pm

Virtual Meeting Only

# Meeting Agenda

**Welcome**

5 min

**2026 Legislative Session Updates**

15 min

**Commission CY 2026 Priorities Update & Recommendations Discussion**

30 min

**HSCRC ED-Hospital Throughput Best Practice Policy Year 1 Summary**

15 min

**Adventist White Oak Medical Center Best Practice Presentation**

45 min

**Public Comment**

10 min

# 2026 Legislative Session Update

# 2026 Legislative Session Updates

## HB1563–Emergency Room Services and Post–Acute Care – Coverage and Facility Studies (Takes Effect 7/1/26)

<https://mgaleg.maryland.gov/2026RS/bills/hb/hb1563t.pdf>

**Requires Multiple Agencies to work together to complete a number of item, including:**

- Authorizing the Maryland Insurance Commissioner to conduct an examination of certain decisions by carriers related to claims or authorization requests for services in, or related to services in, emergency departments;
- Authorizing the Commissioner to have certain decisions independently reviewed under certain circumstances;
- Requiring that a certain report required to be compiled by the Maryland Insurance Commissioner include data on certain adverse decisions and grievances;
- ***Requiring the Maryland Health Care Commission, in conjunction with the Health Services Cost Review Commission, to conduct a study to quantify bed capacity in hospitals and post–acute settings in the State and make a recommendation on a certain collection and auditing process;***
- ***Requiring the Maryland Health Care Commission, in consultation with the Health Services Cost Review Commission, to study analyzing options to facilitate clinically appropriate transitions from acute to post–acute care settings in the State; and generally relating to emergency room services and post–acute care.***

# HB1563 Overlap with ED WTR Commission

- Access & Capacity Subgroup previously discussed similar recommendations and had begun assessing current state bed capacity data and occupancy metric availability and identified gaps.
  - MHCC, HSCRC, MIEMSS, & MDH met on April 23, 2026 to discuss scope of the work and next steps for collection and standardization.
- HSCRC and Mathematica met to begin Gap Analysis of current reports on bed capacity and occupancy (i.e., MIEMSS reports) and requirements in the Bill on April 29, 2026.
- MHCC, HSCRC, MIEMSS, & MDH will meet in May to review Gap Analysis. We will continue to request continued input from the Access & Capacity Subgroup, and will discuss at the May 28, 2026 meeting.
- The ED WTR Commission will provide recommendations related to this work in the 2026 November Final Legislative Report.

# 2026 Legislative Session Update Continued

## **HB1151–Maryland Department of Health – Study on Maryland Medical Assistance Program Reimbursement of Hospice Room and Board Services (Takes Effect 7/1/26)**

<https://mgaleg.maryland.gov/2026RS/bills/hb/hb1151E.pdf>

Requires MHCC and Maryland Medical Assistance Program jointly to study the impact of requiring the Maryland Medical Assistance Program to provide reimbursement for room and board services provided by a hospice house; and generally relating to a study of reimbursement for hospice room and board services under the Maryland Medical Assistance Program.

The study required under subsection (a) of this section shall:

- analyze overall Maryland Medical Assistance Program savings per enrollee death associated with hospice care utilization during the last 6 months of life compared with costs associated with other services provided to Program enrollees during the last 6 months of life, including the impact on:
  - (i) avoided inpatient hospital stays
  - **(ii) emergency department utilization**
  - (iii) intensive treatments near the end of life

## HB1151 Overlap with ED WTR Commission

- Access & Capacity Subgroup previously discussed appropriate palliative care utilization and increased education as a opportunity to impact overall throughput and ED Potentially Avoidable Utilization.
- The Interim Legislative Report noted palliative care as a potential area of focus.
- The ED WTR Commission could provide recommendations related to palliative care in the November 2026 Final Legislative Report.

# ED Wait Time Reduction Commission CY 2026 Priorities & Recommendations Discussion

# Commission Priorities & Subcommittees - CY 2026

## 1. Standardize Bed Capacity & Occupancy Metrics

**Inputs:** Updates from MHCC, MIEMSS, HSCRC on availability of bed capacity data and occupancy metrics.

**Outcome:** Develop recommendations re: standardization and uses of metrics for monitoring and making policy recommendations. Align work with HB1563 requirements.

### Subgroup Action Items (Capacity & Access):

- Bed Count and Capacity Analysis.
- Recommendations for alternate capacity types.

## 3. ED-Hospital Throughput Modeling

**Inputs:** Review HSCRC modeling work on impact of interventions on ED LOS.

**Outcome:** Consider need for additional analysis to prioritize interventions ripe for policy development and consider making recommendations to hospital industry, payers, regulators and others based on modeling.

### Subgroup Action Items (Data & Best Practices):

- Develop modeling to estimate impact of interventions on Inpatient and ED LOS.

## 2. Post-Acute Access

**Inputs:** Review current work in space from MDH, MHCC, HSCRC, and Multi-Agency Working Group.

**Outcome:** Develop recommendations and key considerations for regulators developing post-acute strategy.

### Subgroup Action Items (Capacity & Access):

- Recommendations on Post-Acute Care Opportunities (aligned with MHCC).

## 4. ED-Hospital Throughput Best Practices

**Inputs:** Review HSCRC Best Practices policy and Yr 1 Reporting.

**Outcome:** Consider recommendations on additional best practices to consider and/or other key performance indicators needed for policy development and monitoring.

### Subgroup Action Items (Data & Best Practices):

- Summarize hospital best practice submissions.
- Recommend refinements to (QBR) ED LOS pay-for-performance methodology.

# Key Drivers for ED LOS

## Intro to Key Drivers

- Throughout our ED WTR Commission work to date, we have consistently noted multiple key drivers that contribute to ED LOS. While some of these key drivers did not have full consensus and may not make the final recommendation list, they can still be noted in the report as an addendum.
- For the key drivers that ED WTR Commission has consensus, we will include formal recommendations in the 2026 November Final Legislative Report.
- The following slides highlight the Key Drivers that were most consistently identified and evaluated. All of the key drivers highlighted have been identified and discussed in some capacity by the ED WTR Commission and it's subgroup on numerous occasions.
- The agencies listed are the recipients of the proposed recommendations.
- The recommendations currently listed are suggestions for discussion by the Commission.
- The final recommendations will be formalized and agreed upon by the Commissioners.

# Key Drivers of ED LOS & Areas for Potential Recommendations

## Access to Post Acute Care

### MHCC

Post Acute Care Workgroup (Draft recommendations to be released Summer 2026)

- Evaluate Value-Based Payment Programs
- Complete Bed Allocation/Capacity Analysis (aligned with HB1563)

### HSCRC

- Evaluate Feasibility of VBP Programs
- Explore Care Transformation Initiatives

### Medicaid

- Value Based Programs for Acute & Post-Acute Care Transitions

### Commercial Payers

- Value-Based Payment Programs for Acute & Pos-Acute Care Transitions

### Post Acute Providers

- Improved Care Transitions
- Standardize Referral Platforms & Auth criteria
- Implement Accountability Measures for Acceptance Rates & Target Occupancy Rates (Value Based Programs)

### Legislature

- Consider Legislation to address reimbursement models, gaps, regulations for authorization and acceptance, etc. (based on MHCC report)

### Hospitals

- Evaluate utilization of post-acute providers (SNF, Home Health)
- Partner in Value Based Arrangements

## Denials or Authorization Delays

### Multi-Agency Working Group

- Streamline authorization process/platform
- Standardized Criteria for Authorizations
- Evaluate Reimbursement Structure

### Maryland Insurance Agency

- Streamline authorization process/platform
- Evaluate Reimbursement Structure

### Commercial Payers

- Streamline authorization process/platform
- Standardize Criteria for Authorizations

## Capacity Alignment

### MHCC and HSCRC

- Assess Regional Inpatient & Post-Acute Bed Needs (Bed count, capacity analysis)
- Partner with hospitals on service line coordination across the state
- Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)
- IP LOS Incentive, indirectly generates capacity

### Hospitals

- Partner with HSCRC on Strategic Service Line Coordination across the state
- Partner with HSCRC to explore Alternate capacity options, throughput improvement and IP LOS gains

### MIEMSS

- Support enhanced bed occupancy, capacity reporting

## Best Practices/ Care Transitions

### HSCRC

- Evaluate reimbursement for case management/ care coordination services (VBP)
- Expansion of Best Practice Policy
- Explore ED LOS incentive transition to ECAT measures
- Consider IP LOS, PAU and Obs Mgmt Incentives
- Collaboration on Long Stay Patients, Guardianship
- Explore Additional Incentives for Palliative Care Coordination and Education

### Hospitals

- Collaborate with HSCRC on all actions above
- Expand community partnerships and investments (primary, BH, SDOH)
- Enhance palliative care investments and utilization

### MDH

- Continue work on pediatric overstay, BH, chronic disease
- Integrate Psychiatric Bed Registry

### Legislature

- Legislation to support above initiatives

# Questions to Consider as we Discuss Recommendations

- What is the overall impact of this recommendation on hospital throughput and ED Wait Times specifically?
- What stakeholders are best positioned to move each recommendation forward? Meaning, who should be the recipient of the recommendation?
- Do we need ED modeling of additional interventions or care delivery approaches to make recommendations?

# Access to Post Acute Care

**Reason Proposed:** Strong anecdotal evidence provided from hospitals across the state, combined with data collection in workgroups, multiple analyses and HSCRC's Preliminary ED-Hospital Modeling work has demonstrated care transition delays to post-acute care have an impact on IP & ED LOS, ED-Hospital throughput, and ED Boarding.

**Listed below are potential areas for recommendations related to Post Acute Care. The agencies listed would be the recipients of the recommendations:**

## **MHCC**

Note: Post Acute Care Workgroup Draft recommendations to be released Summer 2026

- Evaluate Value-Based Payment Programs
- Complete Bed Allocation/Capacity Analysis (aligned with HB1563)

## **HSCRC**

- Evaluate Feasibility of VBP Programs
- Expand Care Transformation Initiatives

## **Medicaid**

- Evaluate Value Based Programs for Acute to Post-Acute Transitions

## **Commercial Payers**

- Evaluate Value-Based Payment Programs for Acute to Post-Acute Transitions

## **Post Acute Providers**

- Improved Care Transitions
- Standardize Referral Platforms & Authorization criteria
- Implement Accountability Measures for Acceptance Rates & Target Occupancy Rates (Value Based Programs)

## **Legislature**

- Consider Legislation to address reimbursement models, gaps, regulations for authorization and acceptance, etc. (based on MHCC report)

## **Hospitals**

- Evaluate utilization of post-acute providers (SNF, Home Health)
- Partner in Value Based Arrangements

# Denials or Authorization Delays

**Reason Proposed:** Both qualitative and quantitative data shared in multiple workgroups, including the Multi-Agency working group and MHCC Post Acute Workgroup have identified denials and authorization delays as a contributor to discharge delays leading to ED boarding and increased ED wait times. Internal data tracked by hospitals also supports denials as a key driver of ED Boarding.

**Listed below are potential areas for recommendations related to Denials and Authorizations. The agencies listed would be the recipients of the recommendations:**

## **Multi-Agency Working Group**

- Streamline authorization criteria, process/platform
- Evaluate Reimbursement Structure

## **Maryland Insurance Agency**

- Streamline authorization process/platform
- Evaluate Reimbursement Structure

## **Commercial Payers**

- Streamline authorization process/platform
- Standardize Criteria for Authorizations

# Best Practices/Care Transitions

**Reason Proposed:** The care transition and best practice opportunities listed below have been identified by the hospital industry and/or multiple agencies throughout the past 18 months. Care Transitions was identified as a priority in the HB1563 legislation. We highlighted many of these opportunities in our Interim Legislative report.

**Listed below are potential areas for recommendations related to Best Practices and Care Transition Planning. The agencies listed would be the recipients of the recommendations**

## HSCRC

- Evaluate reimbursement for case management/ care coordination services (Value Based Program)
- Consider expansion of Best Practice Policy to include additional care transition opportunities as identified by hospitals and regulating agencies
- Explore/Consider ED LOS incentive transition to ECAT measures in 2027(baseline monitoring) to allow increased analysis and understanding of other metrics such as ED boarding times and LWBS
- Explore IP LOS, PAU and Observation Management Incentives
- Collaboration with other agencies, hospitals and Legislature to address challenges with Long Stay Patients, Guardianship
- Explore Additional Incentives for Palliative Care Coordination and Education

## Hospitals

- Collaborate with HSCRC on all actions above
- Assess community partnerships and investments (primary, BH, SDOH)

## MDH

- Continue work on pediatric overstay (HB1559 and HB 1181), BH, chronic disease
- Consider Integration of Psychiatric Bed Registry with other initiatives for collection of hospital and ED bed capacity data

## Legislature

- Develop Legislation to support above initiatives

# Capacity Alignment

**Reason Proposed:** Accurately identifying and analyzing hospital and post-acute bed capacity and occupancy was a key priority identified by our Access & Capacity Subgroup and included in our Interim Legislative report. In addition, HB1563 has further prioritized this important initiative. Increasing capacity across the state through a combination of decreasing patient days, evaluating physical capacity, and exploring alternate capacity options is critical to addressing ED LOS improvement.

**Listed below are potential areas for recommendations related to Capacity Alignment. The agencies listed would be the recipients of the recommendations:**

## **MHCC and HSCRC**

- Assess Regional Inpatient & Post-Acute Bed Needs (Bed count, capacity analysis)
- Partner with hospitals on service line coordination across the state
- Explore alternate capacity options (Hospital at Home, Expanded Home Health, Bridge Clinics)
- IP LOS Incentive, indirectly generates capacity

## **Hospitals**

- Partner with HSCRC on Strategic Service Line Coordination across the state
- Partner with HSCRC to explore Alternate capacity options, throughput improvement and IP LOS gains

## **MIEMSS**

- Support enhanced bed occupancy, capacity reporting

# CY 2026 Commission Meeting Schedule & Draft Agendas

Date	Agenda and Activities
January 7	Strategic Planning Session; Reconfirmed Priorities
March 4	MHCC Presentation Acute and Post Acute Bed Count ED Modeling Demo
April 30	2026 Legislative Session Updates Commission CY2026 Priorities: Key Drivers & Recommendations Discussion HSCRC Presentation on the CY2025 ED-Hospital Throughput Best Practice Policy <ul style="list-style-type: none"> <li>• Spotlight: Adventist White Oak Medical Center</li> </ul>
July 17	Update on MHCC Post Acute Access Work Update on ED-Hospital Modeling on Interventions to Reduce ED LOS Commission to discuss draft recommendations for the following focus areas: <ul style="list-style-type: none"> <li>• Post-Acute Care Access</li> <li>• Denials &amp; Authorization Delays</li> </ul>
September 2	Update on Bed Capacity Data and Occupancy Metrics Spotlight: Consider BHA Presentation on Psychiatric Services Bed Capacity Commission to discuss draft recommendations for the following focus areas: <ul style="list-style-type: none"> <li>• Care Transitions Planning (including Palliative Care Utilization)</li> <li>• Capacity Alignment</li> </ul>
September 23	Final review of recommendations
December 2	Commission CY2026 Priorities Update

# HSCRC ED-Hospital Throughput Best Practice Policy Year 1 Summary & Hospital Presentation

# Purpose of Presentation

- Provide annual summary of Best Practice Report reports and highlight improvement and barriers as requested by the ED WTR Commission and legislature.
- Provide ED Commission with understanding of current Best Practices policy and seek input on how the framework can support future integration of additional interventions or care delivery approaches.



The Best Practices policy is centered around a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS). Each best practice includes three levels (tiers) with measures showing how well and how fully it's being implemented. Year 1 (RY2027/CY2025) was a partial year, and Year 2 (RY 2028/CY2026) is focused on starting implementation, developing reports, and collecting and analyzing data; no points will be assigned to these tiers.



## Hospital Requirements for RY2028 (CY2026)

- Hospitals will continue the two Best Practices implemented and reported on in Year 2 with a focus on hardwiring and expanding implementation.
- Hospitals must notify HSCRC in writing if they wish to change Best Practice selections from Year 1.



## Key Dates and Requirements

### December 15, 2026: Final Deadline

- Missing this deadline will result in a 0.1% penalty on inpatient revenue in January 2027
- Extraordinary events (e.g., cyberattacks, disasters) will be handled under the exception policy.



## Ongoing Work

- The subgroup will work to update the reporting templates
- The subgroup will focus on analysis of the reports and sharing of best practices.
- They'll also study how the practices affect LOS and make future recommendations about tying performance to payment.

# CY25 & CY26 ED-Hospital Throughput Best Practices

Interdisciplinary Rounds & Discharge Planning

Standard Daily Shift Huddles

Bed Capacity Alerts

Clinical Pathways and Observation Management

Expedited Care Bucket

Patient Flow throughput Council

# ED-Hospital Throughput Best Practice Hospital Selections

## Standardized Daily/Shift Huddles

20 hospitals implemented

**10 had ED LOS improvement**

## Patient Flow Throughput Performance Council

19 hospitals implemented

**9 had ED LOS improvement**

## Expedited Care Intervention

16 hospitals implemented

**9 had ED LOS improvement**

## Interdisciplinary Rounds & Discharge Planning

13 hospitals implemented

**8 had ED LOS improvement**

## Bed Capacity Alert System

10 hospitals implemented

**7 had ED LOS improvement**

## Clinical Pathways & Observation Mgmt

4 hospitals implemented

**3 had ED LOS improvement**

- Not reflected is improvement in other metrics (IP LOS, ED Boarding, LWBS, etc.).
- In Year 2, the subgroup will discuss the feasibility of tracking these secondary metrics via the Best Practices Report or ED LOS Dashboard.

# Summary of Reported Best Practice Successes

- ✓ ED throughput and boarding time improvements, including rapid decompression and decreased ambulance diversion, earlier discharges, improved capacity metrics and increased efficiency
- ✓ Improved frontline staff understanding of the “why”
- ✓ Interdisciplinary engagement, leadership support and clear expectations
- ✓ Earlier initiation of discharge to a post-acute rehab due to early recognition
- ✓ Earlier bed availability, reduced ED boarding, reduced left without being seen
- ✓ Improved care coordination and continuity
- ✓ Cross-functional collaboration across departments and disciplines
- ✓ Enhanced hand-off process improved communication, transparency, trust and teamwork
- ✓ Multidisciplinary rounds on boarders led to increased discharges from ED, avoiding unnecessary bed transfers and earlier interventions

# Summary of Reported Best Practice Barriers

- ⚠ Early implementation challenges (lengthy meetings, communication gaps, staff buy-in and learning curve)
- ⚠ Infrastructure and space limitations (e.g., aging infrastructure, physical space constraints)
- ⚠ Staffing and resource constraints, staff burnout
- ⚠ Discharge barriers included social needs, placement issues and delayed diagnostics
- ⚠ Lack of access to post-hospitalization resources led to extended IP LOS (e.g., primary care, legal assistance, nursing home beds, medical waivers).
- ⚠ Skilled nursing facility lack of or delayed acceptance of patients
- ⚠ System-level and population challenges such as a culture shift for Maryland hospital's capacity management, use of EDs for primary care, peds psychiatric placement limitations
- ⚠ Additional External constraints (e.g., EMS batching patterns, contracted specialty services, limited SNF transportation hours, payer policies related to observation and post-acute placement etc.)

## Next Steps-Best Practices

- Best Practices Subgroup (5/14): Discuss opportunities to enhance the Best Practice Policy and Reporting Template
- ED Commission:
  - Provide an update on subgroup Draft Recommendations on ED-Hospital Throughput Best Practice Policy (7/17)

Note: Recommendations from the ED Commission regarding the Best Practice Policy are to the HSCRC

# Adventist White Oak Medical Center Best Practice Presentation

## ED WTR Commission Next Steps

- Next ED Wait Time Reduction Commission Meeting: July 17, 2026  
11AM-1PM
- ED WTR Commission Agendas
  - Work related to identified 2025/2026 priorities will be a standing item on meeting agendas
  - Any commissioner can propose agenda items; all proposals will be discussed by the commissioners at the next meeting to obtain consensus for approval
  - Final agenda is approved by the co-chairs from HSCRC and MDH
- Please visit the [ED Wait Time Reduction Commission Webpage](#) for all materials.
  - [2026 Calendar](#)

# Public Comment

# White Oak Medical Center

ED Wait Time Reduction Commission

4/30/2026

Jim Rost, MD FACHE – Chief Medical Officer, White Oak Medical Center  
Katie Eckert – SVP of Strategic Operations, Adventist HealthCare



# WOMC Overview

Governmental Payer Mix

**69%**

ED Visits per year

**~42,000**

(ranked 26th in the state)

Volume from Prince  
George's County

**~48%**

Census Capacity

**100%+**

IP Adult Admissions Entered through the ED

**~57%** (ranked 36th in the state)

ED Diversion

**5 Hours  
in 2026**

HSCRC MPA TCOC Ranking\*  
(CY 2025)

**#4 in MD**

Leap Frog Safety Grade A  
Healthgrades Patient  
Safety Excellence Award

Longest ED LOS Rank (CMS)

**#22 in US**

Lowest ED Use Rate per Capita – Medicare FFS

**Top 20% in US**

# White Oak Medical Center ED Length of Stay

## Problem:

One of the highest ED LOS in the state  
> 1100 minutes in CY23



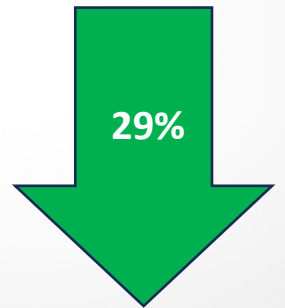
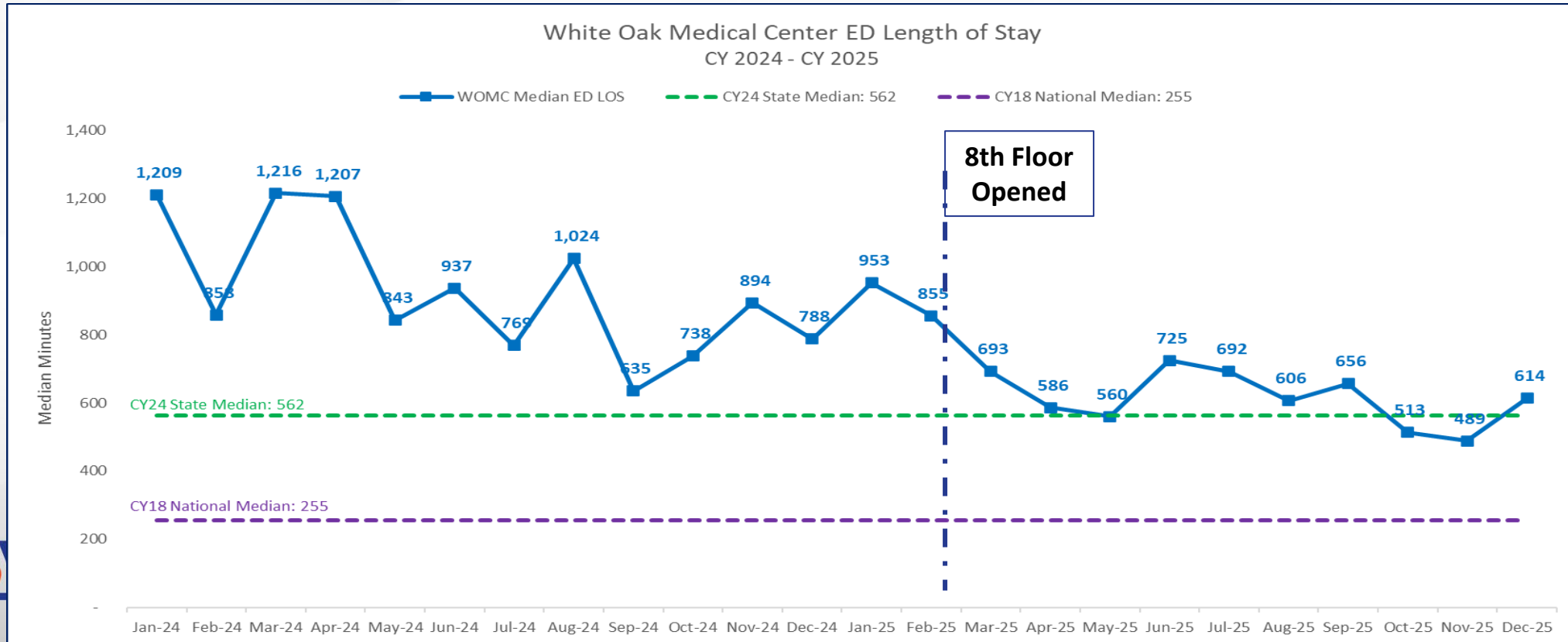
## Effort:

Focused throughput work & additional IP capacity added in 2025



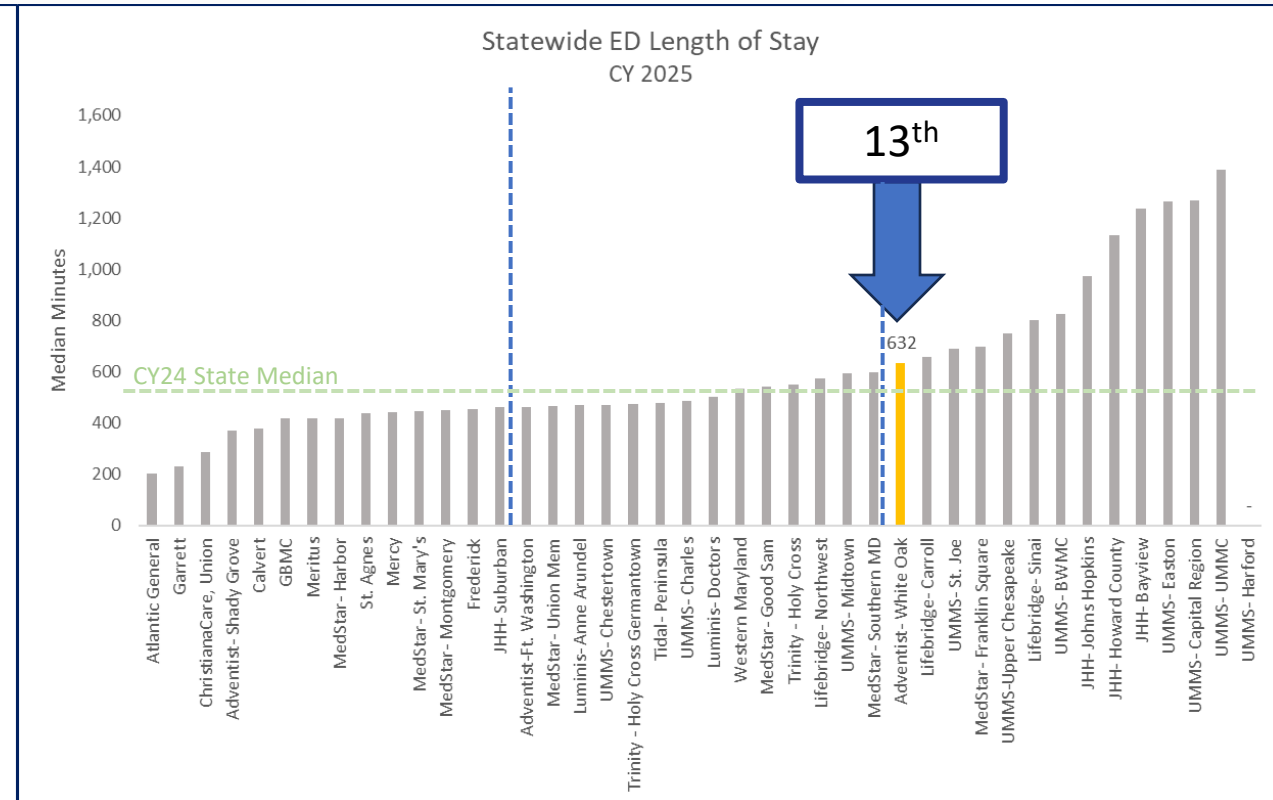
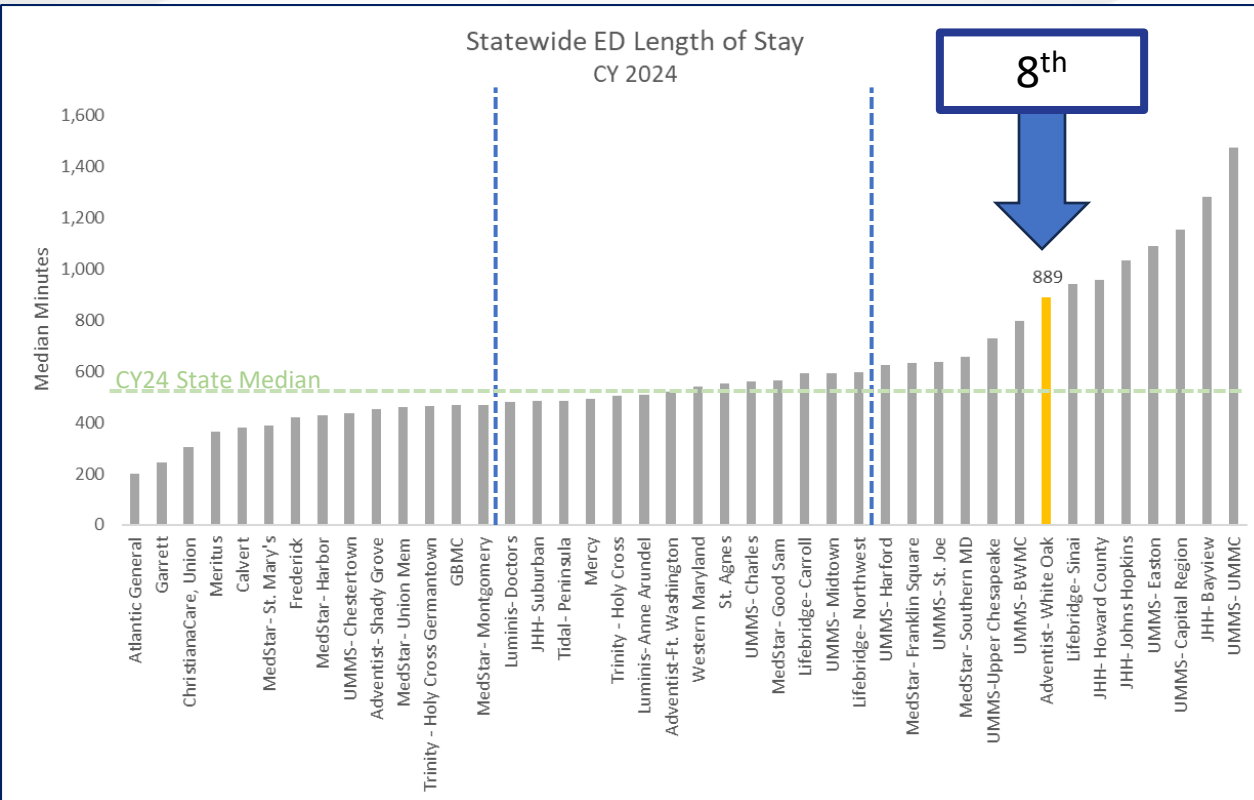
## Results:

More than 29% decrease in ED LOS since CY24



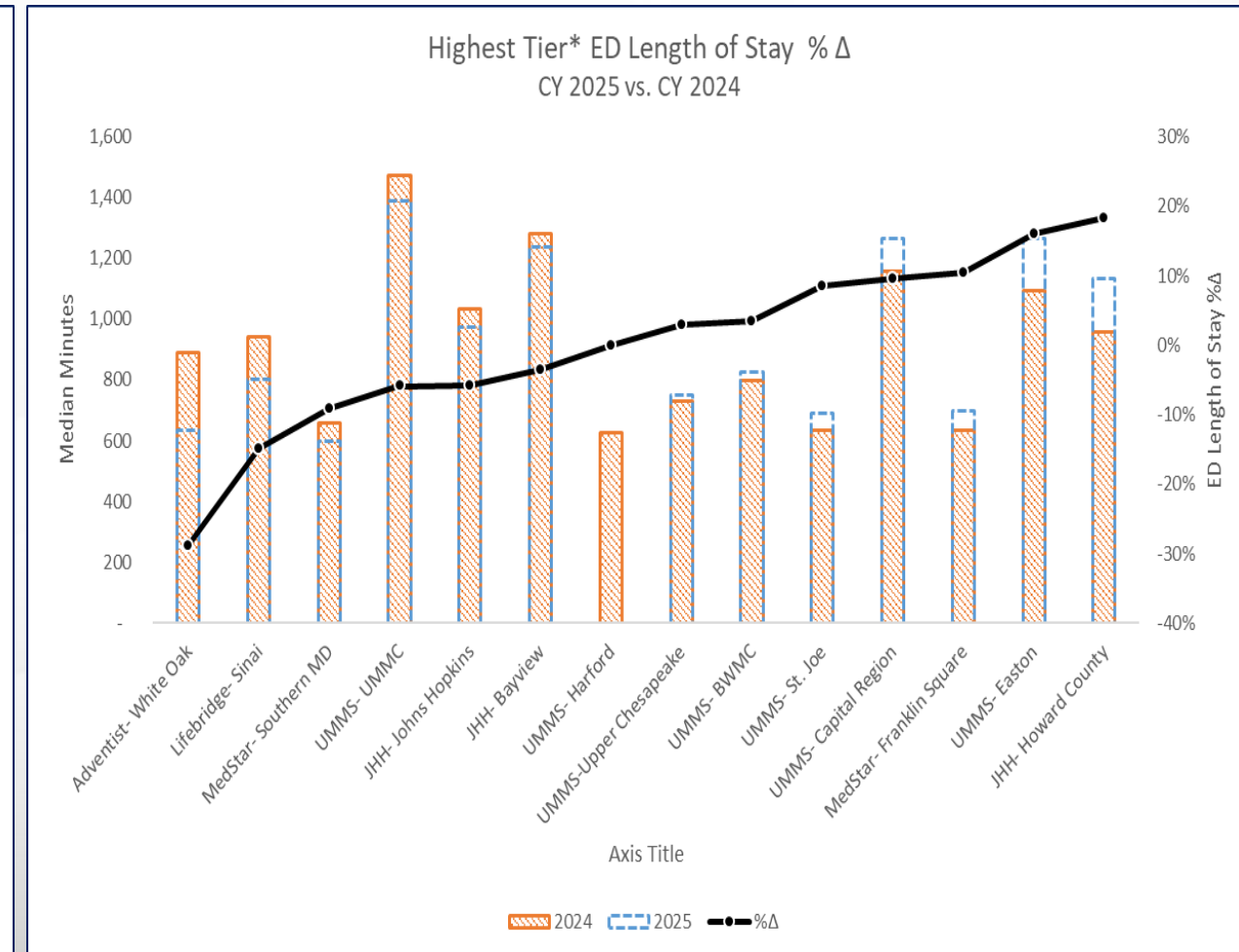
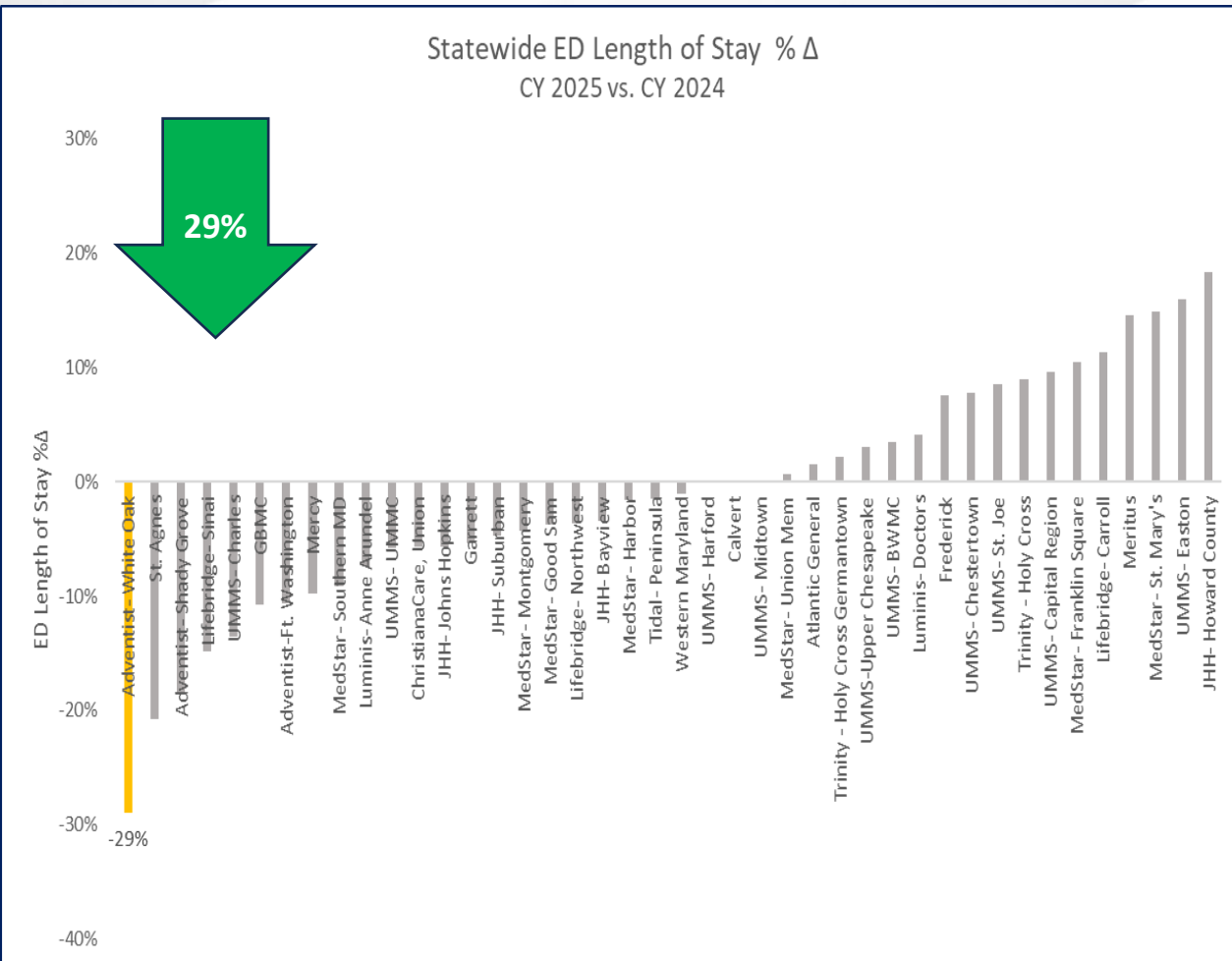
# Statewide ED Length of Stay – 2024 vs. 2025

- White Oak had the **8<sup>th</sup> longest** ED LOS in the State in 2024 (889 minutes) → reduced by **29%** to **13<sup>th</sup>** in 2025 (632 minutes)
- **58% above** state median in 2024 to **only 12% above** in 2025



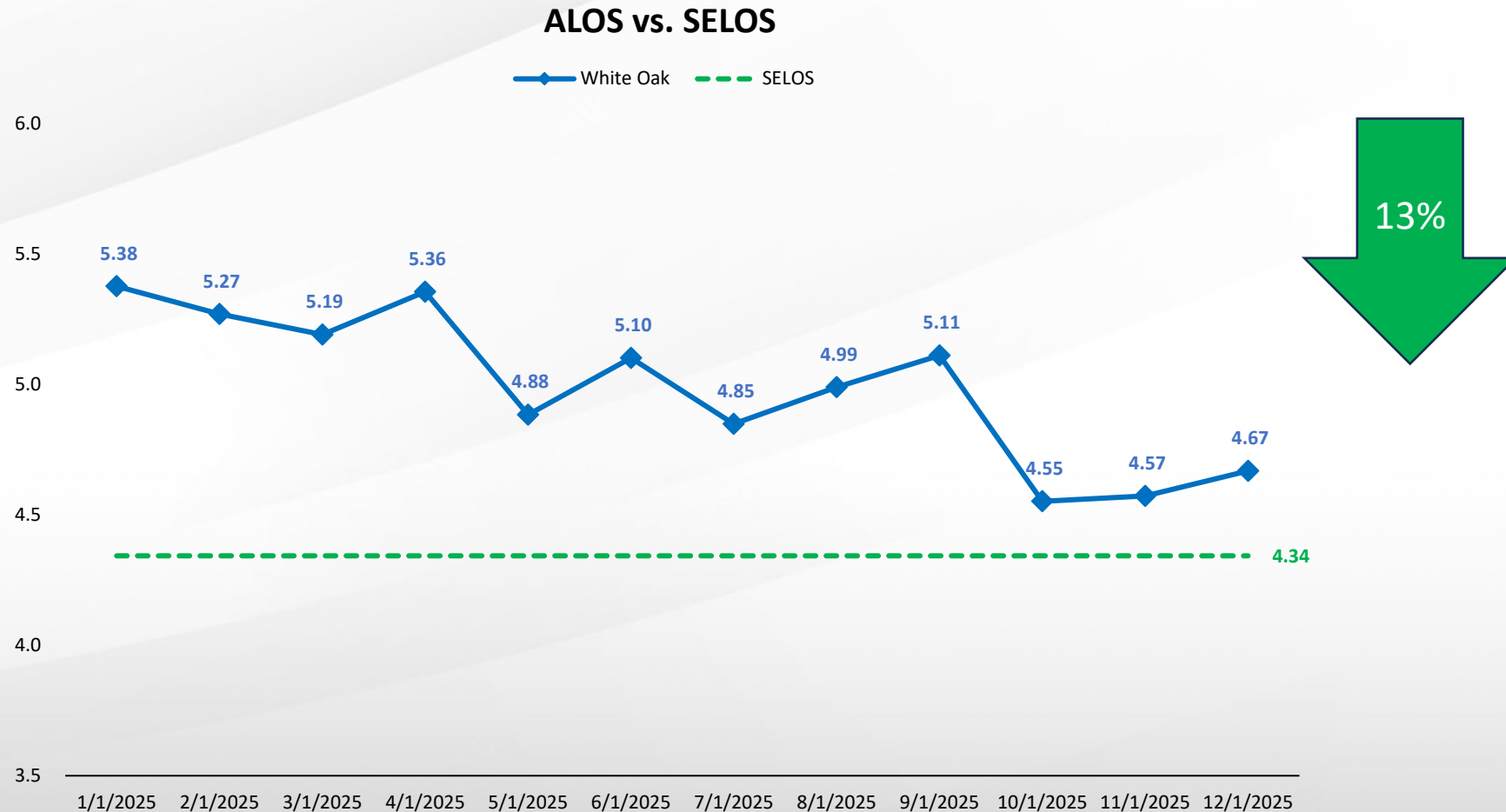
# Statewide ED Length of Stay Reduction – Overall vs. Top Tertile

- White Oak had the **greatest reduction (29%)** in ED LOS in the state between 2024 and 2025
- Among hospitals with the longest ED LOS, the next largest reduction was 18%



# Inpatient Length of Stay Continues to Decrease

- Adult IP LOS **decreased 13%** between Jan 2025 & Dec 2025



# What have we done to achieve these improvements?

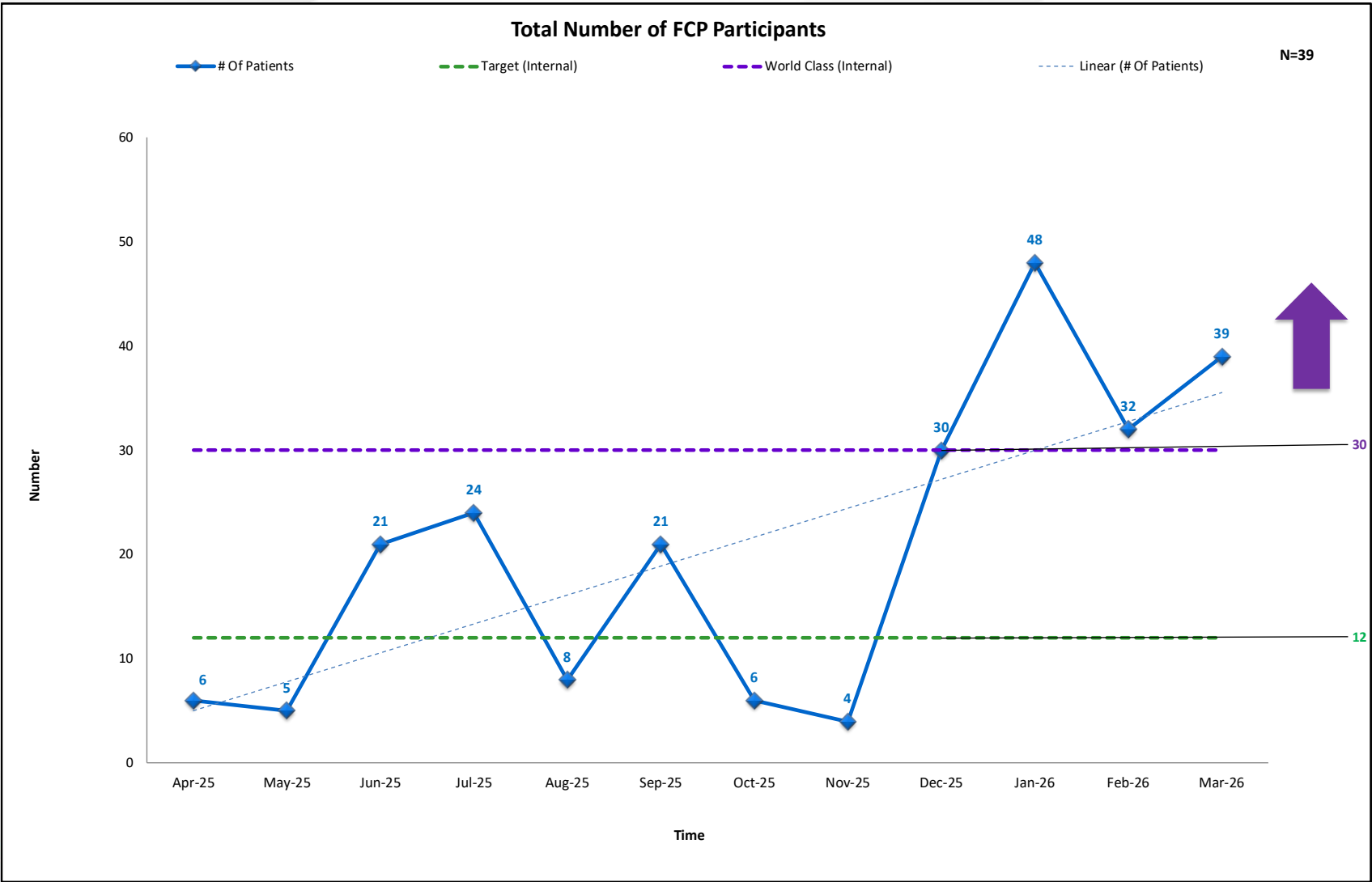


## **Emergency Department LOS**

**Full Capacity Protocol (FCP)**

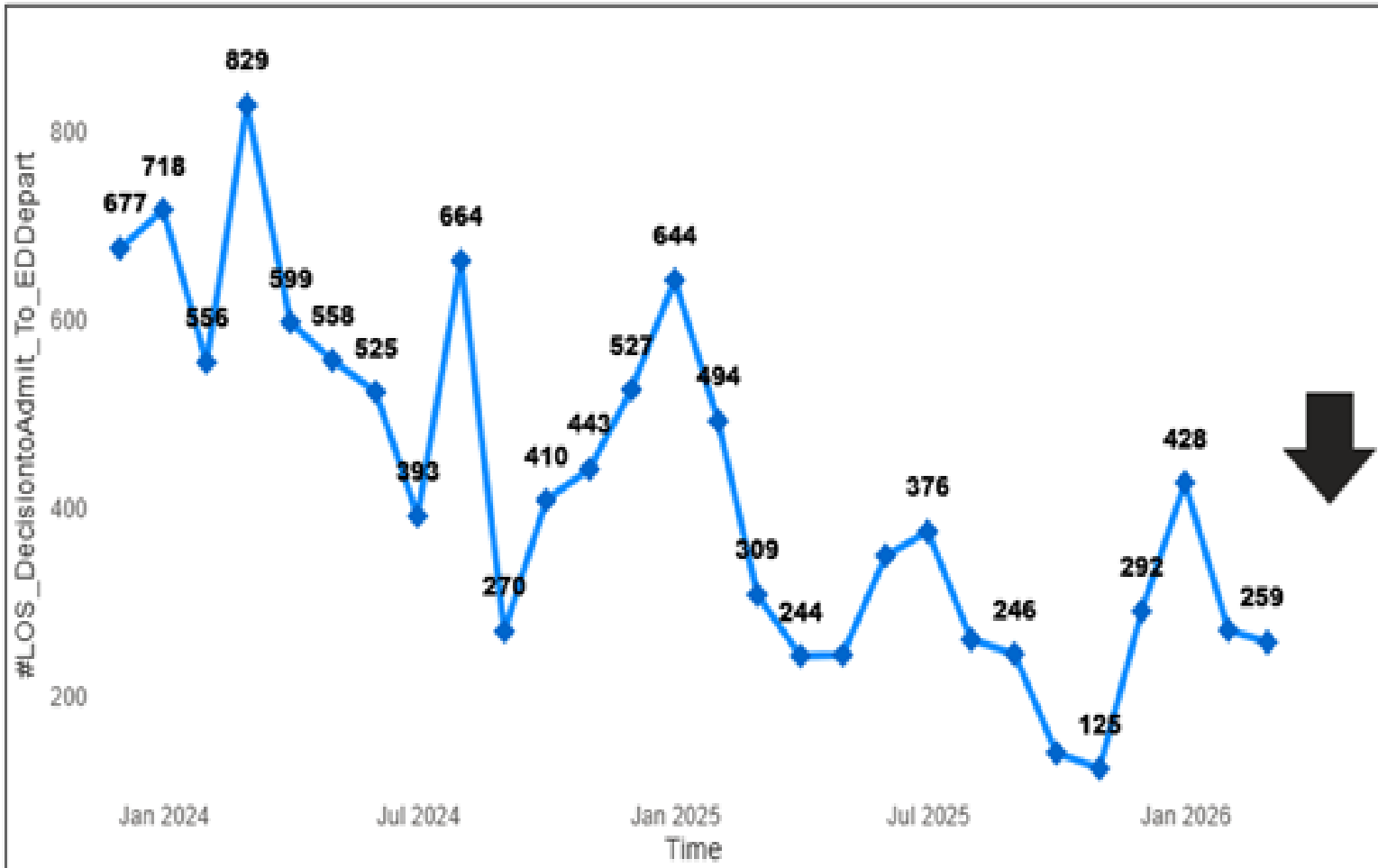
# Full Capacity Protocol Number of Patients by Month

BETTER - EXPERIENCE



# Boarding Time-Decision To Admit (Bed Request) To ED Depart (Inpatient only)

## Better - Experience



Initiatives	Status

Status Key

- Complete: Green
- Not Yet Started: Grey
- On Task: Yellow
- Delayed: Red

<b>Surprises / Solid Wins / Important Learnings</b>	
Status Updates	
Identified Risks for Discussion	

# What have we done to achieve these improvements?



## **Emergency Department LOS**

Full Capacity Protocol (FCP)

Post Discharge Area (PDA)

# What have we done to achieve these improvements?



## **Emergency Department LOS**

**Full Capacity Protocol (FCP)**

**Post Discharge Area (PDA)**

**Rapid Assessment Zone (RAZ)**

# What have we done to achieve these improvements?



## **Emergency Department LOS**

**Full Capacity Protocol (FCP)**

**Post Discharge Area (PDA)**

**Rapid Assessment Zone (RAZ)**

**ED BEST PRACTICE: Expedited Care  
Interventions**



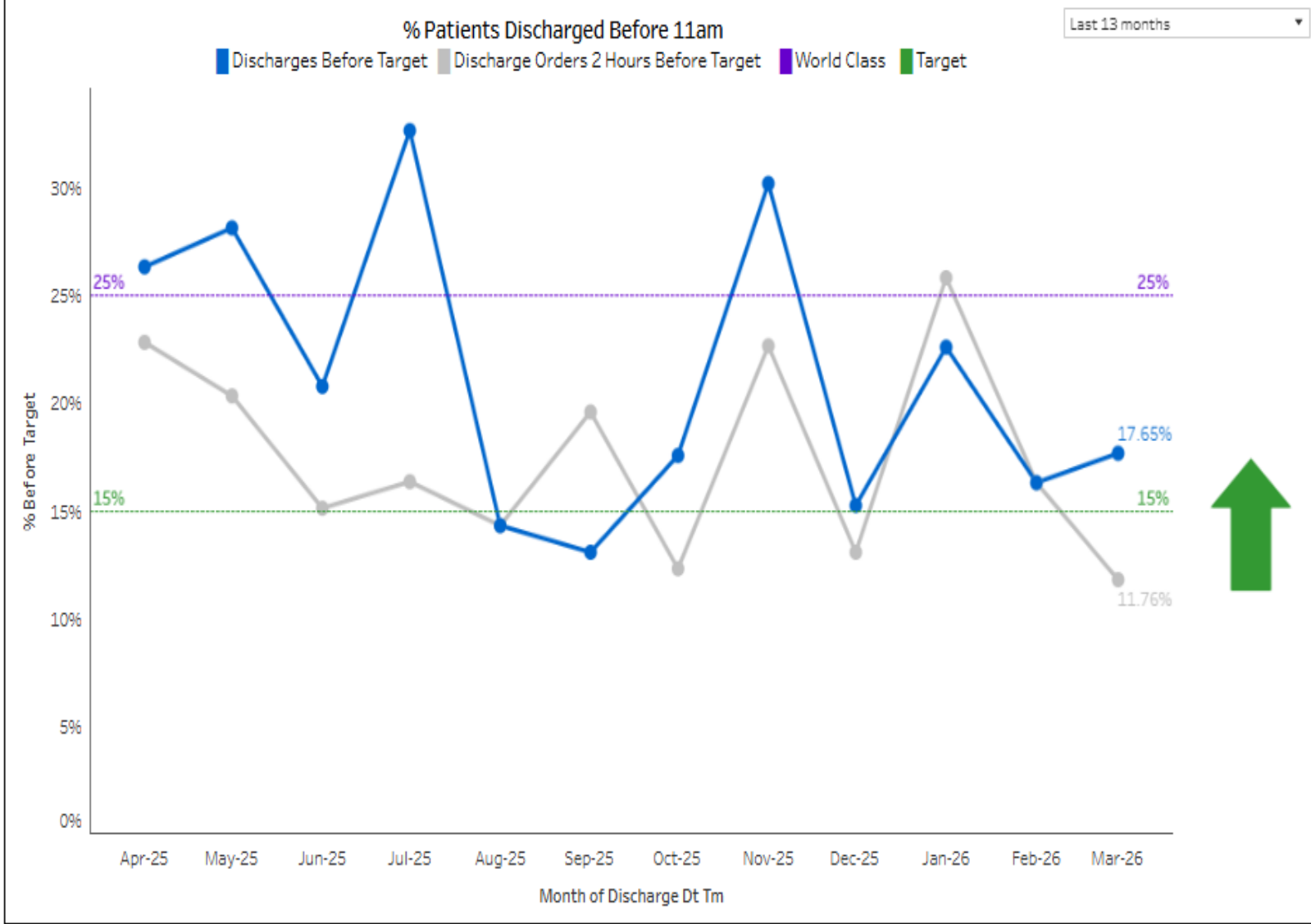
## **Hospital LOS**

**Hospital Throughput Committee**

# 8S MS HOME DISCHARGES by 11am

Discharge Orders= 11.76%

Discharges= 17.65%



# What have we done to achieve these improvements?



## **Emergency Department LOS**

Full Capacity Protocol (FCP)

Post Discharge Area (PDA)

Rapid Assessment Zone (RAZ)

ED BEST PRACTICE: Expedited Care  
Interventions



## **Hospital LOS**

Hospital Throughput Committee

New Complex Care Navigator

Bridging the Weekend Discharge Gap

ED BEST PRACTICE: Interdisciplinary Rounds  
& Early Discharge Planning

# ED KPIs Monitored for Improvement

ED Door to Provider

70% ↓

(194 to 60 minutes)

Bed to Provider

54% ↓

(28 to 13 minutes)

ED Arrival to ED  
Discharge LOS (Non-IP)

34% ↓

ED Decision to Admit  
to Bed Assignment  
Time

74% ↓

% Left Without Being Seen

78% ↓

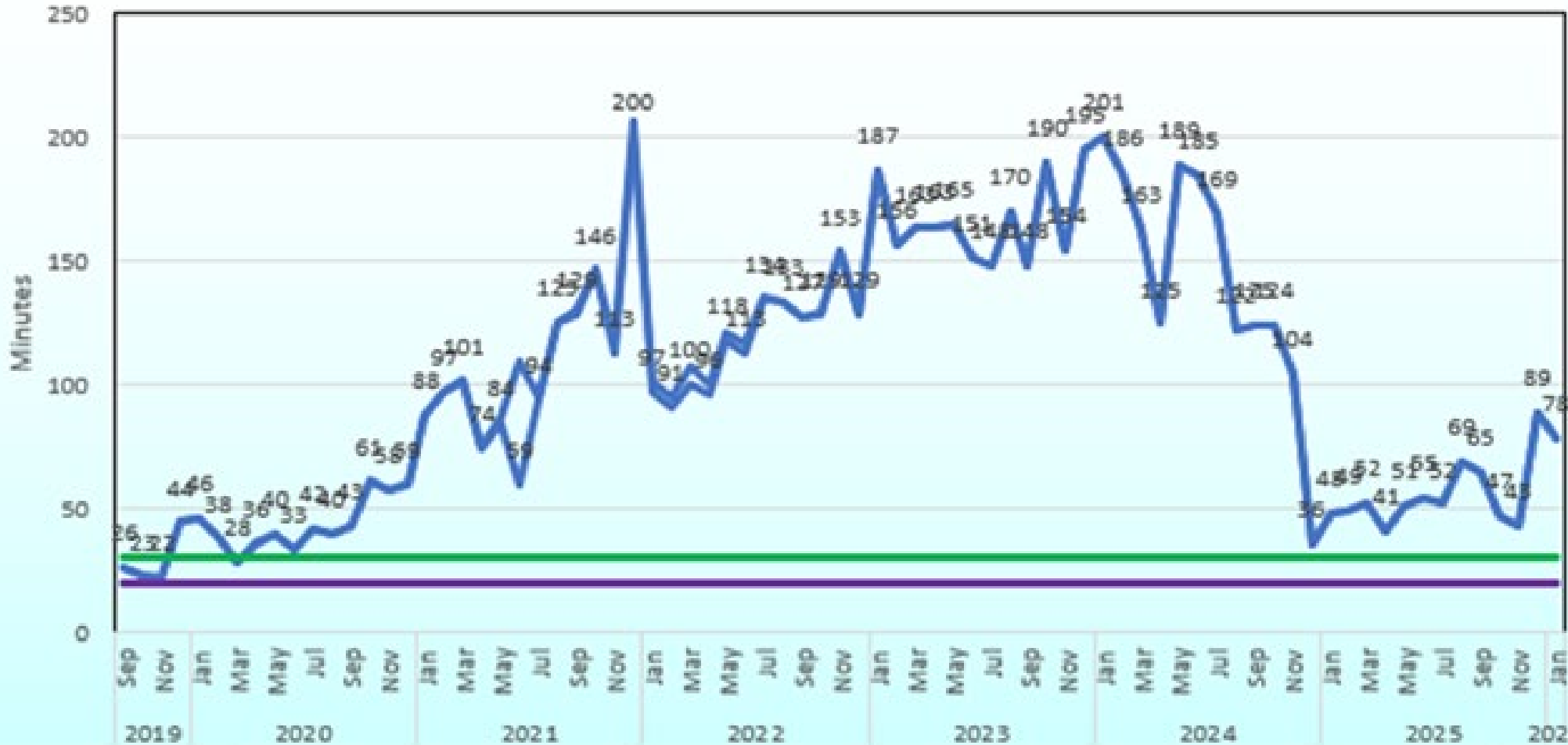
% of Patients Left  
Against Medical Advice

Avg ~ 0.6%

# Median Door to Provider (Monthly)

M5

- Median Door to Definitive Provider
- Median Door to PIT or Provider
- Door to provider Target
- Door to Provider WC
- Arrow Door to Provider

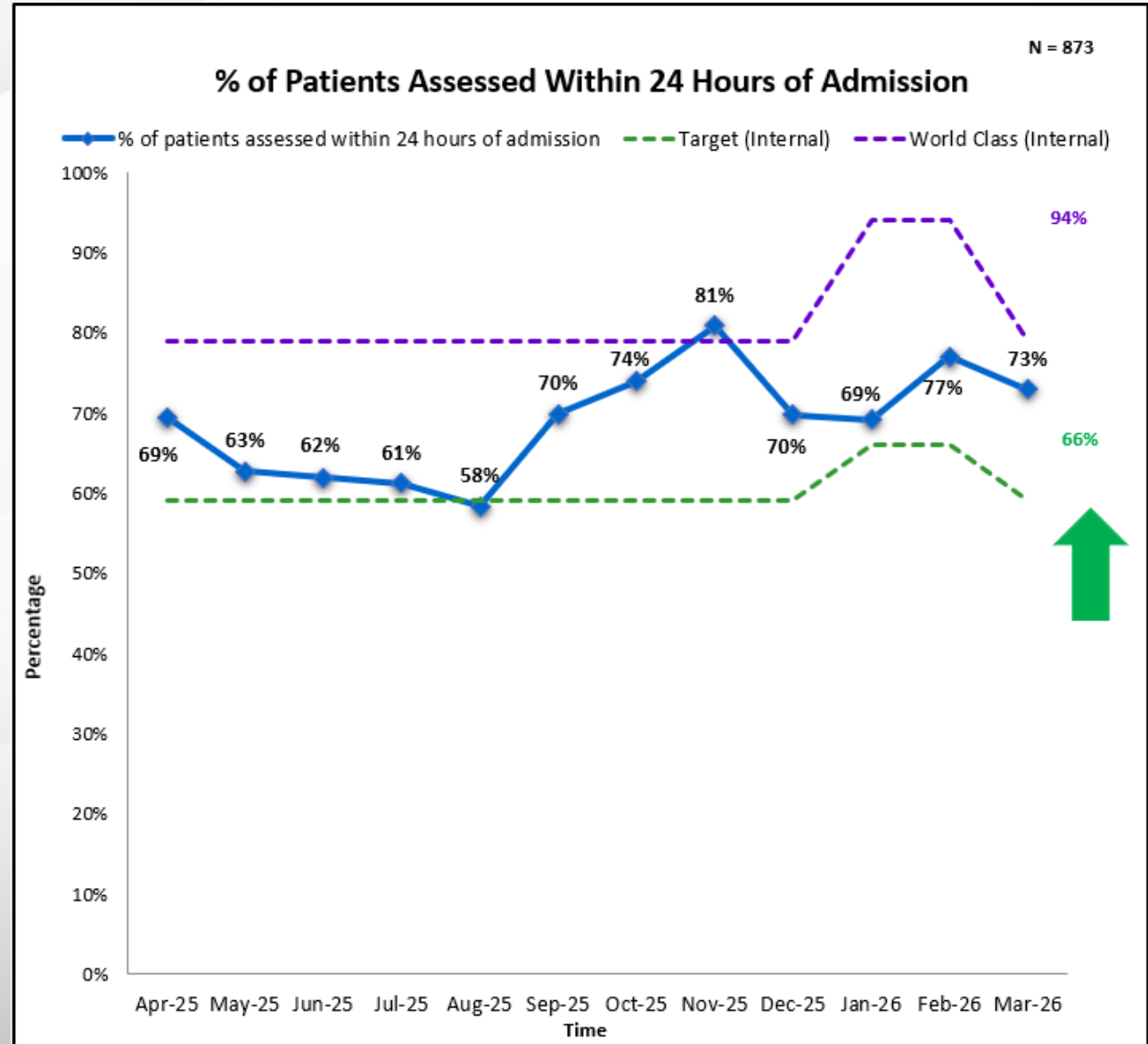


# ED Best Practice #1: Interdisciplinary Rounds & Early Discharge Planning

**KPI #1:** 70% document discharge planning within 48 hours of admission for adult Med Surg Inpatient Admissions

## Initiatives

- Assign one Care Navigator (CN) to manage ED Hold and House Assessments
- Recruit to fill weekday and weekend staffing gaps
- Leverage new Silver Stay weekend partnership for:
  - Staffing
  - Quality Assessments
  - Discharge Planning
- Collaborate across AHC to streamline CN PowerForms (assessments and progress notes)

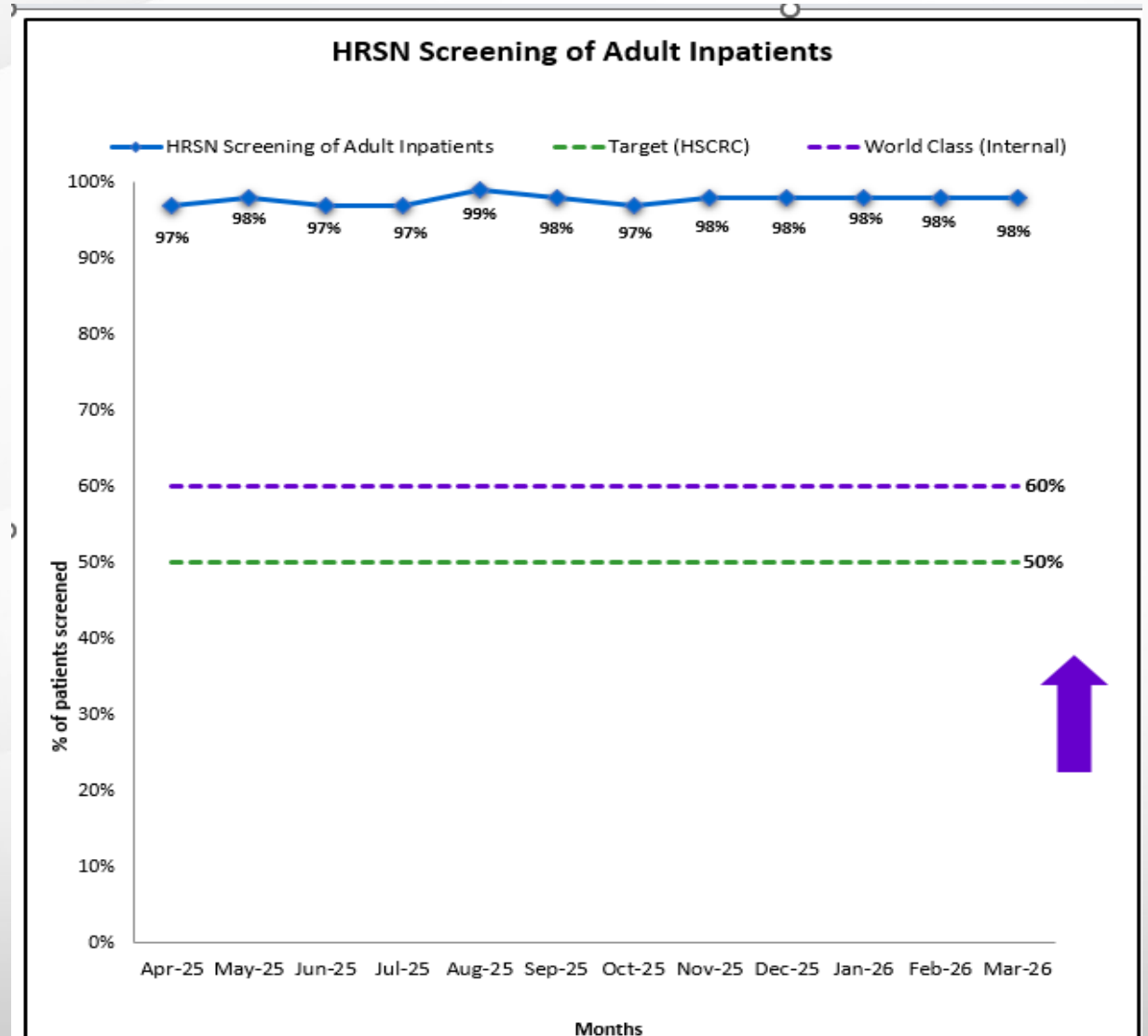


# ED Best Practice #1: Interdisciplinary Rounds & Early Discharge Planning

**KPI #2:** 50% screen adult inpatients for the 5 HRSN before discharge

## Initiatives

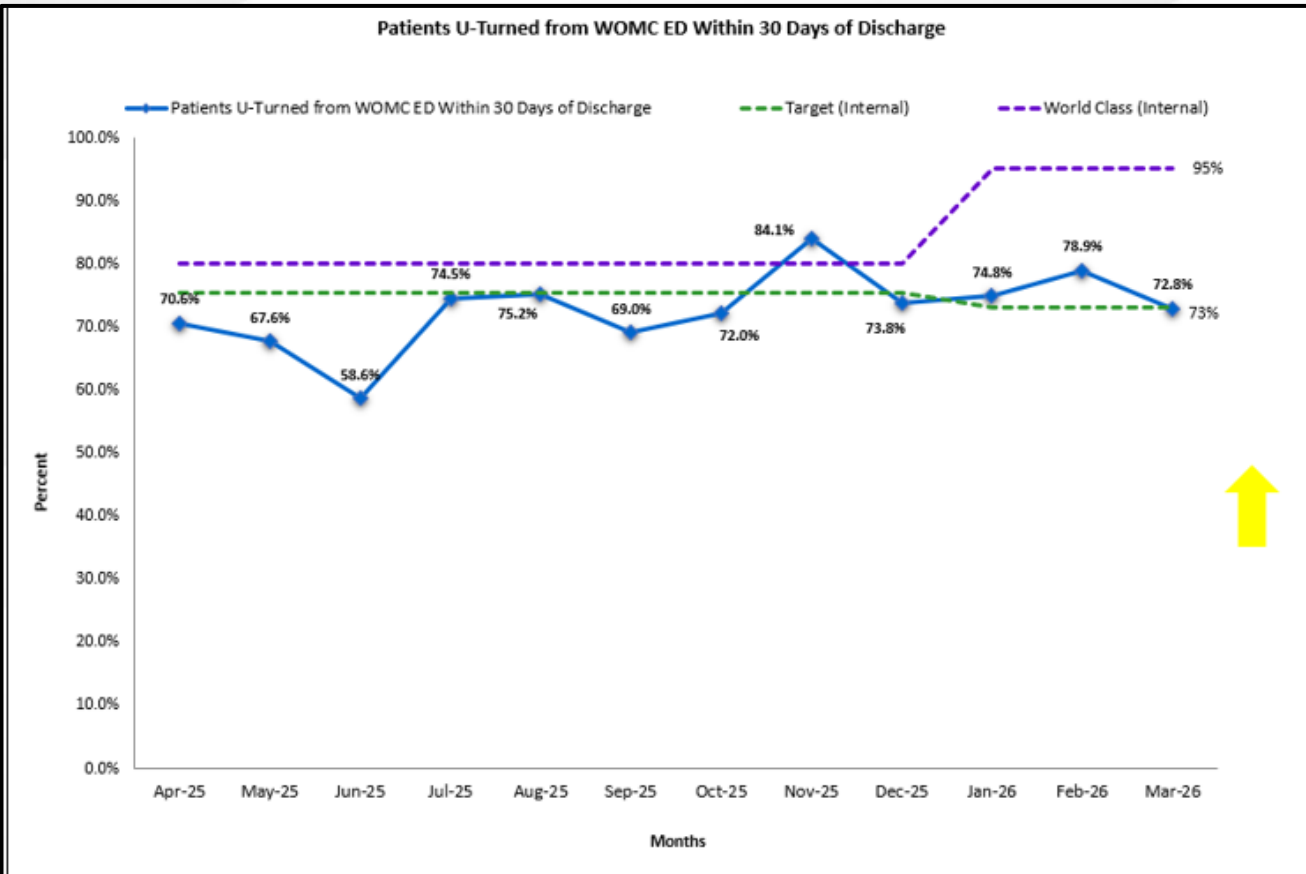
- Empower nurses to lead comprehensive triage by embedding risk and HRSN screenings into routine care
- Strengthen nursing–care navigation collaboration to support safe discharge for patients with high-risk social needs
- Expand use of interpreter services to improve health literacy, equity, and understanding of care plans



# ED Best Practice #2: Expedited Care Interventions

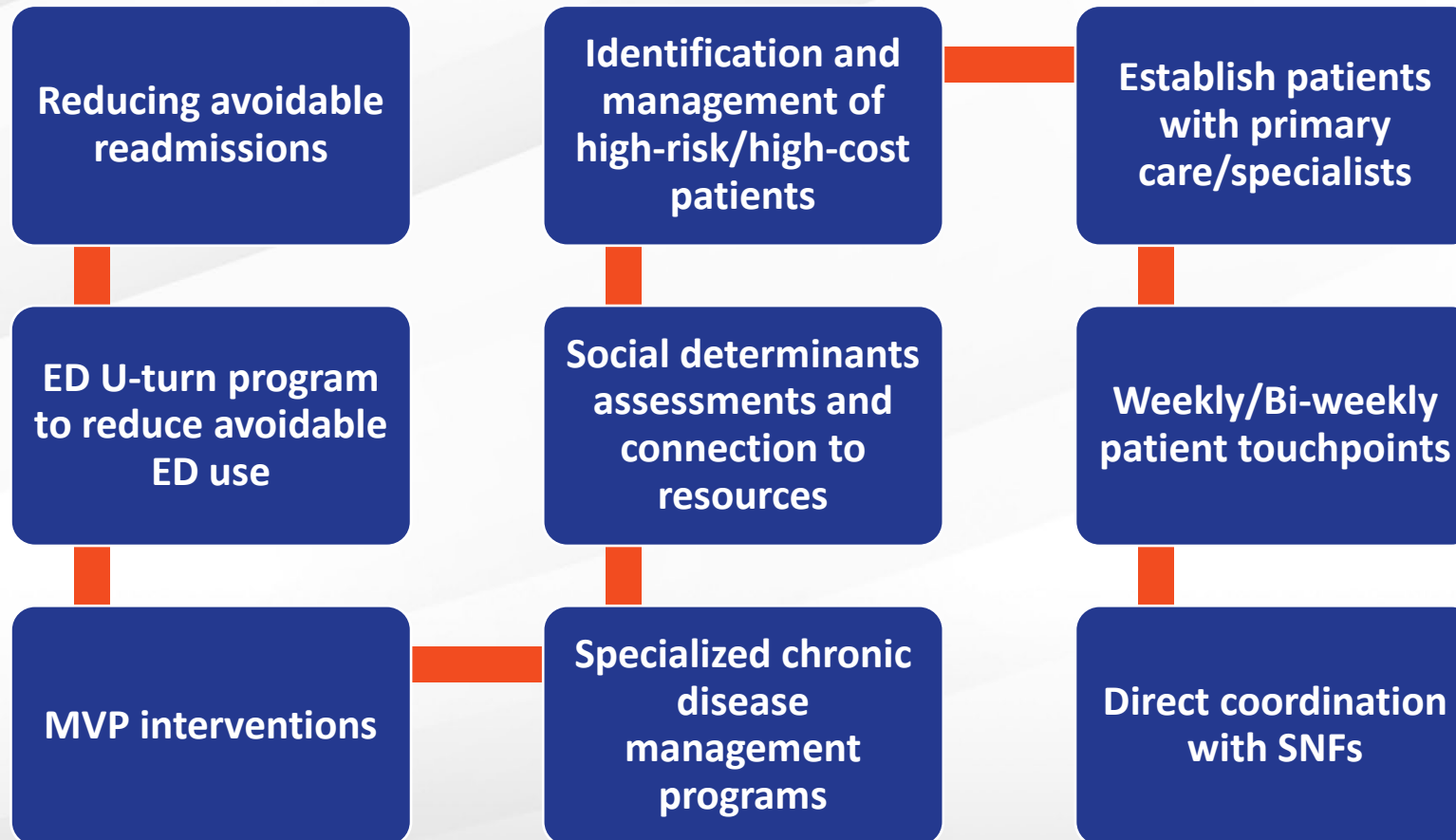
## Practice 3: Patients U-Turn from ED Within 30 Days of Discharge

### Initiatives



- Use the tracking shell to prioritize returning ED patients for Care Navigator follow-up
- Implement real-time ED Care Navigator consults to address patient needs before discharge
- Strengthen ED–OP Care Navigator collaboration for patients with ongoing or long-term needs

“Care Navigation” focus on preventing PAUs, optimizing discharge coordination with external providers and coordinating care in the community



# LOS Opportunity concentrated with SNF placements and Managed Care

**Average LOS by Discharge Location & Payer**  
Above/(Below) State

Discharge to:	Medicare FFS	Medicare HMO	MD Medicaid HMO	MD Medicaid FFS	Commercial / All Other	Self Pay	All Payer
SNF	0%	5%	(18%)	(22%)	(15%)	-	(3%)
Home Health	(10%)	6%	(18%)	(18%)	(9%)	33%	(6%)
Rehab	6%	(21%)	36%	(37%)	(25%)	-	(12%)
Home	(13%)	(1%)	(30%)	(19%)	(3%)	(15%)	(15%)

# Opportunities for Improvement: Reduce Readmissions

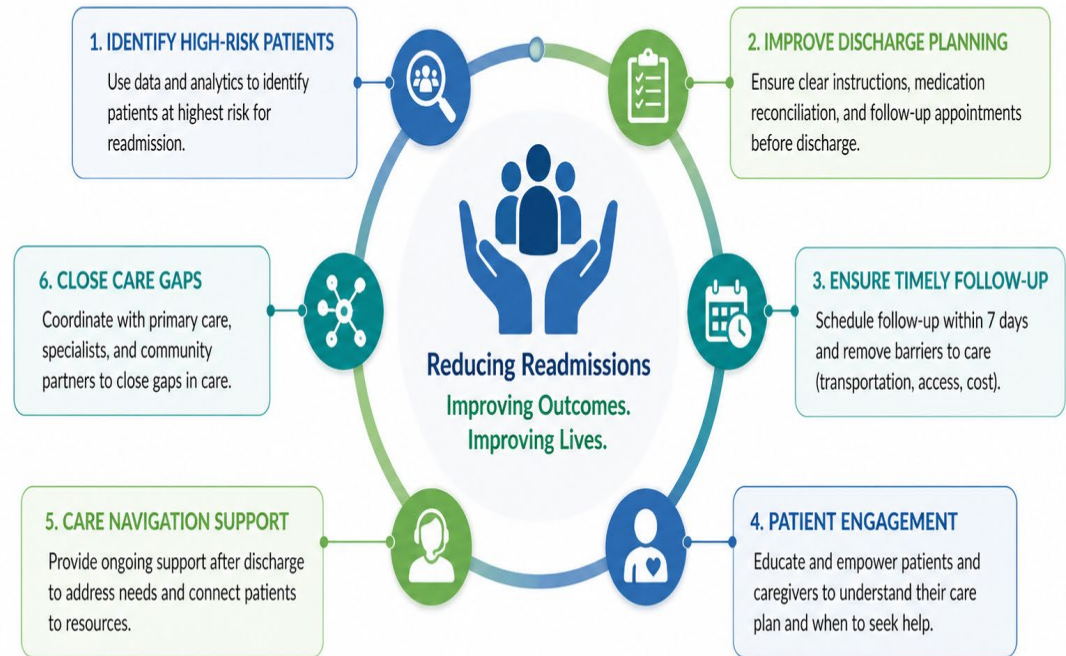
**Supplement Outpatient Care  
Navigation Staffing – Funded**

**Partner with Adventist Medical Group  
to create High-Risk Discharge Clinic –  
Funded**

**Provider Home Visits for High  
Utilizers**

## Opportunities for Improvement: Reduce Readmissions

*Right Patient. Right Care. Right Time.*



**OUR GOAL:** Fewer readmissions. Better patient experience. Lower costs. Healthier communities.

# Next Steps



Continuous improvement through White Oak Hospital Operations Throughput Committee



Implement and track ED Best Practices metrics in collaboration with HSCRC



Partnership with State to address SNF and Managed Care post acute capacity



Monitor housing development expansion & potential impact on throughput/capacity.

# Appendix

# WOMC Excellence and Honors

- **Pathway to Excellence Designation®** by the American Nurses Credentialing Center
- **"A" Hospital Safety** Group from The Leapfrog Group (Fall 2023 & Spring 2024)
- **3-Star** Rating from The Society of Thoracic Surgeons
- Blue Cross Blue Shield Blue Distinction for Maternity Care
- Designation by CMS as a Birthing-Friendly Hospital
- **3-Star** Hospital Rating from CMS
- American Heart Association/American Stroke Association's 2024 Get With the Guidelines–Stroke **GOLD PLUS** quality achievement award with Target: Stroke **Elite Honor Roll** and Target: Type 2 Diabetes Honor Roll recognitions
- American Heart Association/American Stroke Association's 2024 Get With The Guidelines–Coronary Artery Disease NSTEMI **Gold** with Target: Type 2 Diabetes recognition

# Adventist HealthCare, Inc.

- A mission driven organization that provides health care to more than 1 million residents in Maryland and the District of Columbia
- An integrated health care delivery system providing a full continuum of care through an integrated team of physicians and care centers that include:
  - Three acute care hospitals
  - A rehabilitation hospital
  - Behavioral health services
  - Two cancer centers
  - Primary care and specialty physicians
  - Free standing emergency center
  - Imaging and outpatient centers
  - Extensive home health services
  - Top-ranked cardiac surgery program
  - Top-ranked stroke center



# WOMC Hospital Throughput Committee (HTC)

*White Oak Medical Center's Throughput Committee, established in March 2021, is an interdisciplinary team dedicated to optimizing patient flow from admission to discharge. Meeting monthly, the committee focuses on reducing delays, enhancing care quality, shortening wait times, and expanding the hospital's capacity.*

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## Key Functions

- 1. Performance Indicators:** Develop and track key performance indicators (KPIs) for patient throughput
- 2. Monitoring Patient Flow:** Analyze patient flow data to identify and address bottlenecks in admissions, diagnostics, surgery, and discharge processes.
- 3. Process Improvement:** Implement strategies to streamline operations, such as revising bed management policies, enhancing interdepartmental communication, and optimizing scheduling.

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The committee includes representatives from nursing, administration, emergency services, surgery, and case management