

September 4, 2014

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

Dear Mr. Steffen,

Please find enclosed the 2014 application for a Certificate of Conformance for Primary and elective PCI services for the University of Maryland Upper Chesapeake Medical Center. The work performed in the Cardiac Catheterization Laboratory is an important service that supports part of our System's vision and overall strategic plan. This remains a key component of our Cardiovascular Service Line and the critical level of care these programs will provide to our community. It is also an integral component of our planning as we move toward the global view of population health.

Thank you for your time and consideration of this application. Should you require further information, please feel free to contact Mark Lewis, Director, Heart and Vascular Institute, at 443-643-3713.

In Good Health,



Lyle E. Sheldon, FACHE
President/CEO

Enclosure



MARYLAND
HEALTH CARE
COMMISSION

**Application for Certificate of Conformance
Non-Primary Percutaneous Coronary Intervention**

**NOTE: ALL PAGES OF A HOSPITAL'S APPLICATION SHOULD BE
NUMBERED CONSECUTIVELY.**

**Information Regarding Application for a Certificate of Conformance to Provide Non-
Primary PCI Services**

The following application form is to be used by hospitals without on-site cardiac surgical backup when applying for a **Certificate of Conformance to Perform Non-Primary Percutaneous Coronary Interventions**. Specific provisions of COMAR 10.24.17 are shown in bold, and listed beneath each is the information that the Commission requires to evaluate each application.

The applicant shall cooperate with the Commission or any of its authorized representatives in supplying additional information in the course of the application's review.

The form is intended to be completed using Microsoft Word. Applicants are expected to enter narrative text where appropriate, complete the provided tables and forms, and/or submit applicant-prepared documents. The applicant must file an original application, including the Applicant Affidavit with ink signature and supporting documents, and six copies of both the application and the affidavit with the Maryland Health Care Commission by September 1, 2014, if a letter of intent was filed by August 1, 2014. The filing should be directed to:

Eileen Fleck
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

If you have any questions regarding the application form, please contact:

Eileen Fleck
Chief, Acute Care Policy and Planning
Maryland Health Care Commission
410-764-3287

MARYLAND

HEALTH

CARE

COMMISSION

MATTER/DOCKET NO:

DATE DOCKETED

Application for Certificate of Conformance to Perform Non-Primary Percutaneous Coronary Intervention

Applicant Information

Applicant University of Maryland Upper Chesapeake Medical Center

Street Address 500 Upper Chesapeake Drive

City Bel Air County Harford State MD Zip Code 21014

Mailing Address (if different) Same

City _____ County _____ State _____ Zip Code _____

Medicare Provider Number(s) 210049 National Provider Identifier 1598761355

Person to be contacted on matters involving this application:

Name Mark S. Lewis

Title Director, Heart and Vascular Institute

Address 500 Upper Chesapeake Drive

Address _____

City Bel Air County Harford State MD Zip Code 21014

Telephone 443-643-3713 Facsimile 443-643-3731 E-mail mlewis@uchs.org

Review Criteria for a Certificate of Conformance (COMAR 10.24.17.06B)

(1) An applicant hospital shall demonstrate its compliance with the general standards in COMAR 10.24.10.04A.

Q1. Is the applicant a Medicare Provider in good standing? Yes **X** No ___
If no, attach an explanation.

Q2. Has the applicant been sanctioned, barred, or otherwise excluded from participating in the Medicare program or been placed on a 23- or 90-day termination track? Yes ___ No **X**
If yes, attach an explanation.

Q3. Is the applicant accredited by the Joint Commission? Yes **X** No ___
If no, attach an explanation.

Q4. Has the applicant had its accreditation denied, limited, suspended, withdrawn, or revoked by the Joint Commission or other accreditation organization, or had any other adverse action taken against it by an accreditation organization in the past 24 months, including Provisional or Conditional Accreditation, Preliminary Denial of Accreditation, or Denial of Accreditation? Yes ___ No **X**

If yes, attach an explanation and provide copies of correspondence from the accreditation organization notifying the hospital of each change in its accreditation status.

Q5. Has the applicant been placed on Accreditation Watch by the Joint Commission? Yes ___ No **X**

If yes, attach an explanation and provide copies of correspondence from the accreditation organization notifying the hospital of each change in its accreditation status.

Q6. Please provide a copy of the written policy for the provision of information to the public concerning charges for its services. At a minimum this policy shall include:

(a) Maintenance of a representative list of services and charges that is readily available to the public in written form at the hospital and on the hospital's internet web site.

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.

See Appendix A- Communication of Hospital Charges policy

Q7. Each hospital shall have a written policy for the provision of charity care for indigent patients to ensure access to services regardless of an individual's ability to pay. Please provide a copy of this policy.

See Appendix B- Financial Assistance Policy

Q8. A hospital with a level of charity care, defined as the percentage of total operating expenses that falls within the bottom quartile of all hospitals, as reported in the most recent Health Services Cost Review Commission Community Benefit Report, shall demonstrate that its level of charity care is appropriate to the needs of its service area population.

Based on the newly published Health Services Cost Review Commission Community Benefit Report, which reports data from FY 2013, the level of charity care for University of Maryland Upper Chesapeake Medical Center is 2.55%, ranking UM UCMC at the 27.7th percentile.

Q9. A hospital with a measure value for a Quality Measure included in the most recent update of the Maryland Hospital Performance Evaluation Guide that falls within the bottom quartile of all hospitals' reported performance measured for that Quality Measure and also falls below a 90% level of compliance with the Quality Measure, shall document each action it is taking to improve performance for that Quality Measure.

A review of the most recent update of the Maryland Hospital Performance Evaluation Guide demonstrates that UM Upper Chesapeake Medical Center does not have any Quality Measures that fall within the bottom quartile of all hospitals and also fall below the 90% level of compliance with the Quality Measure.

See Appendix C- Quality Measures- University of Maryland Upper Chesapeake Medical Center

(2) An applicant shall document that its proposed elective PCI program is needed to preserve timely access to emergency PCI services for the population to be served.

Q10. Please provide information on the expected transit time for the population to be served, if that population was not able to obtain emergency PCI services at the applicant hospital and alternatively had to seek this service at the nearest available provider of primary PCI services.

UM Upper Chesapeake Medical Center is the principle provider of primary PCI services to the communities within Harford County and the majority of Cecil County. The eastern portion of Cecil County is closer time-wise to Christiana Hospital in Newark, Delaware. Harford County comprises 526 square miles. Cecil County comprises an additional 417 square miles, with roadways that don't always allow ambulances to move at maximum speed, affecting travel time. Residents from Cecil County have the added challenge of crossing a river, with limited number of access points. Transit times from the furthest points in Harford County to University of Maryland Upper Chesapeake Medical Center can reach 30 minutes from the Whiteford area in Northeast Harford County, to up to 40 minutes from central Cecil County. During periods of high traffic or inclement weather, ambulances may take longer to arrive at UM UCMC. If these ambulances had to go to the next closest PCI program if UM UCMC were denied the ability to provide primary PCI services, the trip to Franklin Square Hospital, the next closest primary PCI

hospital, will add a minimum of 20 minutes to the overall transit time. In light of the potential target of 90 minutes from first medical contact to balloon time, this would severely limit the ability to provide the desired medical intervention according to established standards of care.

In the case of transfers from UM Harford Memorial Hospital, the transit time is approximately 26 minutes to UM Upper Chesapeake Medical Center. This timeframe increases to 37 minutes to Franklin Square Hospital, again putting patients at greater risk of a greater than 120 minute door to balloon time for transfers. These patients could also be taken to Christiana Hospital in Delaware in approximately 34 minutes. Any of these alternatives, if our program did not exist, would increase the transit time from the patient's location when the call was made to a site where the intervention could be performed. As the Maryland Institute for Emergency Medical Services Systems investigates moving toward a format of measuring first-medical-contact-to-balloon-time, loss of UM UCMC as a PCI resource will put the patient at greater risk of not obtaining needed critical intervention in the optimal timeframe.

In our current state, the two interventional labs (the Cardiac Catheterization Laboratory and the Interventional Angiography Laboratory) are located in close proximity with staffing and oversight from a common group. As such, we are able to shift resources so that changes in volumes for the various services who utilize the Labs contribute to the overall financial viability of both laboratories. Our STEMI volume, along with our cardiac catheterization volume, is supplemented by our electrophysiology, interventional vascular and interventional radiology procedure volumes. These specialty volumes fluctuate from year to year. Providing a robust PCI program will assure that these fluctuations do not present a detrimental effect on our financial viability.

Concurrently, the introduction of an elective program will benefit our patients. During a diagnostic cardiac catheterization, if an intervention is found to be indicated, the patient must be inconvenienced and placed at potential risk by our need to remove the catheter and transport the patient to another institution where a second catheter must be introduced to complete their treatment. The reduction in the added expense associated with transport and the additional intervention will be a benefit as we move toward a population health model.

(3) An applicant shall document that its proposed elective PCI program will achieve a volume of 200 or more total PCI cases by the end of the second year of providing elective PCI services. The Commission may waive the volume requirement of 200 or more total PCI cases by the end of the second year, if the applicant demonstrates that adding an elective PCI program at its projected annual case volume will permit the hospital's PCI service (emergency and elective) to achieve financial viability.

Q11. Are you requesting that the volume requirement of 200 cases be waived?
Yes ___ No X

If yes, skip question 12.

Q12. Please provide information that supports a projected PCI case volume of 200 or more. Please provide projections for primary PCI cases and elective PCI cases separately, and include an explanation of the assumptions used to develop the projected primary and elective PCI case volumes.

Over the past four years, the volume of primary PCIs have increased steadily, from 124 in 2010 to 138 in 2013. Annualizing the first six months of 2014, we will perform 164 emergency PCIs, although 150 seems more realistic in light of seasonal fluctuations. In addition to this volume,

we have been referring patients from both the Upper Chesapeake Cardiology practice and directly from multiple locations within the hospital (i.e.- the Cardiac Catheterization Laboratory, the Emergency Department, and inpatient nursing units) to the University of Maryland Medical Center (UMMC), St. Joseph Medical Center, Johns Hopkins Hospital, Union Memorial Hospital, and others. Transfers to UMMC have totaled over 300 per year. While these patients do not all require interventions, Dr. Michael Drossner, our Medical Director of the Cardiac Interventional program has performed 129 interventions at UMMC over the past four quarters. Combining our primary volume and the pool of patients who are currently transferred to these other hospitals, we can easily demonstrate a projection of greater than 200 PCI cases per year, limited only by our current capacity. We do not foresee a major downward trend in PCI volume over the next several years. Thus our ability to meet and exceed the 200 case minimum will remain intact.

(4) An applicant shall document that its proposed elective PCI program will achieve financial viability.

Q13. Will the introduction of elective PCI services require a capital expenditure by the hospital? Yes ___ No X

If yes, please provide an estimate of these costs using Form A.

Q14. Please complete and submit a schedule of revenues and expenses for PCI services, using Form B. Please note that this schedule requires the reporting of revenues and expenses associated with the existing primary PCI program, for the current fiscal year and the two most recently ended fiscal years. In addition, it requires projected revenue and expenses for future years through the third year of operation as a provider of both emergency and elective PCI services.

See Pages 14-16- Form B: Revenue and Expenses

(5) An applicant shall commit to providing elective PCI services only for suitable patients. Suitable patients are patients described as appropriate for elective PCI in the Guidelines of the American College of Cardiology Foundation/American Heart Association (ACCF/AHS) for Management of Patients with Acute Myocardial Infarction or in the Guidelines of the American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) for Percutaneous Coronary Intervention. For elective PCI programs without cardiac surgery on-site, patients at high procedural risk are not suitable for elective PCI, as described in the ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention.

Q15. Please provide a signed statement from the hospital's chief executive officer and medical director of cardiac interventional services indicating agreement with the above statement.

See Appendix D- Letter of agreement to treat suitable patients

(6) An applicant shall commit to providing elective PCI services only for suitable patients. Suitable patients are patients described as appropriate for primary PCI in the Guidelines of the American College of Cardiology Foundation/American Heart Association (ACCF/AHA) for Management of patients with Acute Myocardial Infarction or in the Guidelines of the

American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI for PCI); patients with acute myocardial infarction in cardiogenic shock that the treating physicians believes may be harmed by transfer to a tertiary institution, either because the patient is too unstable or because of the temporal delay will result in worse outcomes; patients for whom primary PCI services were not initially available and who received thrombolytic therapy that subsequently failed. Such cases should constitute no more than 10 percent of total PCI cases; patients who experience a return of spontaneous circulation following cardiac arrest and present at a hospital without on-site cardiac surgery for treatment, when the treating physician(s) believe that transfer to a tertiary institution may be harmful for the patient.

Q16. Please indicate how many patients received thrombolytic therapy because primary PCI services were not initially available and how often this therapy failed, since the end of the period last reported on the hospital’s waiver renewal through June 30, 2014.

UM Upper Chesapeake Medical Center does not administer thrombolytic therapy for STEMI patients. There have been no instances of the use of this protocol since inception of the program.

(7) An applicant shall demonstrate that primary PCI services will be available for all appropriate patients with acute myocardial infarction, 24 hours per day, seven days per week.

Q17. Use the table below to indicate the routine availability of each procedure room in the hospital’s cardiac catheterization laboratory (CCL) suite for the period since this information was last reported through a waiver renewal, through June 30, 2014.

Reporting Period: 120112 – 063014
 From (mmddyy) To (mmddyy)

CCL Room	Days and Hours of Operation							
	Hours	Mon	Tue	Wed	Thu	Fri	Sat.	Sun
#1	Regular:	7:00am-5pm	7:00am-5pm	7:00am-5pm	7:00am-5pm	7:00am-5pm	N/A	N/A
	On-Call:	5pm-7:00am	5pm-7:00am	5pm-7:00am	5pm-7:00am	5pm-7:00am	24 hours	24 hours
#2	Regular:	7:00am-5pm	7:00am-5pm	7:00am-5pm	7:00am-5pm	7:00am-5pm	N/A	N/A
	On-Call:	5pm-7:00am	5pm-7:00am	5pm-7:00am	5pm-7:00am	5pm-7:00am	24 hours	24 hours

Q18. Using the table shown below, indicate all dates when CCL services were unavailable, since this information was last reported through a waiver renewal application, through June 30, 2014.

Since prior reporting period: 9/30/12 – 6-30-14

From (Month/Day/Year)

To (Month/Day/Year)

Room	CCL Downtime			
	Date		Duration (Hours)	Reason Unavailable
	Begin	End		
1	6/16/13	6/16/13	4.1 hours	Preventive maintenance
1	1/20/14	1/20/14	3.5 hours	Preventive maintenance
1	11/9/13	11/9/13	3 hours	Table would not move. Found to be bad foot switch. Replaced and table function restored.
1	1/21/14	1/23/14	39.25 hours	Cap sense errors in log. On check, chiller not working. Had to wait for shipment and install of new chiller.
1	1/24/14	1/24/14	4 hours	Pump on new chiller not working. Pump taken from old chiller and installed temporarily. Second new chiller ordered.
1	1/31/14	1/31/14	1 hour	Second new chiller installed
1	3/24/14	3/24/14		Monitors not working in Lab or control room
	6/15/14	6/15/14	3 hours	Preventive Maintenance
2	6/18/13	6/18/13	5.5 hours	Preventive Maintenance
2	12/17/13	12/17/13	4.5 hours	Preventive Maintenance
2	6/25/14	6/25/14	3 hours	Preventive Maintenance
2	6/26/14	6/26/14	3.5 hours	Preventive Maintenance

Please note: During the time indicated above that the primary Cath Lab Room 1 was unavailable, all services were still available in the Angio/Cath Lab Room 2

During Preventive Maintenance sessions, the system is able to be brought back into service if needed emergently.

(8) The hospital shall have adequate physician, nursing, and technical staff to provide cardiac catheterization laboratory and coronary care unit services to patients with acute myocardial infarction 24 hours per day, seven days per week.

Q19. Have there been any changes to the number or the on-call availability of physicians, nurses, technicians, and other staff who comprise each on-call team (e.g., 1 MD, 1 nurse, and 2 technicians) since the MHCC granted an extension of the hospital's primary PCI waiver? Yes ___ No X

If yes, use the following chart to specify the changes in the frequency and duration of on-call service (e.g., days/week or month, 1700-0700 hours; weekends/month), and the time established by hospital policy for on-call staff to respond to the call (e.g., telephone or pager). Note that response time covers the period from receipt of call until arrival at the hospital.

Type of Clinical Staff on Team	Number of Staff	Call Rotation	Response Time
MD		Unchanged from prior report	
Fellow			
Nurses			
Technicians			
Other (specify)			

Q20. Complete the following table to show the number of physicians, nurses, and technicians who currently provide cardiac catheterization services to acute myocardial infarction patients (as of one week before the due date of the application). Also indicate whether the nursing and technical staff are cross-trained to scrub (S), circulate (C), and monitor (M).

Total Number of CCL Physician, Nursing, and Technical Staff:

8/12/14

(mmddyy)

	Number/FTEs	Cross-Training (S/C/M)
Physician	4	
Nurse	11/(FTE) 1 PRN	C/M (1 S/C/M) C/M
Technician	8 (FTE) 3 PRN	S/C/M S/C/M

(9) The hospital shall commit to providing primary PCI services as soon as possible and not to exceed 90 minutes from patient arrival at the hospital, excluding transfer cases, for at least 75 percent of appropriate patients. The hospital shall also track door-to-balloon times for transfer cases and evaluate areas for improvement.

Q21. Please provide information in the first table below on the number and percentage of STEMI patients meeting the door to balloon time standard of 90 minutes or less for each quarter since the hospital last reported DTB time information in its waiver renewal application, excluding patients who were transferred to the

hospital from another acute care hospital. Please also report information on the number of transfer cases and mean door-to-balloon time for transfer cases in the second table-shown below.

Quarter Ending	Number of STEMI Patients*	Number of STEMI Patients Receiving Primary PCI	STEMI Patients* with DTB Time < 90 Minutes ²	
			Number	%
3/31/13	43	34	32	94.1
6/30/13	61	35	27	77.1
9/30/13	52	26	24	92.3
12/31/13	53	29	22	75.9
3/31/14	61	37	27	73.0
6/30/14	51	36	27	75.0

Note: STEMI patients refers to both STEMI patients and STEMI equivalent patients, as defined in the NCDR CathPCI Data Registry. DTB time is the difference in minutes between the patient's arrival in the hospital emergency room and the time of insertion of the first device (usually a balloon-type device, but occasionally a thrombectomy device). Exceptions to this calculation method most commonly occur when the patient arrives with a *history* of chest discomfort but a normal or non-diagnostic initial electrocardiogram (ECG). *If and only if* the first ECG is normal/non-diagnostic *and* is noted in the NCDR CathPCI Registry database for review and confirmation along with a second ECG showing STEMI, then the date and time of the second (diagnostic) ECG are used as the "door" or "clock start" time to calculate DTB time.

Quarter Ending	Number of STEMI Patients* Transferred Receiving Primary PCI	Transfer Patients with DTB Time < 120 Minutes	Median DTB Time for Transfer Patients
3/31/13	2	1	123.5
6/30/13	3	3	112
9/30/13	2	2	100.5
12/31/13	5	4	112
3/31/14	6	4	112
6/30/14	3	2	102

Note: STEMI patients refers to both STEMI patients and STEMI equivalent patients, as defined in the NCDR CathPCI Data Registry. DTB time is the difference in minutes between the patient's arrival in the hospital emergency room and the time-of insertion of the first device (usually a balloon-type device, but occasionally a thrombectomy device). Exceptions to this calculation method most commonly occur when the patient arrives with a *history* of chest discomfort but a normal or non-diagnostic initial electrocardiogram (ECG). *If and only if* the first ECG is normal/non-diagnostic *and* is noted in the NCDR CathPCI Registry database for review and confirmation along with a second ECG showing STEMI, then the date and time of the second (diagnostic) ECG are used as the "door" or "clock start" time to calculate DTB time.

Q22. Is the hospital meeting the door-to-balloon (DTB) time requirements in its provision of primary PCI for the time period following the hospital's last primary PCI waiver renewal through June 30, 2014?

Yes No

If no, for each quarter in which the hospital did not meet the DTB time standard, please identify the DTB time for each case that had excessive DTB time and list the reason(s) for the excessive DTB time for each case. In addition, please explain what steps the hospital is taking to assure that it will meet the primary PCI requirements in the future.

See Appendix E- Q1 2014 patients who exceeded 90 minute door-to-balloon time

Eight of the ten patients experienced issues that created delays that can be deemed unavoidable, for which there are no steps to take. These are:

- Four patients undergoing cardiopulmonary resuscitation prior to moving to the Cath Lab
- One patient in respiratory distress who required intubation prior to moving to the Cath Lab
- One patient in V-tach who had to be cardioverted before being taken to the Cath Lab
- One patient with tortuous anatomy and with difficulty crossing the lesion.
- On two occasions, two patients arrived at the same time as another STEMI patient and therefore had to wait, for which we followed our written policy on multiple STEMI patients arriving at the same time. One of these two was the patient in respiratory distress, described above, so this particular patient had two issues that created a delay in DTB time.

Two patients had delays that we are working to avoid in the future. The first patient arrived when there were patients on the tables in each of the two labs. This is not always an avoidable issue, but in this particular circumstance, there were two procedures with prolonged case times. One patient was having a biventricular implantable cardioverter defibrillator implanted in the Cath Lab. This is slated as a 4 hour procedure. At the same time, in the Angio Lab, another patient was undergoing an Abdominal Aortic Aneurysm repair, which is a 3 hour procedure. Once these procedures are started, they cannot be stopped. This is problematic if a STEMI patient arrives. We are working to assure that only one extended timeframe procedure is being done in either Lab at a given time. With a procedure with an extended timeframe occurring in only one Lab at a time, with a shorter patient procedure in the other, we can complete the shorter procedure and provide a quicker turn-around time to make the lab available for the care of the STEMI patient.

The second patient had a delay secondary to the patient not being moved from the ED to the Cath Lab as quickly and efficiently as possible. This issue has been addressed with our on-call staff. The first two call team members to arrive are responsible for preparing the Cath Lab. The third to arrive will go to the ED and work with the ED staff to assure the patient is ready and available to move as soon as it is deemed appropriate. The fourth prepares paperwork and assists where needed. This has already worked to save valuable minutes, especially in cases like this, where the DTB time was 91 minutes.

We have also focused on a 30 minute turn-around time (from arrival in the ED to leaving the ED) for patients who present at UM Harford Memorial Hospital, which has contributed to our improving transfer door-to-balloon times. Our biggest challenge continues to be identification of the STEMI patient who presents with signs and symptoms that are obscure and difficult to diagnose quickly.

(10) The hospital president or Chief Executive Officer, as applicable, shall provide a written commitment stating the hospital administration will support the program.

Q23. Submit a letter of commitment, signed by the hospital chief executive officer, indicating that the hospital will provide primary PCI services in accord with the requirements for primary PCI programs established by the Maryland Health Care Commission.

See Appendix F- Letter of support to provide primary PCI in accord with MHCC requirements

(11) The hospital shall maintain the dedicated staff necessary for data collection, management, reporting, and coordination with institutional quality improvement efforts.

Q24. Please list each position responsible for these activities for primary PCI services and the FTEs devoted to these activities.

1. The STEMI/Stroke Data Coordinator position was created to collect STEMI patient data and to report this data via data entry into the NCDR databases (CathPCI and ACTION registries). Currently, this position dedicates 0.7 FTE to the STEMI program. The Data Coordinator reports information monthly to the STEMI Process Action Team and leads the weekly STEMI huddles in which each STEMI case is reviewed and discussed in depth to determine timelines and actions necessary to improve DTB time. She also interacts with MIEMSS on data and quality concerns.
2. Quality Health Information Management maintains portions of their staff to collect and report quality data (CORE measures) to the hospital and to external quality organizations. Approximately 0.2 FTE equivalents are dedicated to this effort.
3. The Clinical Manager of the Cardiac Catheterization and Interventional Angiography Labs devotes approximately 0.2 FTE to lead the STEMI Process Action Team (PAT) meeting; to attend and contribute to the weekly STEMI huddle meetings; to review findings, develop improvement plans, and share these with the Cath Lab staff; to review all data along with the Data Coordinator prior to final submission to NCDR. The Clinical Manager also provides clinical oversight of the Lab and assures appropriate reporting and efforts related to quality improvement.
4. The nurses who work in the Cath Lab assist in data collection for the NCDR as they can. Approximately 0.05 FTEs are dedicated to this effort.

(12) A hospital shall develop and complete a PCI development plan that includes an on-call coverage back-up plan for primary PCI cases, when an on-call interventionalist covers more than one hospital on a given shift, as well as when two simultaneous STEMI patients present at the hospital.

Q25. Please submit a copy of the applicable policies and procedures. If simultaneous on-call coverage is not permitted, please state this.

See Appendix G- Cardiac Catheterization (STEMI) and Interventional Angiography Laboratories On-Call Process policy, On-call Responsibilities for Emergency Department, Hospital Departments and In-patient Units Requiring Specialty Consultation policy and Multiple STEMI Patients Arriving in the Cardiac Catheterization Laboratory Procedure policy.

(13) The hospital shall design and implement a formal continuing medical education program for staff, particularly the cardiac catheterization laboratory and coronary care unit.

Q26. Please provide a list of continuing educational activities in which staff in the CCL and the Coronary Care Unit participated, from the time last reported in the hospital's most recent waiver renewal through June 30, 2014.

See Appendix H- Continuing education activities of Cardiac Cath Lab and Coronary Care Unit (ICU) staff

(14) The hospital shall maintain a formal and properly executed written agreement with a tertiary care center that provides for the unconditional transfer of each non-primary PCI patient who requires additional care, including emergent or non-primary cardiac surgery or PCI, from the applicant hospital to the tertiary institution.

Q27. Does the hospital have a current signed and dated agreement with a tertiary care center that provides for the unconditional transfer of primary PCI patients from the applicant hospital to the tertiary institution and that covers the transfer of each non-primary PCI patient who requires additional care, including emergent or non-primary cardiac surgery or PCI?
Yes ___ No X

If yes, please provide a copy. If no, provide either a new agreement or a signed and dated amendment to an existing agreement.

See Appendix I- Letter of affirmation of the continuation of the transfer agreement between UM UCMC and UMMC

(15) A hospital shall maintain its agreement with an advanced cardiac support emergency medical services provider that guarantees arrival of the air or ground ambulance at the applicant hospital within 30 minutes of a request for non-primary PCI patient transport by the applicant.

Q28. Does the hospital's signed and dated formal written agreement with a currently licensed advanced cardiac support emergency medical services provider guarantee the arrival of an air or ground ambulance at the applicant hospital within 30 minutes of a request from that hospital for the transport of an npPCI patient to a tertiary care center? Yes ___ No X

If yes, please provide a copy. If no, provide either a new agreement or a signed and dated amendment to an existing agreement with a currently licensed advanced cardiac support emergency medical services provider that provides such a guarantee.

See Appendix J- Letter of affirmation of the continuation of the transport agreement between UM UCMC and UM ExpressCare

(16) A hospital shall develop a formal, regularly scheduled (meetings at least every other month) interventional case review that requires attendance by interventionalists and other physicians, nurses, and technicians who care for primary PCI patients.

meetings.

See Pages 17-20- Form C: Cardiac Cath Lab Case Review

(17) A hospital shall create a multiple care area group (emergency department, coronary care unit, and cardiac catheterization laboratory) that includes, at a minimum, the physician and nursing leadership of each care area and meets monthly to review any and all issues related to the primary PCI system, identify problem areas, and develop solutions.

Q30. Please use Form D to report attendance at the multiple care area group meetings.

See pages 21-22- Form D: STEMI Process Action Team attendance

(18) Each physician who performs primary PCI services at a hospital that provides primary PCI without on-site cardiac surgery shall achieve an average annual case volume of 50 or more PCI cases over a two-year period.

Q31. Please use Form E to report individual physician volumes for the previous two years.

See pages 23-26- Form E: Physician PCI volumes

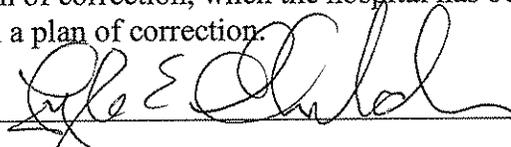
Section E – Applicant Affidavit

I solemnly affirm under penalties of perjury that the contents of this application, including all attachments, are true and correct to the best of my knowledge, information, and belief. I understand that if any of the facts, statements, or representations made in this application change, the hospital is required to notify the Commission in writing.

If the Commission issues a Certificate of Conformance to permit the hospital to perform npPCI procedures, the hospital agrees to timely collect and report complete and accurate data as specified by the Commission. I further affirm that this application for a Certificate of Conformance to perform non-primary percutaneous coronary intervention has been duly authorized by the governing body of the applicant hospital, and that the hospital will comply with the terms and conditions of the Certificate of Conformance and other applicable State requirements.

I acknowledge that the hospital shall agree to voluntarily relinquish its authority to provide elective PCI services if it fails to meet the applicable standards for a Certificate of Conformance or performance standards included in a plan of correction, when the hospital has been given an opportunity to correct deficiencies through a plan of correction.

Signature of Hospital-designated Official



Printed Name of Hospital-designated Official Lyle E. Sheldon, FACHE

Title: President/CEO

Date: 9-3-2014

Form B: REVENUES AND EXPENSES – Percutaneous Coronary Intervention Services

INSTRUCTIONS: Specify whether data are for calendar year or fiscal year. All projected revenue and expense figures should be presented in current dollars. Specify sources of non-operating income. This table must be accompanied by a statement of all assumptions used in projecting all revenues and expenses. Please assure that the revenue and expenses figures in this table are consistent with the historic and project utilization of PCI services at the applicant hospital and the information on staffing of this service provided elsewhere in this application.

	Two Most Actual Ended Recent Years		Current Year Projected	Projected Years (ending with third full year in which the applicant projects provision of npPCI services)			
	2012	2013		2014	2015	2016	2017
1. Revenue							
a. Inpatient Services	\$ 2,526,436	\$ 2,639,560	\$ 2,639,560	\$ 2,828,100	\$ 2,900,349	\$ 2,914,074	\$ 2,931,231
b. Outpatient Services	\$ 56,562	\$ 18,854	\$ 18,854	\$ 1,885,400	\$ 2,605,019	\$ 2,742,126	\$ 2,913,509
c. Gross Patient Services Revenues	\$ 2,582,998	\$ 2,658,414	\$ 2,658,414	\$ 4,713,500	\$ 5,505,368	\$ 5,656,200	\$ 5,844,740
2. Adjustments to Revenue							
d. Allowance for Bad Debt (6%)	\$ 154,980	\$ 159,505	\$ 159,505	\$ 282,810	\$ 330,322	\$ 339,372	\$ 350,684
e. Contractual Allowance (6%)	\$ 154,980	\$ 159,505	\$ 159,505	\$ 282,810	\$ 330,322	\$ 339,372	\$ 350,684
f. Charity Care (3%)	\$ 77,490	\$ 79,752	\$ 79,752	\$ 141,405	\$ 165,161	\$ 169,686	\$ 175,342
g. Net Patient Services Revenue	\$ 2,195,548	\$ 2,259,652	\$ 2,259,652	\$ 4,006,475	\$ 4,679,563	\$ 4,807,770	\$ 4,968,029
h. Other Operating Revenues (Specify)							
i. Net Operating Revenue	\$ 2,195,548	\$ 2,259,652	\$ 2,259,652	\$ 4,006,475	\$ 4,679,563	\$ 4,807,770	\$ 4,968,029

2. Expenses										
a. Salaries, Wages, and Professional Fees, (including fringe benefits)	\$ 140,294	\$ 138,257	\$ 138,257	\$ 338,926	\$ 575,305	\$ 575,305	\$ 575,305	\$ 575,305	\$ 575,305	\$ 575,305
b. Contractual Services	\$ 46,765	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086	\$ 46,086
c. Interest on Current Debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
d. Interest on Project Debt	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Current Depreciation	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637	\$ 4,637
f. Project Depreciation										
g. Current Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
h. Project Amortization	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
i. Supplies	\$ 878,307	\$ 903,951	\$ 903,951	\$ 1,602,750	\$ 1,872,012	\$ 1,923,300	\$ 1,923,300	\$ 1,923,300	\$ 1,923,300	\$ 1,987,410
j. Other Expenses (Specify)										
k. Total Operating Expenses	\$ 1,070,003	\$ 1,092,931	\$ 1,092,931	\$ 1,992,399	\$ 2,498,040	\$ 2,549,328	\$ 2,549,328	\$ 2,549,328	\$ 2,549,328	\$ 2,613,438
3. Income										
a. Income from Operation	\$ 1,125,545	\$ 1,166,721	\$ 1,166,721	\$ 2,014,076	\$ 2,181,523	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,354,591
b. Non-Operating Income										
c. Subtotal	\$ 1,125,545	\$ 1,166,721	\$ 1,166,721	\$ 2,014,076	\$ 2,181,523	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,354,591
d. Income Taxes	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -	\$ -
e. Net Income (Loss)	\$ 1,125,545	\$ 1,166,721	\$ 1,166,721	\$ 2,014,076	\$ 2,181,523	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,258,442	\$ 2,354,591

4. Patient Mix:						
A. Percent of Total Revenue						
1) Medicare	36%	29%	29%	29%	29%	29%
2) Medicaid	11%	4%	4%	4%	4%	4%
3) Blue Cross	13%	10%	10%	10%	10%	10%
4) Commercial Insurance	17%	19%	19%	19%	19%	19%
5) Self-Pay	2%	6%	6%	6%	6%	6%
6) Other (Specify)	21%	32%	32%	32%	32%	32%
7) TOTAL	100%	100%	100%	100%	100%	100%
B. Percent of PCI Cases (as applicable)						
1) Medicare	36%	28%	28%	28%	28%	28%
2) Medicaid	7%	6%	6%	6%	6%	6%
3) Blue Cross	15%	13%	13%	13%	13%	13%
4) Commercial Insurance	20%	22%	22%	22%	22%	22%
5) Self-Pay	2%	7%	7%	7%	7%	7%
6) Other	20%	23%	24%	24%	24%	24%
7) TOTAL	100%	100%	100%	100%	100%	100%

Assumptions:

1. Revenue - reported at charge per case however, this revenue will be part of a GBR reallocation within UMMS affiliated hospitals
2. Allowance for Bad Debt based upon CY 2014 experience at 6%
3. Contractual Allowance based upon CY 2014 experience at 6%
4. Charity Care based upon CY 2014 experience at 3%
5. No capital expense is anticipated to be needed to accommodate the additional npPCI cases needed to meet the volume requirement of 200 cases
6. Other payers include Champus, Workers Comp, HMO

Form C. Identify all physicians, nurses, technicians, and other staff who participated in formal, regularly scheduled cardiac catheterization case review meetings. Provide the dates and staff attendance at all formal case review meetings during the period from the hospital's last waiver renewal application, until June 30, 2014.

Name and Credential	Title	Date of Cardiac Catheterization Laboratory Case Review - 2013																
		1/30	2/4	2/6	2/14	2/21	3/26	5/9	6/20	7/2	8/8	9/17	9/19	10/2	10/7	10/14	11/6	
Physicians																		
Michael Drossner, MD	Medical Director	X		X	X					X								X
Martin Albornoz, MD	Interventional Cardiologist		X															X
Raymond Plack, MD	Interventional Cardiologist						X		X									
Matthew Voss, MD	Interventional Cardiologist					X								X				X
Nurses																		
Beth Barron	RN			X					X									
Sue Blackstock	RN				X													
Greg Boor	RN													X				
Jen Ferguson	RN			X											X			
Cheryl Foxwell	RN		X								X				X			
Anne Marie Hoke	BSN						X								X			
Derek Ogle	BSN	X														X		

Name and Credential	Title	Date of Cardiac Catheterization Laboratory Case Review - 2014												
		1/14	1/16	1/21	1/31	2/17	3/4	4/1	4/9	4/21	5/16	6/3	6/11	6/16
Physicians														
Michael Drossner, MD	Medical Director	X		X	X		X					X		
Martin Albornoz, MD	Interventional Cardiologist										X			
Raymond Plack, MD	Interventional Cardiologist		X											
Matthew Voss, MD	Interventional Cardiologist					X			X	X	X			X
Nurses														
Beth Barron	RN			X										X
Susan Blackstock	RN													
Greg Boor	RN	X	X											
Jen Ferguson	RN						X							
Cheryl Foxwell	RN		X				X				X			
Anne Marie Hoke	BSN					X				X				
Derek Ogle	BSN		X			X								
Mindy Potts	RN					X				X				
Andrea Sonntag	RN								X					
Keith Trimble	BSN									X				
Technologists														
Diane Durm, Manager	RT(R)(CV)								X					
Jenn Beam	RT(R)(CI)								X					X
Anita Cregghan	RT(R)												X	
Jess Landon	RT(R)	X												X
Will Ford	RT(R)					X						X		
Kim Hensler	RT(R)				X									

Form D. Identify all physicians, nurses, technicians, and other staff who participated in formal, regularly scheduled multiple area care group meetings (STEMI Process Action Team). Provide the dates and staff attendance at all formal case review meetings during the period from the hospital's last waiver renewal application, until June 30, 2014.

Name and Credential	Title	12912	011613	022013	032013	041713	051513	071713	082113	91813	101613	112013	121813	11514	21914	31914	41614	52114	6181.
Physicians																			
Michael Drossner, MD	Director, Cath Lab	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Steven Bentman, MD	Emergency Medicine	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Vivek Dhiruva, DO	Director, Echo Lab	X	X	X	X			X			X	X	X				X	X	
Timothy Chismar, MD	Em Medicine; Asst Med Dir,Harford Cnty Vol Fire & EMS; MIEMSS Reg III Med Director														X				
Michael Drossner, MD	Director, Cath Lab	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X
Nurses																			
Nancy Pilkenton, RN	Quality Management Specialist	X	X	X		X			X					X	X		X	X	X
Sue Cameron, RN	STEMI Data Coordinator	X	X	X	X	X	X	X	X	X			X	X	X	X	X	X	X
Laura Stewart, RN	Director, ED HMH						X	X		X			X						
Jerry Creighton, RN	Director, ED UCMC	X	X	X	X	X	X	X	X	X			X	X		X		X	X
Dennis Campbell	UCMC ED CN Mgr													X		X			
Suzie McHugh, RN	Nurse Manager, ICU	X	X	X		X	X	X											X
Meg Schmitzlein, RN	Nursing Educator	X			X	X	X	X	X		X	X	X	X	X		X	X	X
Beth Barron, RN	Cardiovascular Specialist																	X	
Claudia Coggins, RN	Maryland ExpressCare						X		X				X	X	X	X			
Michelle Preston, RN	HMH ED CN Mgr	X	X	X	X	X	X		X	X					X	X	X	X	X
Kelly Lambert, RN	HMH ED CN Mgr														X	X	X	X	X
Tina Simmons, RN	Quality Manager	X	X	X	X	X	X	X	X		X	X	X	X	X		X	X	X
Christine Pappas, RN	Nursing Educator		X							X		X	X	X		X	X	X	X
Jennifer Price, RN	Hart to Heart Ambo									X	X	X	X	X	X		X	X	X
Denise Deel, RN	Administrative Coordinator									X					X	X	X	X	X
Joan Chapman, RN	HMH, Educator										X	X	X	X	X		X	X	X
Judy Saghy, RN	QHIM		X			X	X				X	X	X	X					X

name and Credential	Title	12912	11613	022013	032013	471713	51513	71713	82113	91813	101613	112013	121813	11514	21914	31914	41614	52114	61814
Technicians																			
Jiane Durr, R.T(R)(CV)	Clinical Manager CCL	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X
Jenn Garrett, RT	Cardiovascular Specialist		X							X									
Other																			
Mark Lewis	Director, HV Institute	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X
Barb Hillman	Director, Cardiac Rehab			X															
Linda Dousa	Harford County EMS	X	X	X	X			X		X	X	X	X		X	X	X	X	X
Bill Dousa	Harford County EMS	X	X	X	X			X		X			X		X		X		X
Katie Schuler	Hart to Heart Ambo																		
Jason Skidmore	Hart to Heart Ambo		X																
Steve Adelsberger	Baltimore County EMS		X																
Andrea Frank	Hart to Heart Ambo																		
Mark Kane	Hart to Heart Ambo								X										X
Amy Hoffman	AC, HMH										X	X							
Michelle Westerman	ExpressCare	X	X	X	X														
Diane Flint	Hart to Heart Ambo			X		X													

Form E. Please use this form to identify for each physician and quarter the volume of primary and non-primary PCI cases performed by the physician.

Interventionalist: Michael Drossner, MD

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
March, 2013	23	0	23	1	32	33	56
June, 2013	14	0	14	2	35	37	51
September, 2013	12	0	12	0	23	23	35
December, 2013	13	0	13	1	36	37	50
March, 2014	30	0	30	0	36	36	66
June, 2014	11	0	11	2	34	36	47

Source of Data:

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 8/29/14

Signature of Physician: Michael N. Drossner

Form E. Please use this form to identify for each physician and quarter the volume of primary and non-primary PCI cases performed by the physician.

Interventionalist Raymond Plack, MD

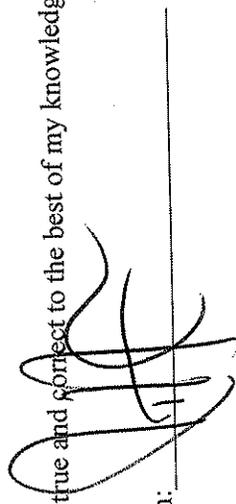
Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
March, 2013	7	0	7	2	49	51	58
June, 2013	8	0	8	9	35	44	52
September, 2013	6	0	6	7	37	44	50
December, 2013	7	0	7	8	54	62	69
March, 2014	7	0	7	7	34	41	48
June, 2014	9	0	9	4	31	35	44

Source of Data:

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 9/3/14



Signature of Physician: _____

Form E. Please use this form to identify for each physician and quarter the volume of primary and non-primary PCI cases performed by the physician.

Interventionalist Martin Albornoz, MD

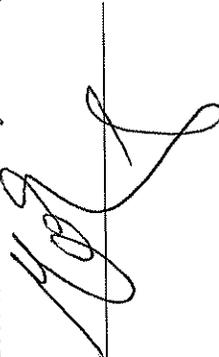
Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
March, 2013	3	0	3	22	47	69	72
June, 2013	5	0	5	20	56	76	81
September, 2013	7	0	7	21	51	72	79
December, 2013	4	0	4	16	48	64	68
March, 2014	1	0	1	17	40	57	58
June, 2014	11	0	11	14	44	58	69

Source of Data:

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 2/3/14

Signature of Physician: 

Form E. Please use this form to identify for each physician and quarter the volume of primary and non-primary PCI cases performed by the physician.

Interventionalist Matthew Voss, MD

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases- All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
March, 2013	3	0	3	6	24	30	33
June, 2013	11	0	11	18	26	44	55
September, 2013	3	0	3	6	33	39	42
December, 2013	10	0	10	5	35	38	48
March, 2014	5	0	5	8	30	38	43
June, 2014	8	0	8	4	31	35	43

Source of Data:

Affidavit

I solemnly affirm under penalties of perjury that the information contained in the above table is true and correct to the best of my knowledge, information, and belief.

Date: 9/3/14



Signature of Physician: _____

Appendix A

Communication of Hospital Charges policy



Upper Chesapeake Health

Subject: Communication of Hospital Charges

Origin Date: 3/1/13

Approved by: _____

Joseph E. Hoffman, III, Exe. VP/CFO

Board of Directors:

To ensure transparency in procedure pricing and accessibility to current charge rates.

Policy

Upper Chesapeake Health System (UCH) shall publicly disclose, on a continuous basis, prices for services and procedures in accordance with State Regulations. Communication of hospital charges requires that current charge prices are accessible to the public either via direct inquiry to hospital staff or the hospital website. A representative list of hospital procedure prices is readily available to the public on the Upper Chesapeake Health (UCH) website (<http://www.uchs.org/pdfs/Visitors/Chargesheet>). The list includes the average price for admitted patients as well, as outpatient diagnostic services.

Description

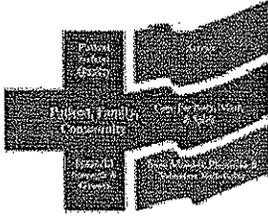
The Communication of Hospital Charges policy ensures the data base containing supplies, diagnostic procedures and medications used in patient care is current and is available to patients who inquire about hospital procedure and service prices. The policy also ensures that hospital staff are educated and properly trained on the communication of charge rates to the public. The public can contact hospital personnel to inquire about charge rates at 443 643-1663 or search the UCH website for a list of the charge rates for services and procedures provided by UCH. Requests for estimates of hospital procedures are provided within two business days of receiving the request.

Maintenance Procedures

- a. The policy requires reimbursement staff to continually update, at least quarterly, the website list of services and procedures with any changes in charge rates. Either the Director of Reimbursement or Manager of Reimbursement will update the list of services and procedures in the Charge Dictionary Master (CDM) and provide this list to the Marketing Department. The Marketing Department is responsible for the upload of the list of charge rates onto the website.
- b. Public inquiries regarding charge rates for services and procedures are directed to either the Director of Reimbursement or Manager of Cost Reporting and Regulatory Compliance with the expectation that inquiries are responded to within twenty four hours; however, patients are asked to allow for up to two days depending on the nature of the request. In some cases an estimate of the procedure price is provided. When an estimate is provided hospital staff should inform the inquirer that the estimate is based on historical data and can vary significantly depending on the outcome of the patient's procedure.
- c. Questions regarding pricing and relevant codes used in the development of the charge rates are forwarded to the Director of Reimbursement with the expectation of a response within twenty four hours. If the Director of Reimbursement is unavailable, the Manager of Reimbursement and Regulatory Compliance follows up on the inquiry.
- d. The public is asked to contact the Health Services Cost Review Commission (HSCRC) if there is a dispute or a question regarding the accuracy of the charge rates quoted or listed on the website that cannot be resolved by hospital staff.

Appendix B

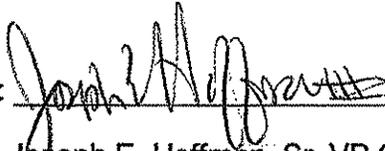
Financial Assistance policy



Upper Chesapeake Health
Subject: Financial Assistance Policy

Effective Date: 01/2013

Approved by:


Joseph E. Hoffman, Sr. VP CFO

Board of Directors

To provide financial relief to patients unable to meet their financial obligation to Upper Chesapeake Health.

1. Policy

- a. This policy applies to Upper Chesapeake Health (UCH). UCH is committed to providing financial assistance to persons who have health care needs and are uninsured, underinsured, ineligible for a government program, or otherwise unable to pay, for medically necessary care based on their individual financial situation.
- b. It is the policy of UCH to provide Financial Assistance (FA) based on indigence or high medical expenses (Medical Financial Hardship program) for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for FA should be made, the criteria for eligibility, and the steps for processing applications.
- c. UCH will post notices of availability at appropriate intake locations as well as the Patient Accounting Office. Notice of availability will also be sent to patients on patient bills. Signs will be posted in key patient access areas. A Patient Billing and Financial Assistance Information Sheet will be provided before discharge and will be available to all patients upon request. A written estimate of total charges, excluding the emergency department, will be available to all patients upon request.
- d. FA may be extended when a review of a patient's individual financial circumstances has been conducted and documented. This may include a

- review of the patient's existing medical expenses and obligations, including any accounts having gone to bad debt.
- e. Patients applying for FA up to 2 years after the service date who have made account payment(s) greater than \$25 are eligible for refund consideration
 - i. Collector notes, and any other relevant information, are deliberated as part of the final refund decision; in general refunds are issued based on when the patient was determined unable to pay compared to when the payments were made
 - ii. Patients documented as uncooperative within 30 days after initiation of a financial assistance application are ineligible for a refund
 - f. UCH retains the right in its sole discretion to determine a patient's ability to pay. All patients presenting for emergency services will be treated regardless of their ability to pay.

2. Program Eligibility

- a. Consistent with our mission to deliver compassionate and high quality healthcare services and to advocate for those who do not have the means to pay for medically necessary care, UCH strives to ensure that the financial capacity of people who need health care services does not prevent them from seeking or receiving care. To further the UCH commitment to our mission to provide healthcare to the surrounding community, UCH reserves the right to grant financial assistance without formal application being made by our patients.
- b. Specific exclusions to coverage under the FA program include the following:
 - i. Physician charges are excluded from UCH's FA policy. Patients who wish to pursue FA for physician related bills must contact the physician directly
 - ii. Generally, the FA program is not available to cover services that are 100% denied by a patient's insurance company; however, exceptions may be made on a case by case basis considering medical and programmatic implications
 - iii. Unpaid balances resulting from cosmetic or other non-medically necessary services
- c. Patients may become ineligible for FA for the following reasons:
 - i. Refusal to provide requested documentation or provide incomplete information
 - ii. Have insurance coverage through an HMO, PPO, Workers Compensation, Medicaid, Motor Vehicle or other insurance

- programs that deny access to UCH due to insurance plan restrictions/limits
- iii. Refusal to be screened for other assistance programs prior to submitting an application to the FA program
- d. Determination for Financial Assistance eligibility will be based on assets, income, and family size. Please note the following:
- i. Liquid assets greater than \$15,000 for individuals, and \$25,000 for families will disqualify the patient for 100% assistance.
 - ii. Equity of \$150,000 in a primary residence will be excluded from the calculation for determination of financial assistance; and
 - iii. Retirement assets, regardless of balance, to which the IRS has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the IRS code or nonqualified deferred compensation plans will not be used for determination of financial assistance.
 - iv. Non-citizens/non-residents may qualify for Financial Assistance for an initial visit for emergency care only as determined by the Financial Counselor/Director of Patient Accounting and/or V.P. of Finance
- e. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a FA application unless they meet Presumptive FA (see section 3 below) eligibility criteria. If a patient qualifies for COBRA coverage, the patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Senior Leadership. Individuals with the financial capacity to purchase health insurance shall be encouraged to do so, as a means of assuring access to health care services and for their overall personal health.
- f. Free medically necessary care will be awarded to patients with family income at or below 200 percent of the Federal Poverty Level (FPL).
- g. Reduced-cost, medically necessary care will be awarded to low-income patients with family income between 200 and 300 percent of the FPL
- h. If a patient requests the application be reconsidered after a denial determination made by the Financial Counselor, the Director of Patient Accounting will review the application for final determination.
- i. Payment plans can be offered for all self-pay balances by our Self Pay Vendor. Payment plans are available to uninsured patients with family income between 200 to 500 FPL.

3. Presumptive Financial Assistance

- a. Patients may also be considered for Presumptive Financial Assistance eligibility with proof of enrollment in one of the programs listed below. There are instances when a patient may appear eligible for FA, but there is no FA form on file. Often there is adequate information provided by the patient or through other sources, which could provide sufficient evidence to provide the patient with FA. In the event there is no evidence to support a patient's eligibility for FA, UCH reserves the right to use outside agencies or information in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is a 100-percent write-off of the account balance. Presumptive FA eligibility shall only cover the patient's specific date of service. Presumptive eligibility may be determined on the basis of individual life circumstances that may include:
- i. Active Medical Assistance pharmacy coverage
 - ii. Special Low Income Medicare Beneficiary (SLMB) coverage (covers Medicare Part B premiums)
 - iii. Primary Adult Care coverage (PAC)
 - iv. Homelessness
 - v. Medical Assistance and Medicaid Managed Care patients for services provided in the ED beyond coverage of these programs
 - vi. Maryland Public Health System Emergency Petition (EP) patients (balance after insurance)
 - vii. Participation in Women, Infants and Children Program (WIC)
 - viii. Supplemental Nutritional Assistance Program (SNAP)
 - ix. Eligibility for other state or local assistance programs
 - x. Deceased with no known estate
 - xi. Determined to meet eligibility criteria established under former State Only Medical Assistance Program
 - xii. Households with children in the free or reduced lunch program
 - xiii. Low-income household Energy Assistance Program
 - xiv. Self-Administered Drugs (in the outpatient environment only)
 - xv. Medical Assistance Spenddown amounts
- b. Specific services or criteria that are ineligible for Presumptive FA include:
- i. Purely elective procedures (e.g. cosmetic procedures) are not covered under the program
 - ii. Uninsured patients seen in the ED under EP will not be considered under the presumptive FA program until the Maryland Medicaid Psych program has been billed

4. Procedures

- a. The Financial Counselor will complete an eligibility check with the Medicaid program to verify whether the patient has current coverage
- b. The Financial Counselor will consult via phone or meet with patients who request FA to determine if they meet preliminary criteria for assistance.
 - i. To facilitate this process each applicant must provide information about family size and income. To help applicants complete the process, we will provide an application that will let them know what paperwork is required for a final determination of eligibility
 - ii. All applications will be tracked and after eligibility is determined, a letter of final determination will be submitted to the patient
 - iii. Patients will have fifteen days to submit required documentation to be considered for eligibility. The patient may re-apply to the program and initiate a new case if the original timeline is not adhered to
- c. There will be one application process for UCH. The patient is required to provide a completed FA application. In addition, the following may be required:
 - i. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return)
 - ii. Proof of disability income (if applicable)
 - iii. A copy of their three most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income
 - iv. A Medical Assistance Notice of Determination (if applicable)
 - v. Proof of U.S. citizenship or lawful permanent residence status (green card)
 - vi. Reasonable proof of other declared expenses may be taken in to consideration
 - vii. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc.
 - viii. A Verification of No Income Letter (if there is no evidence of income)
 - ix. Three most recent bank statements
- d. A patient can qualify for FA either through lack of sufficient income, insurance or catastrophic medical expenses. Within two (2) business days following a patient's request for Financial Assistance, application for Medical Assistance, or both, the hospital will make a determination of probable eligibility. Completed applications will be forwarded to the

- Director of Patient Accounting who will determine approval for adjustments up to \$10,000. Adjustments of \$10,000 or greater will be forwarded to the V.P. of Finance for an additional approval.
- e. Once a patient is approved for FA, eligibility will be extended to the following accounts:
 - i. All accounts in an FB (Final Billed) status
 - ii. All accounts in a BD (Bad Debt) status that were transferred within one year of the service date of the oldest FB account being adjusted using the current application
 - iii. All future visits within 6 months of the application date
 - f. Social Security beneficiaries with lifelong disabilities may become eligible for FA indefinitely and may not need to reapply
 - g. UCH does not report debts owed to credit reporting agencies.
 - h. Based on the following criteria, UCH reserves the right to place a lien on a patients income, residence, and/or automobile;
 - i. Account is greater than \$10,000
 - ii. Account/s is/are in Bad Debt
 - iii. Account/s greater than 120 days old (from date of final bill)
 - iv. Based on information submitted, patient has ability to pay debt

5. Financial Hardship

- a. Financial Hardship is a separate, supplemental determination of Financial Assistance and may be available for patients who otherwise do not qualify for Financial Assistance under the primary guidelines of this policy
- b. Financial Hardship Assistance is defined as facility charges incurred at UCH owned hospitals or physician practices for medically necessary treatment by a family household that exceeds 25% of the family's annual income. Family annual income must be less than 500% of the Federal Poverty Limit
- c. Once a patient is approved for Financial Hardship Assistance, coverage may be effective starting with the first qualifying date of service and the following twelve (12) months
- d. Financial Hardship Assistance may cover the patient and the immediate family members living in the same household. Each family member may be approved for the reduced cost and eligibility period for medically necessary treatment.
- e. Coverage will not apply to elective or cosmetic procedures.
- f. In order to continue in the program after the expiration of an eligibility period, each patient (family member) must reapply to be considered.

- g. Patients who have been approved for the program should inform UCH of any changes in income, assets, expenses or family (household) status within 30 days of such changes
- h. All other eligibility, ineligibility and procedures for the primary Financial Assistance program criteria apply for the Financial Hardship Assistance, unless otherwise stated

DEVELOPER:

Patient Financial Counselor, UCH

Reviewed / Revised: 12/2012

ORIGIN DATE: 10/2010

NEXT REVIEW DATE: 12/2014

Appendix C

Quality Measures- University of Maryland Upper Chesapeake Medical Center

Quality Measures- University of Maryland Upper Chesapeake Medical Center

Find a Quality Measure Find a Patient Experience Measure Healthcare-Associated Infections Pricing Guide About MHCC Project Philosophy Letter From The Chairman Legal Disclaimer Site Map  MARYLAND HEALTH CARE COMMISSION © Copyright Maryland Health Care Commission	Return to Previous Page					
	Quality of Care Provided to Surgeries Patients at University of Maryland Upper Chesapeake Medical Center					
	Last Updated: 6/28/2013 Measurement Timeframe: Jan 2012 - Dec 2012					
	Look at all Maryland Hospitals	Measure	Number of Cases	Hospital Performance	State Average	Highest Rate in Maryland What does it mean?
	Surgical Care Improvement Project (SCIP) Performance Over Time					
	Preventing Infection					
		Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision Why this is important	453	98%	98%	100%
		Prophylactic Antibiotic Selection for Surgical Patients Why this is important	452	99%	99%	100%
		Prophylactic Antibiotic Discontinued Within 24 Hours After Surgery End Time Why this is important	448	99%	98%	100%
		Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Blood Glucose Why this is important	N/A	N/A	95%	98%
	Surgery Patients with Appropriate Hair Removal prior to surgery Why this is important	670	100%	100%	100%	
	Urinary catheter removed on Postoperative Day 1 (POD 1) or Postoperative Day 2 (POD 2) with day of surgery being day zero Why this is important	421	95%	95%	100%	
	Surgery Patients with Perioperative Temperature Management Why this is important	666	100%	100%	100%	
Managing Heart Drugs						
	Surgery patients who received the appropriate Beta-Blocker during the perioperative period Why this is important	220	98%	97%	100%	
Preventing Blood Clots						
	Surgery patients whose doctors ordered treatments to prevent blood clots Why this is important	560	99%	99%	100%	
	Surgery patients who received treatment at the appropriate time to help prevent blood clots Why this is important	560	99%	98%	100%	
Hospitals that reported 20 or fewer cases are shown as N/A.						

Maryland Hospital Performance Evaluation Guide Hospital Guide Home Comparison Reports Find a Hospital Find a Medical Condition Find a Quality Measure Find a Patient Experience Measure Healthcare-Associated Infections Pricing Guide About MHCC Project Philosophy Letter From The Chairman Legal Disclaimer Site Map  MARYLAND HEALTH CARE COMMISSION © Copyright Maryland Health Care Commission	Hospital Guide					
	Home > Find a Hospital > Search Results					
	Return to Previous Page					
	Quality of Care Provided to Heart Conditions Patients at University of Maryland Upper Chesapeake Medical Center					
	Last Updated: 6/28/2013 Measurement Timeframe: Jan 2012 - Dec 2012					
	Look at all Maryland Hospitals	Measure	Number of Cases	Hospital Performance	State Average	Highest Rate in Maryland What does it mean?
	Heart Attack (AMI) Performance Over Time					
		Giving you aspirin when you arrive Why this is important	231	99%	99%	100%
		Giving you aspirin when you leave Why this is important	148	100%	99%	100%
		Giving the recommended medication Why this is important	N/A	N/A	98%	100%
	Giving you beta blockers when you leave Why this is important	140	100%	99%	100%	
	AMI patients whose time from hospital arrival to primary PCI is 90 minutes or less Why this is important	76	93%	92%	100%	
Heart Failure (HF) Performance Over Time						
	Giving full instructions when you leave the hospital Why this is important	258	99%	94%	100%	
	Performing the recommended heart function test Why this is important	331	100%	99%	100%	
	Giving the recommended medication Why this is important	57	100%	97%	100%	
Hospitals that reported 20 or fewer cases are shown as N/A.						

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Quality of Care Provided to Children's Asthma Care Patients at University of Maryland Upper Chesapeake Medical Center

Last Updated: 6/28/2013
Measurement Timeframe: Jan 2012 - Dec 2012

Look at all Maryland Hospitals	Measure	Number of Cases	Hospital Performance	State Average	Highest Rate in Maryland What does it mean?
Children's Asthma Care (CAC) Performance Over Time					
	Children Who Received Reliever Medication While Hospitalized for Asthma Why this is important	50	100%	100%	100%
	Children Who Received Systemic Corticosteroid Medication Why this is important	50	100%	100%	100%
	Children and their Caregivers Who Received a Home Management Plan of Care Document Why this is important	49	92%	93%	100%

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Quality of Care Provided to Immunization (IMM) Patients at University of Maryland Upper Chesapeake Medical Center

Last Updated: 6/28/2013
Measurement Timeframe: Jan 2012 - Dec 2012

Look at all Maryland Hospitals	Measure	Number of Cases	Hospital Performance	State Average	Highest Rate in Maryland What does it mean?
Immunization (IMMI) Performance Over Time					
	Pneumococcal Immunization (PPV23) Why this is important	691	97%	91%	99%
	Influenza Immunization Why this is important	549	95%	92%	99%

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Quality of Care Provided to Lung Conditions Patients at University of Maryland Upper Chesapeake Medical Center

Last Updated: 6/28/2013
Measurement Timeframe: Jan 2012 - Dec 2012

Look at all Maryland Hospitals	Measure	Number of Cases	Hospital Performance	State Average	Highest Rate in Maryland What does it mean?
Pneumonia (PN) Performance Over Time					
	Performing the recommended blood test Why this is important	359	99%	97%	100%
	Given the Most Appropriate Initial Antibiotic(s) Why this is important	215	97%	96%	100%

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Appendix D

Letter of agreement to treat suitable patients

August 18, 2014

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

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, we are submitting this agreement to commit to providing elective PCI services only for suitable patients. Suitable patients are patients described as appropriate for elective PCI in the Guidelines of the American College of Cardiology Foundation/American Heart Association/Society for Cardiovascular Angiography and Interventions (ACCF/AHA/SCAI) for Percutaneous Coronary Intervention. We also agree that any patients at high procedural risk, as described in the ACCF/AHA/SCAI Guideline for Percutaneous Coronary Intervention, are not suitable for elective PCI at this facility where we do not have on-site cardiac surgical backup and these patients will be transferred to an appropriate affiliated facility.

Thank you for your time and attention to our commitment to this standard of practice.

In Good Health,



Lyle E. Sheldon, FACHE
President/CEO

University of Maryland Upper Chesapeake Health



Michael N. Drossner, MD
Medical Director, Cardiac Catheterization Laboratory
University of Maryland Upper Chesapeake Medical Center

Appendix E

**Q1 2014 patients who exceeded 90 minute
door-to-balloon time**

Q1 2014 Patients With Door-To-Balloon Times Greater Than 90 Minutes

DATE	INITIALS	DTB	ARRIVAL	NOTES
Jan '14				
Admit				
Dischg				
01/06	bb	152	Ambo	Patient in cardiac arrest on admission. Delay secondary to CPR being administered.
01/14	eb	104	Ambo	DTB delay- Unable to cross the lesion
01/26	ge	114	Ambo	Patient in cardiac arrest on admission. Delay secondary to CPR being administered.
February '14				
01/09	rc	123	ambo	Patient in cardiac arrest on admission. Delay secondary to CPR being administered.
02/13	cw	174	ambo	Patient in ventricular tachycardia on admission. Cardioverted in ED prior to going to the Cath Lab
02/15	hs	109	ambo	Patient came into ED in respiratory distress. Intubated prior to going to the lab. Additional delay secondary to another STEMI patient already in the Cath Lab
02/19	jd	148	car	Patients in both the Cath Lab (Bi-V procedure) and in the Angio Lab (AAA procedure).
02/23	st	186	car	STEMI patient already in the Cath Lab.
March '14				
02/12	ct	91	ambo	57 minute door to table time. Delays in moving patient from ED to Cath Lab
02/28	dj	91	N/A	Chest pain on admission. V-fib arrest on the Intermediate Care Unit. Delay secondary to CPR being administered.

Appendix F

**Letter of support to provide primary PCI in accord
with MHCC requirements**

August 18, 2014

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

Dear Mr. Steffen,

As part of our application for a Certificate of Conformance, I am submitting this letter of commitment to provide the staffing and facility support necessary to maintain primary PCI services in accordance with the requirements established by the Maryland Health Care Commission.

The Primary PCI program was developed as part of our System's vision and overall strategic plan. We remain 100% committed to our program as a key component of our Cardiovascular Service Line and the critical level of care this program provides our community.

Thank you for your time and attention.

In Good Health,



Lyle H. Sheldon, FACHE
President/CEO
University of Maryland Upper Chesapeake Health

Appendix G

**Cardiac Catheterization (STEMI) and Interventional
Angiography Laboratories On-Call Process policy,
On-call Responsibilities for Emergency Department,
Hospital Departments and In-patient Units Requiring
Specialty Consultation policy and Multiple STEMI
Patients Arriving in the Cardiac Catheterization
Laboratory Procedure policy**

**UPPER CHESAPEAKE HEALTH
UPPER CHESAPEAKE MEDICAL CENTER
HEART AND VASCULAR INSTITUTE
INTERVENTIONAL ANGIOGRAPHY/CARDIAC CATHETERIZATION
LABORATORIES**

**TITLE: Cardiac Catheterization (STEMI) and Interventional Angiography
 Laboratories On-Call Process**

Approved by:

Manager, Angiography/Cardiac Cath Labs: _____

Director, Heart and Vascular Institute: _____

Vice President, Clinical Service Lines: _____

Medical Director, Cardiac Cath Labs: _____

Medical Director, Interventional Angiography: _____

Original Date: 10/10

Reviewed Date: 8/14

Revised Date: 10/12

PURPOSE

To provide guidelines to the EDs and in-patients areas that require emergent intervention during off hours between 4:00pm and 7:00am, Monday through Friday and 7:00am on Saturday through 7:00am Monday.

PROCEDURE: Cardiac Catheterization (STEMI)

- I. When a patient presents to the ED or is an in-patient and is determined to meet STEMI criteria, the following will occur:
 - A. The ED physician or intensivist will call the primary on-call Interventional Cardiologist and discuss the case. The on-call Interventional Cardiologist schedule and phone numbers can be found on the Intranet: (Departments, Heart and Vascular Institute, HVI On-call Schedules). The ED will scan the STEMI EKG to the Interventional Cardiologist upon request.
 - B. The ED charge nurse will activate the STEMI on-call page by calling 410-588-0133, and the AC will be contacted to secure an ICU bed.
 - C. The on-call team members will respond and are expected to arrive at the hospital within 30 minutes of page. A STEMI page will be activated every five minutes until all on-call team members return a call to the paged number. The manager or lead cardiovascular specialist will contact the ED to confirm who has called in. The same individual will contact the team member(s) that has not responded in an attempt to complete the four man team.
 - D. The first team member on site will call ED for patient information and request that the ED begin preparing the patient for transfer to the Cath Lab. As soon as the third team member arrives on site the ED, through the charge nurse (4042), is notified to transport the patient to the Cath Lab.

Title: Cardiac Catheterization (STEMI) and Interventional Angiography Laboratories On-Call Process

- E. Upon transfer to the Cath Lab, the ED nurse will give bedside report to the STEMI team. The patient will be discharged from the ED and be registered as a “CathU” patient. The ED nurse will deliver to the STEMI nurse a signed, timed and dated STEMI EKG and the patient chart.
- II. The Interventional Cardiologist on-call schedule will be emailed monthly and the schedule will be posted on all units including the ED. The schedule is posted on the intranet: Department, Heart and Vascular Institute, HVI on-call schedules, Cardiac Cath/Interventional Angio Lab, Interventional Cardiologist on-call (to the right of the screen).

Click on the physician name and the hours and contact number are listed. If this physician is involved in another procedure, he will inform you of the back-up physician on the schedule OR this tab will open up a calendar and the back-up physician is listed:

Interventional Cardiologist On-Call

There will always be two cardiologists available.

PROCEDURE: Interventional Angiography

- III. When a patient presents to the ED or is an inpatient and the referring physician or vascular surgeon orders a procedure, the following will occur:
 - A. **Vascular Surgeon:**
 - 1. The vascular surgeon will contact the Imaging Department at extension 2200, and request the on-call technologist contact him. The Imaging Department will contact him/her. The on-call technologist’s phone numbers can be found on the Intranet: (Departments, Cardiovascular Institute, Cardiac Cath Lab & Interventional Angiography). The accountability for the call belongs to the RT at this point. Once it is determined what is being done, the RT will contact two other team members for the case. All team members will be reached by their pager or cell phone.
 - 2. If the patient is from ICU, the patient will be returned to ICU immediately following the case. If the patient is from the ED or the floor, the patient may be returned to the unit of the physician’s request one hour post last sedation given with an Aldrete score above 7.
 - B. **Interventional Radiologist:**
 - 1. The referring physician will contact the Imaging Department at extension 2200 and request to speak to the interventional radiologist on-call. It will be the IR’s decision to call the on-call team in. He will contact Imaging at extension 2200, ask to have the technologist call him and the same will follow as in A.1 above.
 - 2. The same applies as above in B.2.
 - C. **Back-up Team:**

The Clinical Manager or designee will be contacted by one of the call team member’s about the angiography procedure. The Clinical Manager or designee

Title: Cardiac Catheterization (STEMI) and Interventional Angiography Laboratories On-Call Process

will put a 911 text page to 410-588-0133 to secure two to three additional team members for a STEMI back-up team.

UPPER CHESAPEAKE HEALTH SYSTEM
Upper Chesapeake Medical Center Harford Memorial Hospital

MEDICAL STAFF ADMINISTRATION

APPROVED BY:

Medical Executive Committee: 1/99 (FGH only), 1/00, 10/03, 04/04, 09/05, 02/09, 8/10

SUBJECT: **ON CALL RESPONSIBILITIES FOR EMERGENCY DEPARTMENT,
HOSPITAL DEPARTMENTS AND IN-PATIENTS UNITS REQUIRING
SPECIALTY CONSULTATION**

POLICY: The Chairmen of the Departments of Medicine, Surgery, Obstetrics and Gynecology, Pediatrics, Psychiatry and Anesthesiology shall provide the names of medical staff members on call for the specialties represented within their departments. It is the responsibility of all Active and Associate members of the medical staff to provide on call coverage for the Emergency Department and, if necessary in-patients requiring specialty consultation, as outlined on the attached specialty-specific grid. The members of any specialty with less than three Active staff members will be responsible for ED call no more than one-in-three days. A transfer agreement will be in place for use when specialty coverage is not available.

In order to be eligible for placement on the on-call rotation list for any Department within the Hospital, a practitioner has to meet all the requirements of the Medical Staff Bylaws/Credentialing Policy and Upper Chesapeake Health System Medical Community Development Policy, including, but not limited to, the requirements concerning the practitioner's commitment to the System Hospital and the location of the practitioner's primary office in relation to the Hospital. Use of the Medical Community Development policy criteria for such on-call eligibility is meant to promote the quality and community development aspects of on-call medical care. Active and Associate (and when deemed necessary, Courtesy) Medical Staff will become eligible for ED call after completing the credentialing process and being approved for privileges by the Board of Directors and will be added to the schedule within two months of appointment. When it is necessary for Courtesy staff to participate in the on-call schedule, additional quality monitoring will be carried out – the type and duration to be determined by the Department Chairman.

Those practitioners who have been providing on-call coverage prior to the effective date of the new on-call eligibility criteria shall be grand-fathered from the criteria, and so will not be affected by them. (The effective date is 9/16/98 for UCMC Staff and 2/1/00 for HMH Staff).

On Call Responsibilities for Emergency Department and
In-Patients Requiring Specialty Consultation
Page 2

PROCEDURE:

1. Monthly on call rosters will be developed by the Medical Staff Office in collaboration with the specialty Division Heads. The rotation will be agreed upon by the individual divisions. After approval by the Chairman of the Department, the Medical Staff Office will distribute the schedules to the appropriate departmental members. Call schedules will be developed and distributed for no more than three months at a time. Barring extraordinary circumstances, the schedule will be available at least one month prior to the start date.
2. Each specialty that is reimbursed for on-call services will have a minimum number of days that will be "volunteered" without payment.
3. All division members will be eligible for an equal number of days which will include a fair and equitable distribution of weekends and holidays per year.
4. Any member of the medical staff may request release from the call schedule for age or years of services as outlined in Article 2 of the Medical Staff Bylaws.
5. Members of the medical staff will not be required to provide on-call services on more than one UCH campus, but may request on-call at both campuses.
6. Daily on-call rosters will be distributed to the Emergency Department, Switchboard, and Nursing Office.
7. Responsibilities of the medical staff members on call shall include:
 - Responding to Emergency Department calls by phone within 30 minutes.
 - Responding to Hospital Departments and In-Patient Unit calls by phone within 30 minutes and responding in person in a timely manner to evaluate the patient, if requested by the attending physician, intensivist, hospitalist, or any physician caring for the patient who is or has been at the bedside.
 - Providing the Emergency Department (through the Medical Staff Office) with a maximum of three telephone numbers through which the practitioner can be reached.
 - Providing requested consultation in a timely manner. If there is disagreement over the necessity for admission, face-to-face evaluation of the patient, or a procedure, the on call person must come in to see the patient and determine proper disposition for the patient, or assume responsibility for the patient's care. A practitioner who is on call cannot refuse to respond. Any such refusal shall be reported immediately to the appropriate clinical department chairman, or the President of the Medical Staff in the absence of the chairman, and to the Senior Vice President for Medical Affairs on the next business day, and will then be evaluated through the medical staff review process which may end in revocation of privileges as defined in the Medical Staff Bylaws/Credentialing Policy.
 - Must provide office follow up for patients whose initial care occurred in the

On Call Responsibilities for Emergency Department and
In-Patients Requiring Specialty Consultation

Page 3

emergency department while the medical staff member was on-call, regardless of method of payment, if any, and without requirement of payment before treatment.

- Direct contact between the ED physician and the on-call physician regarding the clinical conditions that require the in-office follow up is mandatory, except for those specialties who request not to be notified.
 - Providing high quality, efficient, compassionate health care to all patients seen in, referred or admitted from the Emergency Department; attending to communication needs of patients and families.
8. The responsibility for on call coverage rests with the assigned medical staff member and should not be delegated to another except in prearranged or unforeseen, emergency situations. A medical staff member may exchange on-call responsibility with another medical staff member or defer to another similar specialist who is available. In either situation, it is the obligation of the on call person to arrange for alternate coverage by a member of the medical staff with similar privileges, and inform the Medical Staff Office and Emergency Department of the change.

If the person on call is unavailable because of the need to provide care at another facility, it is the on-call person's responsibility to find another physician or hospital to accept the patient in transfer (see Appendix I for specialties able to take call simultaneously at more than one hospital and/or specialties able to perform elective procedures while on call).

9. The ED physician is expected to make the determination as to which physician (specialist vs primary care) would be the most appropriate to admit the patient, keeping in mind the patient's best interest at all times.

Therefore, when a physician is called by the ED to admit a patient and this physician feels that the patient would be more effectively treated on another physician's service, it is up to the physician receiving the initial ED call to speak with the other physician. It is not the responsibility of the ED physician to make multiple telephone calls to see who will admit a patient. If the admitting physician and the ED physician feel urgent consultation is needed, it is expected that the ED physician, at the request of the admitting physician, will review the case with the consultant. (For example, a patient presents with GI bleed and unstable vital signs. The ED physician calls the private or on-call internist who gives admission orders. The ED physician will also call the surgeon to be on standby, if requested by the internist.)

10. In order to help facilitate throughput, medical staff members are expected to respond to ED calls immediately. If a medical staff member fails to respond within 30 minutes or more, or refuses to admit the patient, the ED physician may ask the hospitalist service to admit the patient.
11. Failure to return the ED call within 30 minutes or refusal to admit a patient when admission is recommended by the ED MD will be reported to the appropriate department chair as a departmental policy violation.

**EMERGENCY DEPARTMENT ON-CALL SPECIALTIES
EMTALA**

On-Call is not necessary for the following specialties. In-house practitioners are felt to be capable of managing emergencies:

- Endocrinology
- Hematology
- Infectious Disease
- Oncology
- Pediatrics
- Plastic Surgery
- Pulmonary Medicine
- Rheumatology

Practitioners on-call in the following specialties may be on call at only one facility and may not be involved in elective procedures due to the burden of call:

- Cardiology
- Internal Medicine/Family Practice
- Obstetrics/Gynecology*

*May only perform emergency procedures, unless in-house back-up has been arranged, and communicated to the FBP and ED.

Practitioners on call in the following specialties may simultaneously provide services in their offices, in the operating room, or at other facilities without making arrangements for back-up:

- Hand Surgery
- Ophthalmology*
- Oral Surgery
- Otolaryngology
- Psychiatry

*Since office equipment is more appropriate than ED equipment to evaluate eye emergencies, ED patients in need of eye consult will be seen by ophthalmology in the office within 24-48 hours of the ED visit. ED patients that cannot wait 24-48 hours for care will be transferred to a higher level of service.

The practitioners on call in the following specialties may simultaneously provide services in their offices, in the operating room, or at other facilities provided the on-call provider has arranged for back-up. Back up arrangements will be communicated to the ED upon request.

- Gastroenterology
- General Surgery
- Interventional Cardiology
- Nephrology
- Neurology
- Neurosurgery
- Orthopedic Surgery
- Urology
- Vascular Surgery

**UPPER CHESAPEAKE HEALTH
UPPER CHESAPEAKE MEDICAL CENTER
HEART & VASCULAR INSTITUTE
INTERVENTIONAL ANGIOGRAPHY/CARDIAC CATHETERIZATION
LABORATORIES**

**TITLE: Multiple STEMI Patients Arriving in the Cardiac Catheterization
Laboratory Procedure**

Approved by:

Manager, Angiography/Cardiac Cath Labs: _____

Director Cardiovascular Institute: _____

Vice President Clinical Services: _____

Medical Director, Cardiac Cath Labs: _____

Medical Director, Interventional Angiography: _____

Original Date: 10/10

Reviewed Date:

Revised Date: 8/14

PURPOSE

To provide guidelines to the ED and Cardiac Catheterization Laboratory (CCL) team members when caring for multiple STEMI patients simultaneously in the CCL.

PROCEDURE

- I. When multiple STEMI patients arrive in the ED simultaneously
 - A. The ED attending physician will call the primary on-call Interventional Cardiologist and discuss the cases.
 - B. The STEMI on-call page will be activated, once for each patient. This ensures the team is aware of multiple STEMI patients in route or on-site.
 - C. The on-call team will respond and are expected to arrive at the hospital within 30 minutes of page.
 - D. The Clinical Manager or designee will call the ED to assess the situation.
 - E. Upon receiving report, the Clinical Manager or designee will send out a 911 alert to the Cath Lab team members to alert the team of the potential need for additional back-up.
 - F. The ICU and the Nursing Coordinator on duty will be informed to provide adequate support for when the patients are ready to be transferred to the ICU following their procedure.
- II. Determining Patient Priority
 - A. The Interventional Cardiologist performs a STEMI procedure on the most critical patient after discussing both cases with the ED physician(s).
 - B. The remaining patient(s) will be monitored in the ED by the ED staff.
 - C. The Interventional Cardiologist performs a STEMI procedure on the second most critical patient, etc.

Title: Multiple STEMI Patients Arriving in the Cardiac Catheterization Laboratory Procedure

- D. If at any time the Interventional Cardiologist determines that a patient cannot wait for the STEMI procedure, the ED will call the back-up Interventional Cardiologist to perform the procedure.
- E. A second STEMI Cath Lab team will be called by the Clinical manager or designee.
- F. As soon as one of the team's completes their case, they are designated as the primary on-call team until all cases are completed and the original primary on-call team resumes responsibility.

Appendix H

Continuing education activities of Cardiac Catheterization Laboratory and Coronary Care Unit (ICU) staff

Cardiac Catheterization Laboratory Staff Continuing Education Activities 2013-2014

- | |
|--|
| <input type="checkbox"/> 2014 Nursing Competency - Objectives Affirmation |
| <input type="checkbox"/> 2014 Nursing Competency Transfusion |
| <input type="checkbox"/> 2014 Nursing Competency Sterile Technique-ORST, Cath
Lab Rad Tech |
| <input type="checkbox"/> 2014 Nursing Competency Restraints |
| <input type="checkbox"/> 2014 Nursing Competency Patient Safety/Core Measures |
| <input type="checkbox"/> 2014 Nursing Competency Oxygen Delivery Devices |
| <input type="checkbox"/> 2014 Nursing Competency Mock Code |
| <input type="checkbox"/> 2014 Nursing Competency Heparin Drips |
| <input type="checkbox"/> 2014 Nursing Competency EKG |
| <input type="checkbox"/> 2014 Nursing Competency Arrhythmia |
| <input type="checkbox"/> Radiation Safety Radiologic Technologist |
| <input type="checkbox"/> MOLST DNR Bracelet |
| <input type="checkbox"/> 2014 A Standards of Business Conduct |
|  Isolation Gown Inservice - O&M |
| <input type="checkbox"/> 2014 A Nursing Update for RN'S May/June |
|  S-ICD Inservice - Boston Scientific |
| <input type="checkbox"/> 2014 A Nursing Update MARCH/APRIL2014 |
|  MOCE 2014 (without APM) (Mandatory Organizational
Compliance Education) |
| <input type="checkbox"/> MOCE 2014 - Population Specific |
| <input type="checkbox"/> MOCE 2014 - Patient Safety and Communication |

Assistance

MOCE 2014 - Infection Prevention and Occupational Health

MOCE 2014 - Emergency Response, Fire and Safety

MOCE 2014 - Corporate Compliance

 Curo's Cap Inservice - Ivera Medical Corp

ACLS Renewal

2014 Annual Glucometer Competency

2014 A Curo's Caps

 2014 Annual Glucometer Skills Check List - Hands On portion

2014 A Nursing update Feb - Nurse

 Patient Safety Fair 2014 - UCH

1. Falls Prevention 2. Pediatric Safety 3. Universal Protocol 4. Medication Safety 5. EOC & SPLAT 6. Oxygen Safety 7. Core Measure 8. Infection Prevention 9. Communication

 IV Temperature Management Inservice - Zoll Medical

 Guidewires Inservice - Abbott Vascular Training

Radiation Safety Radiologic Technologist

2013 A ICD-10-CM/PCS Training "It's not just for coders"

Monthly Update - 2013 Winter Nurse

Complications of Diabetes

 3M Electrode Training Inservice - 3M

Radiation Safety - EKG

 Nursing Competencies 2013 -UCMC Interventional Angiography & Cath Lab RN

Nursing Competencies

 Eliquis Inservice - Bristol-Myers Squibb

Nursing Competencies 2013 - HMH 3 South Tele RN

Nursing Competencies 2013 - Course Group 02

 Pleurx for Abdominal Access Inservice - Carefusion

 Plasma Blade Inservice - Medtronic

Radial Artery Access

 38th Emergency Care Symposium

 Super Cross Catheters Inservice - Vascular Solutions

 Azure Coils Inservice - Terumo

 IV Temperature Management Inservice - Zoll Medical

NTM Specimen Collection, Labeling, and Requisition - UCH-02260

Atrial Fibrillation

Cardiac Medication Drips for 1 West

 Nursing Competencies 2013 -UCMC Interventional Angiography & Cath Lab RN

Medical Ethics (CE)

Fall Prevention-Nursing

ICU Staff Continuing Education Activities 2013-2014

MOLST DNR Bracelet

- 2014 A Junctional-AV Block review
- 2014 A Notification of Outpatient in Observation Status
- 2014 A Blanket Warming Modification
- 2014 A Standards of Business Conduct
- 2014 A Using evidence to reduce the risk of stroke in women
- 2014 A Certified and Primary Stroke Center: what do these designations really mean?
- 2014 A An inter-professional approach: the patient after stroke
- 2014 A Activating a stroke alert: a neurological emergency
- Skin Champion Breakfasts
-  Eliquis Inservice - Bristol Myers/Pfizer
- 2014 A Medtronic 5391 temporary pacemaker review
- 2014 A Nursing Update for RN'S May/June
-  Delirium Updates Inservice - UCH
-  Medtronics 5391 Temp Pacer Inservice - Medtronics
- 2014 A Exparel
- 2014 A Documentation Changes for Observation and Inpatients for Nurses
- 2014 Competency ON LINE High Alert Heparin Drips
- 2014 Competency ON LINE 12 Lead EKG
- 2014 Nursing Competency Transvenous Pacemaker
- 2014 Nursing Competency Transfusion

- 2014 Nursing Competency Restraints
- 2014 Nursing Competency R Series Zoll
- 2014 Nursing Competency Pleurx
- 2014 Nursing Competency Patient Safety/Core Measures
- Oxygen Delivery Devices 2011 - Nurse
- 2014 Nursing Competency Oxygen Delivery Devices
- 2014 Nursing Competency Mock Code
- 2014 Nursing Competency Heparin Drips
- 2014 Nursing Competency Falls Prevention
- 2014 Nursing Competency EKG
- 2014 Nursing Competency Chest Tubes
- 2014 Nursing Competency Arrhythmia
-  MOCE 2014 (with APM) (Mandatory Organizational Compliance Education)
- MOCE 2014 - Aggressive Patient Management
- MOCE 2014 - Population Specific
- MOCE 2014 - Patient Safety and Communication Assistance
- MOCE 2014 - Infection Prevention and Occupational Health
- MOCE 2014 - Emergency Response, Fire and Safety
- MOCE 2014 - Corporate Compliance
- 2014 A Adult Code Record
- 2014 A Oxygen Delivery Devices RN's
- 2014 A Nursing Update MARCH/APRIL2014

 Curo Cap Inservice - Ivera Medical Corp

2014 A Atrial Rhythm review

2014 A Curo Caps

 2014 Annual Glucometer Skills Check List - Hands On portion

2014 Annual Glucometer Competency

2014 A Sinus Rhythm review

2014 A The JHH Fall Risk Assessment Tool

2014 A Fall Prevention Clinical Team Member

2014 A R series Zoll

2014 A Nursing update Feb - Nurse

Enteral Feeding 2014 A ver.2

2014 A Neurotips

2014 A Modified Rankin Scale ver.2

Mechanical thrombectomy for acute ischemic stroke

Assessing for Pronator Drift

Role of Patent Foramen Ovale in stroke

Brain Attack think TPA!

Implementation of Stroke Dysphagia Screening in the Emergency department

2014 A Emergency Petitions, Voluntary involuntary

2014 A - Basic Arrhythmia Review Module-one

Enteral Feeding 2014 A

Hemodialysis order set-Acknowledging Orders 2014 A

IV drip medication orders-resuscitation events

- How To View Documentation From Another Discipline
- Improving the Discharge Transition Experience
- 2013 A. Medical Devices and Pressure ulcers
- Patient Communication Boards
- 2013 A ICD-10-CM/PCS Training "It's not just for coders"
- Monthly Update - 2013 Winter Nurse
- 2013 A. Humulin R U-500 Order Set
-  3M Electrode Training Inservice - 3M
- Peritoneal dialysis cleansing solutions
- 2013 A Room Service Education
- BARD® DIGNISHIELD® Advance Stool Management System (SMS) Patient Selection, Insertion, Care, and Maintenance
- 2013 A. Delirium Education for Nurses
- 6.07 ALERT WHEN CONFIRMED REPORT
- Skin Champion Breakfasts
- General Inpatient Hospice
-  Catheter Management with Cathflo Activase Review Inservice - Genetech
- Automated Discrepancy Policy Update
- Nurse's Survey on Discharge Planning and Teaching
- 6.07 HOME MEDICATION LIST EDUCATION
-  CCRN Review Course - Education Enterprises
-  Dignishield Fecal Management Inservice - BARD Medical
-  Pneumostat Inservice - Atrium Medical Corp.

Management of the Neuro Patient with ICP Monitoring

2013 Capnography (ETCO2) Mandatory Education

 Micromedex Inservice - Truven Health Analytics

 Nursing Competencies 2013 - UCMC 2 East RN

Nursing Competencies

Rapid Response Documentation – Emergent Event Screen

BLS for HealthCare Providers/CPR Renewal

 COPD Med Update Inservice - Glaxo-Smith-Kline

 Catheter Management with Cathflo Activase Review Inservice - Genetech

Life Vest Inservice - Zoll

 One Touch Verio Glucometer Inservice

 Tolvaptan (Samsca) Inservice - Otsuka America
Pharmaceuticals

Peritoneal dialysis cleansing solutions

Pneumostat Inservice - Atrium Medical Corp.

Zoll R Series Defibrillator Training sessions - 1 Hour Full Training

 Changes in Ostomy Care: Best Practices 2013 - Johns Hopkins
Bayview Medical Center

 Micromedex Inservice - Truven Health Analytics

Capnography - Respiratory

Moderate / Procedural Sedation

 Triadyne Bed Inservice - KCI

Radial Artery Access

Appendix I

**Letter of affirmation of the continuation of the
transfer agreement between UM UCMC and UMMC**

August 22, 2014

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

RE: Application for Elective Angioplasty

Dear Mr. Steffen:

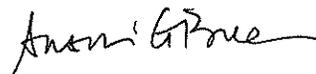
As indicated in our Application for Elective Angioplasty specifically Question 27, the University of Maryland Upper Chesapeake Medical Center (UM UCMC) has a written agreement in place with the University of Maryland Medical Center (UMMC), dated February 15, 2011, which provides for the unconditional transfer of each non-primary PCI patient who requires additional care, including emergent or non-primary cardiac surgery or PCI. UM UCMC and UMMC represent and warrant that this agreement is current and effective as of the date hereof, and have not been terminated by either party.

Please let us know if you require any additional information pertaining to either of these written agreements.

Very truly yours,



Robin Luxon
Vice President, Clinical Service Lines
UM Upper Chesapeake Health



Alison G. Brown
Senior Vice President
University of Maryland Medical Center

Appendix J

**Letter of affirmation of the continuation of the
transport agreement between UM UCMC and
UM ExpressCare**

August 22, 2014

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

RE: Application for Elective Angioplasty

Dear Mr. Steffen:

As indicated in our Application for Elective Angioplasty specifically Question 28, the University of Maryland Upper Chesapeake Medical Center (UM UCMC) has a written agreement in place with the University of Maryland ExpressCare, dated February 15, 2011, which guarantees arrival of air or ground ambulance at UM UCMC within 30 minutes of a request for non-primary PCI patient transport. UM UCMC and the University of Maryland ExpressCare represent and warrant that these agreements are current and effective as of the date hereof, and have not been terminated by either party.

Please let us know if you require any additional information pertaining to either of these written agreements.

Very truly yours,



Robin Luxon
Vice President, Clinical Service Lines
UM Upper Chesapeake Health



David G. Hunt
Vice President
Patient Access, Patient Flow & Emergency Services
University of Maryland Medical Center