MARYLAND HEALTH CARE COMMISSION

19-13-CC008

MATTER/DOCKET NO.

DATE DOCKETED

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

Applicant Information

Applicant *Howard County General Hospital (HCGH)*

Street Address *5755 Cedar Ln*

City *Columbia* County *Howard* State *MD* Zip Code *21044*

Mailing Address (if different) ____________

City ____________ County ____________ State ______ Zip Code ______

Medicare Provider Number(s) *210048* National Provider Identifier *1144291899*

Person to be contacted on matters involving this application:

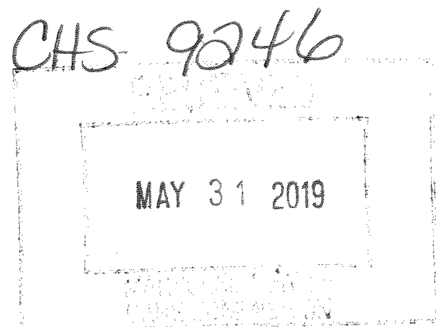
Name *John Dunn*

Title *Administrator, Diagnostic Imaging*

Address *5755 Cedar Ln*

City *Columbia* County *Howard* State *MD* Zip Code *21044*

Telephone *410-884-4549* Facsimile *410-884-4677* e-mail *jdunn5@jhmi.edu*



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.

YES, Howard County General Hospital (HCGH) is a Medicare Provider in good standing. The Medicare.gov/HospitalCompare listing for HCGH (as of 5/29/19) is below:

Medicare.gov | Hospital Compare
The Official U.S. Government Site for Medicare

Hospital Compare Home | About Hospital Compare | About the data | Resources | Help

Home → Hospital Results → Hospital Profile   Share

Select to print all information

Hospital profile

Back to Results

General information | Survey of patients' experiences | Timely & effective care | Complications & deaths | Unplanned hospital visits | Use of medical imaging | Payment & value of care

HOWARD COUNTY GENERAL HOSPITAL
5755 CEDAR LANE
COLUMBIA, MD 21044
(410) 740-7890

Overall rating: ★★★●●
Learn more about the overall ratings
View rating details

Distance: 0.8 miles

Add to My Favorites
Map and directions

General information

- Hospital type: Acute Care Hospitals
- Provides emergency services: Yes
- Participates in: Multispecialty Surgical Registry
- Able to receive lab results electronically: Not Available
- Able to track patients' lab results, tests, and referrals electronically between visits: Not Available
- Uses outpatient safe surgery checklist: Not Available
- Uses inpatient safe surgery checklist: Not Available

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.

Howard County General Hospital (HCGH) is accredited by the Joint Commission. Our accreditation history (printed from the Joint Commission website on 5/29/19) is included as Attachment A.

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.

NO, HCGH has not 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. Our accreditation history (printed from the Joint Commission website on 5/29/19) is included as Attachment A.

Q5. Has the applicant been placed on Accreditation Watch by the Joint Commission?
Yes __ No_X__ ***See Attachment A for accreditation history***

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. ***See https://www.hopkinsmedicine.org/patient_care/billing-insurance/billing/charges-fees.html.***

(b) Procedures for promptly responding to individual requests for current charges for specific services/procedures; and
Johns Hopkins Health System's policy (which covers HCGH) on responding to inquiries regarding charges for procedures is policy PFS008, and is Attachment B.

(c) Requirements for staff training to ensure that inquiries regarding charges for its services are appropriately handled.
Johns Hopkins Health System's policy (which covers HCGH) on responding to inquiries regarding charges for procedures is policy PFS008, and is Attachment B.

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.
The Johns Hopkins Health System policy (which covers HCGH) on financial assistance is policy PFS039, and it is Attachment C.

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.
Per data provided to HCGH on 5/15/19 by Brett McCone of the Maryland Hospital Association (M.H.A.), HCGH's charity care as a percentage of total operating expenses in FY18 ranked 21st out of 49 Maryland hospitals; so, it does not fall within the bottom quartile of all hospitals. Please see Attachment D for the source data from M.H.A.

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.

As of 5/29/19, there are nine measures where the *Maryland Hospital Performance Evaluation Guide* lists HCGH as "below average". They are:

1. *Consumer Ratings – Communication – How often did staff always explain about medications before giving them to patients?*
   HCGH does not fall within the bottom-quartile of all hospitals' reported performance measured for this Quality Measure. Per HCAHPS data available on the Medicare.gov website, HCGH is currently in the 62nd percentile among all Maryland hospitals on this measures (see Attachment E for details).

2. *Consumer Ratings – Communication – Were patients always given information about what to do during their recovery at home?*
   HCGH does not fall within the bottom-quartile of all hospitals' reported performance measured for this Quality Measure. Per HCAHPS data available on the Medicare.gov website, HCGH is currently in the 52nd percentile among all Maryland hospitals on this measures (see Attachment F for details).

3. *Consumer Ratings – Environment – How often did patients always receive help quickly from hospital staff?*

HCGH does not fall within the bottom-quartile of all hospitals' reported performance measured for this Quality Measure. Per HCAHPS data available on the Medicare.gov website, HCGH is currently in the 50th percentile among all Maryland hospitals on this measures (see Attachment G for details).

4. *Emergency Department – Wait Times – How long patients spent in the emergency department before leaving for their hospital room*

   HCGH has extensive efforts underway to reduce wait times in the Emergency Department. An oversight council (including the hospital's Vice President of Operations, Vice President of Medical Affairs, Emergency Department Medical Director, Emergency Department Administrative Director, and other HCGH leaders) meets regularly to ensure that appropriate interventions are being planned, implemented, reviewed and (as needed) adjusted. Among the interventions which have been completed, or are underway, are:

   - LWBS reduction
   - LOS for discharge patients – operationalize green zone
   - Sepsis bundle using TREWS
   - ED to inpatient handoff process
   - ED Front End Process (provider and nursing)
   - DVT outpatient protocol
   - Surge protocol
   - TREWS pilot
   - Restraints process improvement
   - Sedation process improvement

   Specific to *this* Quality Measure (how long patients spent in the emergency department), HCGH has:

   - implemented a blood and urine collection process in October 2018 to minimize delays related to specimen collection (October 2018).
   - implemented a new process for emergency department patients being transported to and from imaging to reduce delays (November 2018).
   - launched a software embedded in the EMR to support provider best practice and evidence based guidelines to reduce variation of tests and treatments ordered by providers (January 2019).

5. *Emergency Department – Wait Times – How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room*

   As noted in #4 above, HCGH has extensive efforts underway to reduce wait times in the Emergency Department.

   Specific to *this* Quality Measure (*How long patients spent in the emergency department after the doctor decided the patient would stay in the hospital before leaving for their hospital room*), HCGH has:

   - implemented a streamlined process for ED to inpatient nurse handoff (June 2018).
   - developed a new process for shift directors, inpatient nursing, environmental services, and transport teams to reduce the time patients spend boarding in the emergency department (January 2019). This process has been implemented in roughly half of HCGH's in-patient units so far.

6. *Emergency Department – Wait Times – How long patients spent in the emergency department before being sent home*
   As noted in #4 above, HCGH has extensive efforts underway to reduce wait times in the Emergency Department.
   Specific to *this* Quality Measure (*How long patients spent in the emergency department before being sent home*), last October HCGH operationalized a lower acuity zone with a dedicated nurse and advance practice provider in October 2018. Length of stay in this lower-acuity zone is significantly quicker than in the main emergency department.

7. *Emergency Department – Wait Times – Patients who left the emergency department without being seen*
   As noted in #4 above, HCGH has extensive efforts underway to reduce wait times in the Emergency Department.
   Specific to *this* Quality Measure (reducing the number of p*atients who left the emergency department without being seen*), HCGH has
   - **increased screening hours during 2018.**
   - **changed the provider work flow in the front end (January 2018).**
   - **Made additional changes to provider work flow (January 2019).**

8. *Hip or Knee Replacement Surgery – Results of Care – Complications after hip or knee replacement surgery*
   HCGH has carried out extensive efforts to reduce complications after hip or knee surgery. We use an "A3" format to summarize our monitoring of those efforts, and that A3 is included as Attachment H.

9. *Imaging – Practice Patterns – Patients who had low-risk surgery and received a heart-related test, such as an MRI, at least 30 days prior to their surgery though they do not have a heart condition.*
   On this Quality Measure, the on-line Medicare data indicates that HCGH did fall within the bottom quartile of all hospitals' reported performance measured for that Quality Measure, but did not fall below a 90% level of compliance with the Quality Measure. See Attachment I. HCGH's score was 6.6. 90% of that score would have been 6.1, which would have been at the 25th percentile (i.e., within compliance).

(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.

Based on Google Maps data, travel times from Howard County to St. Agnes Hospital varies from 30-50 minutes based on the time of day and location in Howard County.

The primary population to be served at HCGH is defined as people living in zip codes 21042, 21043, 21044, 21045, 21046, 21075, 20723, 20707, 21041, 21150, 20725, 20726, 21036, 20763, 20759, and 21737.

(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 l 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 cases by the end of the second full year of operation as a provider of elective PCI. 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.

HCGH believes there is sufficient case volume to justify an elective PCI program at HCGH. We also believe that such a program will strengthen our vitally-important emergency angioplasty program, which provides a critical medical service for the citizens of Howard County. The following information supports a projected case volume (for cases with intervention) at HCGH of 200 or more:

- *Emergency PCI's – 100:*
  HCGH has the busiest primary angioplasty program in the Johns Hopkins Health System (JHHS). During the last five complete fiscal years (7/1/13 through 6/30/18), HCGH performed 502 primary PCI procedures, or an average of 100.4 per year. Assuming that emergency angioplasty volumes continue at a similar level as they did in recent years, we would anticipate 100 emergency cases per year at HCGH going forward.

- *In-Patient Non-Emergent PCI's – 39:*
  Since HCGH does not perform elective angioplasty, patients at HCGH in need of diagnostic cardiac catheterization are typically referred to hospitals where the diagnostic portion of the procedure as well as any necessary intervention can be done as part of the same procedure. This need to transfer patients, some of whom end up having only a diagnostic procedure, results in unnecessary increased lengths of hospital stay and increased costs related to transportation. In March of 2019, HCGH's Senior Director for Project Coordination and Business Planning provided data on patients who were transferred from HCGH to Johns Hopkins Hospital (JHH) between 1/31/18 and 1/31/19 (the source of this data was the JHHS Epic Electronic Medical Record). This data indicated that 999 such patient transfers occurred. HCGH Diagnostic Imaging management reviewed these

transfers and found that, of the 999, 188 were patients who would likely have remained if HCGH had an elective angioplasty program in place. On an annualized basis, this is 174 patients. The three most-common principal diagnoses among the transferred patients were "non-STE myocardial infraction"; "other chest pain"; and, "ventricular tachycardia". We estimated that, of the 174 patients transferred per year, at least 39 per year would be likely to have non-emergency angioplasty at HCGH (if it were available).
With an elective angioplasty program in-place, those patients would no longer need to be transported by ambulance to JHH for their cath and PCI.

- *Out-Patient Non-Emergent PCI's – 81:*
  In June of 2017, the Johns Hopkins Planning & Marketing Analysis division prepared a review of angioplasty volumes for patients in the HCGH "primary service area" ("PSA"). That analysis found that, in the most recent year covered by the review (the year ending 6/30/16), 237 residents of the HCGH PSA had an elective out-patient coronary angioplasty procedure. 101 of those 237 patients had their PCI procedure at Johns Hopkins Hospital (JHH). Johns Hopkins's Division of Cardiology leadership have indicated their support for opening an elective angioplasty program at HCGH, and redirecting to HCGH the patients from our county who currently would receive elective PCI at JHH. Assuming that the number of residents in our service area who need elective out-patient angioplasty remains steady, we would anticipate at least 81 such cases to be redirected to HCGH each year going forward.

  So, even without attracting business away from any of our competitors, and by simply redirecting existing volume within the Johns Hopkins Health System, HCGH can confidently expect to achieve a volume of well over 200 cases by the end of the second full year of operation as a provider of elective PCI.

  In projecting these volumes, we considered the primary population to be served at HCGH as those living in zip codes 21042, 21043, 21044, 21045, 21046, 21075, 20723, 20707, 21041, 21150, 20725, 20726, 21036, 20763, 20759, and 21737.

(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.
Form B is attached

(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 C.E.O. and medical director of cardiac interventional services indicating agreement with the above statement.
Please see Attachment J.

(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, 2018.
Since our primary PCI waiver was last renewed by MHCC on 12/19/2013, one received thrombolytic therapy because primary PCI services were not available at HCGH. In that case, the thrombolytic therapy did not "fail." The case in question occurred during 2016, and it occurred because a STEMI patient was already in the cath lab when a second STEMI patient arrived at HCGH.

(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 December 31, 2018.

Reporting Period: 12/19/13 – 12/31/18
From (mmddyy) To (mmddyy)

CCL Room	Days and Hours of Operation							
	Hours	Mon	Tue	Wed	Thu	Fri	Sat	Sun
Cath Lab 1	*Regular:*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	-	-
	On-Call:	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*7A-7A*	*7A-7A*
Cath Lab 2	*Regular:*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	*8A-4:30P*	-	-
	On-Call:	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*4:30P-8A*	*7A-7A*	*7A-7A*

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 December 31, 2018.

Since at least 9/1/13, there have been no days at HCGH when CCL services were not available. For the past ten years, HCGH has maintained two cardiac catheterization labs in order to ensure that in the event that one cath lab is unavailable the other lab may be utilized for primary PCI services.
Specific times when one of the two labs was out-of-service during the time period in question are listed in the table in Attachment K.

Room	CCL Downtime			
	Date		Duration (Hours)	Reason Unavailable
	Begin	End		

(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_

NO, at HCGH there have been no changes to the number or on-call availability of physicians, nurses and technologist who comprise the on-call team. We continue to have one physician, two nurses and two radiologic technologists available and on-call at all times.

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			
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:
052419
(mmddyy)

	Number/FTEs	**Cross-Training (S/C/M)**
Physician	*8*	
Nurse	*6 / 4.5 FTE*	*C*
Radiologic Technologists	*7 / 3.5 FTE*	*S/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.

Attachment L shows the table with the number and % of STEMI patients meeting the DTB time standard of 90 minutes or less for each quarter since 7/1/13.
We have no patients who were transferred to the hospital from another acute care hospital for PCI.

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, 2019?

Yes _X_ No__

YES – please see data in Attachment L.

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.

(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.
Please see Attachment J.

(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.

HCGH has one person (0.8 FTE) cath lab "data coordinator" who is responsible for the data collection, management, reporting and coordination with institutional quality improvement efforts. There is also another "PRN" data coordinator to provide back-up and assistance as needed.

(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.

HCGH does not permit physicians who participate in the on-call schedule to have simultaneous on-call duties for two or more hospitals. The hospital's policy which speaks to back-up for primary PCI cases (for when two simultaneous STEMI patients present at the hospital) is included as Attachment M (HCGH policy ED029, "Managing Multiple STEMI Patients in the E.D.").

(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 December 31, 2018.

A table of PCI-related continuing education activities is included as Attachment N.

(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 _X_ No ___

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

YES, HCGH does have a current signed and dated agreement with a tertiary care center

(Johns Hopkins Hospital) that provides for the unconditional transfer of primary PCI patients from HCGH to Johns Hopkins Hospital. That agreement does cover the transfer of each non-primary PCI patient who requires additional care, including emergent or non-primary cardiac surgery or PCI. This agreement is included as Attachment O.

(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 _X_ No ___

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.
Please see Attachment P.

(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.

Q29. Please use Form C to report attendance at the interventional case review meetings.

Our multidisciplinary STEMI Committee meets monthly; the agenda includes both interventional case review, and review of any and all issues related to the primary PCI system, including identifying problem areas, and developing solutions. Participants at this meeting include Howard County Department of Fire and Rescue personnel, ED nursing and physician leadership, CVL nursing and technologist representatives, CVL physician and administrative leadership, ICU nursing and physician leadership, a cardiac rehabilitation representative, and quality leadership. Cases identified as needing in-depth review are referred for M&M or root cause analysis on an as-needed basis.

(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.

As noted on Question 29, our multidisciplinary STEMI Committee meets monthly; the agenda includes both interventional case review, and review of any and all issues related to the primary PCI system, including identifying problem areas, and developing solutions. Participants at this meeting include Howard County Department of Fire and Rescue personnel, ED nursing and physician leadership, CVL nursing and technologist representatives, CVL physician and administrative leadership, ICU nursing and physician leadership, a cardiac rehabilitation representative, and quality leadership. Cases identified as needing in-depth review are referred for M&M or root cause analysis on an as-needed basis.

(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.

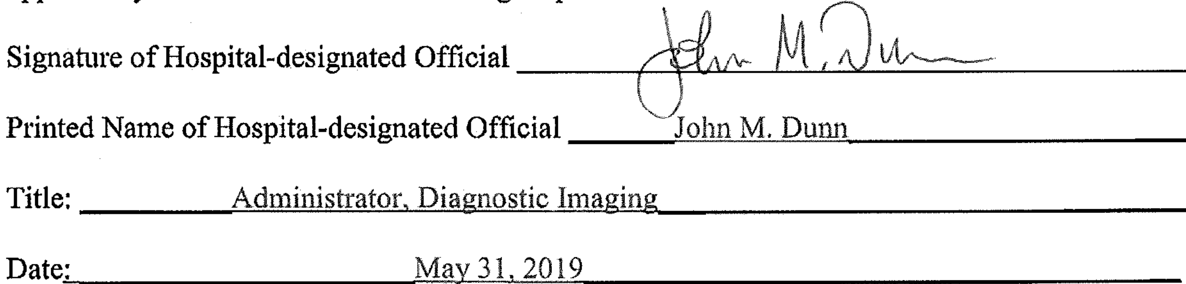
Q31. Please use Form E to report individual physician volumes for the previous two years.

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 John M. Dunn

Title: Administrator, Diagnostic Imaging

Date: May 31, 2019

FORM A, 1of 2

Form A: PROJECT BUDGET

INSTRUCTION: This form is to be completed if capital expenditures will be necessary for the applicant hospital to provide npPCI services. All estimates for 1.a.-d., 2.a.-h., and 3 are for current costs as of the date of application submission and should include the costs for all intended construction and renovations to be undertaken. DO NOT CHANGE THIS FORM OR ITS LINE ITEMS. IF ADDITIONAL DETAIL OR CLARIFICATION IS NEEDED, ATTACH ADDITIONAL SHEET.

A. Use of Funds

1. Capital Costs:

a.	New Construction	$ ____________
(1)	Building	____________
(2)	Fixed Equipment (not included in construction)	____________
(3)	Land Purchase	____________
(4)	Site Preparation	____________
(5)	Architect/Engineering Fees	____________
(6)	Permits, (Building, Utilities, Etc)	____________
SUBTOTAL		$ ____________
b.	Renovations	
(1)	Building	$ ____________
(2)	Fixed Equipment (not included in construction)	____________
(3)	Architect/Engineering Fees	____________
(4)	Permits, (Building, Utilities, Etc.)	____________
SUBTOTAL		$ ____________
c.	Other Capital Costs	
(1)	Major Movable Equipment	____________
(2)	Minor Movable Equipment	____________
(3)	Contingencies	____________
(4)	Other (Specify)	____________
TOTAL CURRENT CAPITAL COSTS (a - c)		$ ________0___
d.	Non Current Capital Cost	
(1)	Interest (Gross)	$ ____________
(2)	Inflation (state all assumptions, Including time period and rate)	$ ____________
TOTAL PROPOSED CAPITAL COSTS		$ _________0__ (a - d)

Form A, 2 of 2

2. Financing Cost and Other Cash Requirements:

a.	Loan Placement Fees	$	____________
b.	Bond Discount		____________
c.	Legal Fees (CON Related)		____________
d.	Legal Fees (Other)		____________
e.	Printing		____________
f.	Consultant Fees		
	CON Application Assistance		____________
	Other (Specify)		____________
g.	Liquidation of Existing Debt		____________
h.	Debt Service Reserve Fund		____________
i.	Principal Amortization Reserve Fund		____________
j.	Other (Specify)		____________
	TOTAL (a - j)	$	____________

3. Working Capital Startup Costs $ ____________

TOTAL USES OF FUNDS (1 - 3) $ ____________

B. Sources of Funds for Project:

1.	Cash	____________
2.	Pledges: Gross ___________, less allowance for uncollectables ___________ = Net	____________
3.	Gifts, bequests	____________
4.	Interest income (gross)	____________
5.	Authorized Bonds	____________
6.	Mortgage	____________
7.	Working capital loans	____________
8.	Grants or Appropriation	
	(a) Federal	____________
	(b) State	____________
	(c) Local	____________
9.	Other (Specify)	____________

TOTAL SOURCES OF FUNDS (1-9) $ ____________

Lease Costs:

a. Land	$____________	x ____________	= $____________
b. Building	$____________	x ____________	= $____________
c. Major Movable Equipment	$____________	x ____________	= $____________
d. Minor Movable Equipment	$____________	x ____________	= $____________
e. Other (Specify)	$____________	x ____________	= $____________

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.

Projected Years (ending with third full year in which the applicant projects provision of primary PCI services)

	FY18	FY19	FY20	FY21	FY22	FY23
REVENUE						
a Inpatient Services -- baseline	$ 1,828,257	$ 1,864,822	$ 1,902,119	$ 1,940,161	$ 1,978,964	$ 2,018,543
Inpatient Services -- incremental	$ -	$ -	$ 225,818	$ 361,006	$ 408,646	$ 458,048
b Outpatient Services	$ -	$ -	$ -	$ -	$ -	$ -
c Gross Patient Services	$ 1,828,257	$ 1,864,822	$ 2,127,937	$ 2,301,167	$ 2,387,610	$ 2,476,591
Adjustments to Revenue						
d Allowance for Bad Debt	$ -	$ -	$ -	$ -	$ -	$ -
e Contractual Allowance	$ -	$ -	$ -	$ -	$ -	$ -
f Charity Care	$ -	$ -	$ -	$ -	$ -	$ -
g Net Patient Services	$ -	$ -	$ -	$ -	$ -	$ -
h Other Operating Revenue (specify)	$ -	$ -	$ -	$ -	$ -	$ -
Net Operating Revenue	$ 1,828,257	$ 1,864,822	$ 2,127,937	$ 2,301,167	$ 2,387,610	$ 2,476,591
EXPENSES						
a Salaries, Wages, + Prof. Fees (inc. fringe bens.)	$ -	$ -	$ -	$ -	$ -	$ -
b Contractual Services	$ -	$ -	$ -	$ -	$ -	$ -
c Interest on Current Debt	$ -	$ -	$ -	$ -	$ -	$ -
d Interest on Project Debt	$ -	$ -	$ -	$ -	$ -	$ -
e Current Depreciation	$ -	$ -	$ -	$ -	$ -	$ -
f Project Depreciation	$ -	$ -	$ -	$ -	$ -	$ -
g Current Amortization	$ -	$ -	$ -	$ -	$ -	$ -
h Project Amortization	$ -	$ -	$ -	$ -	$ -	$ -
i Supplies	$ -	$ -	$ -	$ -	$ -	$ -
j Other Expenses -- existing VARIABLE expenses	$ 777,877	$ 793,435	$ 809,303	$ 825,489	$ 841,999	$ 858,839
Other Expenses -- new VARIABLE expenses	$ -	$ -	$ 192,160	$ 295,058	$ 335,355	$ 377,145
Other Expenses -- total FIXED expenses	$ 872,548	$ 889,999	$ 907,799	$ 925,955	$ 944,474	$ 963,363
Total Operating Expenses	$ 1,650,425	$ 1,683,434	$ 1,909,262	$ 2,046,502	$ 2,121,828	$ 2,199,348
INCOME						
Income from Operations	$ 177,832	$ 181,389	$ 218,675	$ 254,665	$ 265,782	$ 277,244
Non-Operating Income	$ -	$ -	$ -	$ -	$ -	$ -
Income Sub-Total	$ 177,832	$ 181,389	$ 218,675	$ 254,665	$ 265,782	$ 277,244
Income Taxes	$ -	$ -	$ -	$ -	$ -	$ -
Net Income	$ 177,832	$ 181,389	$ 218,675	$ 254,665	$ 265,782	$ 277,244
PATIENT MIX (as percent of total revenue)						
Medicare	32%	32%	32%	32%	32%	32%
Medicaid	6%	6%	6%	6%	6%	6%
Blue cross	12%	12%	12%	12%	12%	12%
Commercial	48%	48%	48%	48%	48%	48%
Self-Pay	0%	0%	0%	0%	0%	0%
Other	1%	1%	1%	1%	1%	1%
Total	100%	100%	100%	100%	100%	100%

KEY ASSUMPTIONS:

-- Revenue associated with incremental (i.e., elective) cases is reduced to 50% of charges under GBR

-- Provision of elective PCI cases is assumed to begin 10/1/19 (so, FY20 includes 75% of full-year elective PCI volumes)

Form C. Identify all physicians, nurses, technologists, and other staff who participated in formal, regularly scheduled cardiac catheterization (STEMI) case review meetings.

Provide the dates and staff attendance at all formal case review meetings ......

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Peter Johnston, M.D.	PCI Medical Director	Physician	X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Eric Schwartz, M.D.	PCI Medical Co-Director	Physician	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X									X	X	X	X	X	X	X	X	X	X	X	X	X	
Jeanette Nazarian, M.D.	Medical Director, ICU & Special Care	Physician	X		X			X	X	X		X	X			X		X			X	X	X		X	X		X			X			X	X						
Robert Linton, M.D.	Medical Director, Emergency Med.	Physician	X				X			X		X	X		X	X				X			X		X	X						X	X	X				X			
Jessica Shackman, M.D.	Emergency Medicine Physician	Physician	X	X		X	X	X	X		X		X	X	X	X	X		X	X	X	X		X		X	X	X		X		X	X	X	X	X	X	X	X	X	X
Joel Christensen, RT(R)	IRCV Radiologic Technologist	Other (cath lab tech)	X		X		X	X	X			X	X		X	X		X		X	X	X			X	X															
William Simpson, RT(R)	IRCV Radiologic Technologist	Other (cath lab tech)	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X
David Stalcup	Manager, IRCV	Other																				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caitlin Roscoe	Lean Team	Other																																		X					
John Dunn	Imaging Administrator	Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X			X			X		X		X
Dave Sabat	Howard Co. Fire & Rescue Captain	Other																																X	X	X	X			X	X
Rick Leonard	Howard Co. Fire & Rescue Captain	Other																											X	X	X				X			X	X		
Tom Gerber	Howard Co. Fire & Rescue Captain	Other																																			X	X	X	X	X
James Brothers	HCF&R Battalion Chief	Other	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X	X

Form C. Identify all physicians, nurses, technologists, and other staff who participated in formal, regularly scheduled cardiac catheterization (STEMI) case review meetings.

Provide the dates and staff attendance at all formal case review meetings ……

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Lisa Grubb, R.N.	Outcomes Manage-ment	Nurse																													X							X			
Bridget Carver, R.N.	Manager, IRCV Clinical Education	Nurse	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X															
Kristina Taylor, R.N.	Manager, IRCV	Nurse	X	X	X		X	X	X		X	X	X	X	X	X	X	X		X	X	X																		
Jane Scanlon, R.N.	Manager, Intensive Care Unit	Nurse	X	X		X	X	X	X		X	X	X	X	X	X	X		X	X	X	X		X	X	X	X		X	X	X	X	X	X	X	X		X		X	X
Stacie Walker, R.N.	Manager, Adult Emer. Dept.	Nurse																			X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X	X
Nellie Bauss, R.N.	Manager SCU	Nurse																												X		X	X	X		X	X	X	X		X
Roxanne Donaldson, R.N.	IRCV Nurse	Nurse																																X							
Jennie Robinson, R.N.	ICU Nurse	Nurse																																					X		
Manjula Das, R.N.	ICU Nurse	Nurse																																		X					
Amanda Bryant, R.N.	ED Nurse	Nurse																													X										
Karen Reyes, R.N.	ED Nurse	Nurse																												X		X	X	X	X			X			X
Sandee Gelven, R.N.	Director ED	Nurse																																X	X	X		X			X
Judy Peck, R.N.	Data Coord-inator, IRCV	Nurse	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
Catherine Miller, R.N.	Clinical Education	Nurse																												X							X	X	X	X	

Form C. Identify all physicians, nurses, technologists, and other staff who participated in formal, regularly scheduled cardiac catheterization (STEMI) case review meetings.

Provide the dates and staff attendance at all formal case review meetings ......

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Devon Dankert, R.N.	Cardiac Rehabilitation Nurse	Nurse																																			X				
Colleen Thornton, R.N.	Cardiac Rehab Nurse	Nurse																																					X		
Proshoba George, R.N.	Cardiac Rehab	Nurse																									X	X	X	X	X	X	X	X	X	X		X	
Cynthia Balmaceda, R.N.	Clinical Coordinator	Nurse																														X	X	X					

Form D. Identify all physicians, nurses, technicians, and other staff who participated in formal, regularly scheduled multiple area care group meetings.

Provide the dates and staff attendance at all formal case review meetings ......

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Peter Johnston, M.D.	PCI Medical Director	Physician	X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X	X		X	X	X		X	X	X	X	X	X	X	X	X	X	X	X
Eric Schwartz, M.D.	PCI Medical Co-Director	Physician	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X									X	X	X	X	X	X	X	X	X	X	X	X	X	
Jeanette Nazarian, M.D.	Medical Director, ICU & Special Care	Physician	X		X			X	X	X		X	X			X		X			X	X	X		X	X		X			X			X	X						
Robert Linton, M.D.	Medical Director, Emergency Med.	Physician	X				X			X		X	X		X	X				X			X		X	X						X	X	X				X			
Jessica Shackman, M.D.	Emergency Medicine Physician	Physician	X	X		X	X	X	X		X		X	X	X	X	X		X	X	X	X		X		X	X	X		X		X	X	X	X	X	X	X	X	X	X
Joel Christensen, RT(R)	IRCV Radiologic Technologist	Other (cath lab tech)	X		X		X	X	X			X	X		X	X		X		X	X	X			X	X															
William Simpson, RT(R)	IRCV Radiologic Technologist	Other (cath lab tech)	X	X	X	X	X		X	X	X	X	X	X		X	X	X	X	X		X	X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X
David Stalcup	Manager, IRCV	Other																				X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Caitlin Roscoe	Lean Team	Other																																		X					
John Dunn	Imaging Administrator	Other	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X			X			X		X		X
Dave Sabat	Howard Co. Fire & Rescue Captain	Other																																X	X	X	X			X	X
Rick Leonard	Howard Co. Fire & Rescue Captain	Other																											X	X	X				X			X	X		
Tom Gerber	Howard Co. Fire & Rescue Captain	Other																																			X	X	X	X	X
James Brothers	HCF&R Battalion Chief	Other	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X	X	X					X	X

Form D. Identify all physicians, nurses, technicians, and other staff who participated in formal, regularly scheduled multiple area care group meetings.

Provide the dates and staff attendance at all formal case review meetings ......

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Lisa Grubb, R.N.	Outcomes Manage-ment	Nurse																													X							X			
Bridget Carver, R.N.	Manager, IRCV Clinical Education	Nurse	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X																
Kristina Taylor, R.N.	Manager, IRCV	Nurse	X	X	X		X	X	X		X	X	X	X	X	X	X	X		X	X	X																			
Jane Scanlon, R.N.	Manager, Intensive Care Unit	Nurse	X	X		X	X	X	X		X	X	X	X	X	X	X		X	X	X	X		X	X	X	X		X	X	X	X	X	X	X	X		X		X	X
Stacie Walker, R.N.	Manager, Adult Emer. Dept.	Nurse																			X	X	X	X	X	X	X	X		X	X	X	X		X	X	X	X	X	X	X
Nellie Bauss, R.N.	Manager SCU	Nurse																												X		X	X	X		X	X	X	X		X
Roxanne Donaldson, R.N.	IRCV Nurse	Nurse																																X							
Jennie Robinson, R.N.	ICU Nurse	Nurse																																					X		
Manjula Das, R.N.	ICU Nurse	Nurse																																		X					
Amanda Bryant, R.N.	ED Nurse	Nurse																													X										
Karen Reyes, R.N.	ED Nurse	Nurse																												X		X	X	X	X			X			X
Sandee Gelven, R.N.	Director ED	Nurse																																X	X	X		X			X
Judy Peck, R.N.	Data Coord-inator, IRCV	Nurse	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X		X	X	X	X	X	X	X	X	X	X	X	X	X
Catherine Miller, R.N.	Clinical Education	Nurse																												X							X	X	X	X	

Form D. Identify all physicians, nurses, technicians, and other staff who participated in formal, regularly scheduled multiple area care group meetings.

Provide the dates and staff attendance at all formal case review meetings ......

Name + Credential	Title	Role	9/23/15	10/28/15	11/25/15	12/23/15	1/27/16	2/24/16	3/23/16	4/27/16	5/25/16	6/22/16	7/27/16	8/24/16	9/28/16	10/26/16	11/23/16	12/28/16	1/25/17	2/22/17	3/22/17	4/26/17	5/24/17	6/28/17	7/26/17	8/23/17	9/27/17	10/18/17	11/15/17	12/20/17	1/17/18	2/21/18	3/21/18	4/18/18	5/16/18	6/20/18	7/18/18	8/15/18	9/19/18	10/17/18	12/19/18
Devon Dankert, R.N.	Cardiac Rehabilitation Nurse	Nurse																																			X				
Colleen Thornton, R.N.	Cardiac Rehab Nurse	Nurse																																					X		
Proshoba George, R.N.	Cardiac Rehab	Nurse																											X	X	X	X	X	X	X	X	X	X		X	
Cynthia Balmaceda, R.N.	Clinical Coordinator	Nurse																																X	X	X					

FORM E

Interventionalist: Dr. Chao-Wei Hwang

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	2	0	2	13	41	54	56
2015 Q2	1	0	1	10	49	59	60
2015 Q3	0	0	0	19	34	53	53
2015 Q4	2	0	2	13	45	58	60
2016 Q1	0	0	0	15	44	59	59
2016 Q2	1	0	1	14	28	42	43
2016 Q3	0	0	0	12	30	42	42
2016 Q4	3	0	3	11	53	64	67
2017 Q1	2	0	2	8	34	42	44
2017 Q2	2	0	2	9	32	41	43
2017 Q3	4	0	4	8	34	42	46
2017 Q4	1	0	1	11	50	61	62
2018 Q1	2	0	2	10	40	50	52
2018 Q2	2	0	2	7	31	38	40
2018 Q3	1	0	1	11	33	44	45
2018 Q4	2	0	2	10	45	55	57
							829

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/1/2019

Signature of Interventionalist:

Interventionalist Dr. Peter Johnston

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	2	0	2	4	30	34	36
2015 Q2	2	0	2	5	37	42	44
2015 Q3	5	0	5	5	32	37	42
2015 Q4	1	0	1	4	25	29	30
2016 Q1	1	0	1	4	32	36	37
2016 Q2	1	0	1	7	23	30	31
2016 Q3	5	0	5	0	35	35	40
2016 Q4	1	0	1	1	21	22	23
2017 Q1	2	0	2	6	29	35	37
2017 Q2	2	0	2	1	34	35	37
2017 Q3	2	0	2	8	32	40	42
2017 Q4	4	0	4	1	35	36	40
2018 Q1	7	0	7	6	26	32	39
2018 Q2	2	0	2	3	38	41	43
2018 Q3	3	0	3	2	28	30	33
2018 Q4	4	0	4	3	20	23	27
							581

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/9/2019

Signature of Interventionalist: ______

FORM E

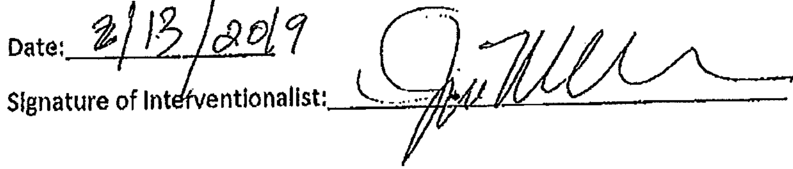
Interventionalist Dr. Julie Miller

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	6	0	6	5	19	24	30
2015 Q2	1	0	1	3	19	22	23
2015 Q3	2	0	2	4	13	17	19
2015 Q4	6	0	6	2	21	23	29
2016 Q1	6	0	6	4	15	19	25
2016 Q2	4	0	4	2	16	18	22
2016 Q3	4	0	4	6	25	31	35
2016 Q4	5	0	5	4	24	28	33
2017 Q1	2	0	2	2	20	22	24
2017 Q2	1	0	1	1	20	21	22
2017 Q3	0	0	0	2	24	26	26
2017 Q4	1	0	1	2	16	18	19
2018 Q1	2	0	2	2	21	23	25
2018 Q2	1	0	1	6	22	28	29
2018 Q3	0	0	0	3	18	21	21
2018 Q4	2	0	2	0	24	24	26
							408

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 2/13/2019

Signature of Interventionalist:

Printed 5/31/2019 9:44 AM

FORM E

Interventionalist Dr. Feroz Padder

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	2	0	2	22	0	22	24
2015 Q2	7	0	7	29	0	29	36
2015 Q3	5	0	5	14	0	14	19
2015 Q4	3	0	3	21	0	21	24
2016 Q1	6	0	6	21	0	21	27
2016 Q2	5	0	5	21	0	21	26
2016 Q3	6	0	6	21	0	21	27
2016 Q4	5	0	5	21	0	21	26
2017 Q1	3	0	3	14	0	14	17
2017 Q2	4	0	4	19	0	19	23
2017 Q3	9	0	9	9	0	9	18
2017 Q4	4	0	4	15	0	15	19
2018 Q1	8	0	8	14	0	14	22
2018 Q2	3	0	3	23	0	23	26
2018 Q3	4	0	4	13	0	13	17
2018 Q4	5	0	5	7	0	7	12
							363

Source of Data: NCDR

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: 3/11/2019

Signature of Interventionalist: Digitally signed by Feroz A. Padder, MD
DN: cn=Feroz A. Padder, MD, o, ou, email=drfpadder@gmail.com, c=US
Date: 2019.03.11 14:30:41 -04'00'

FORM E

Interventionalist: Dr. Jon Resar

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	1	0	1	2	33	35	36
2015 Q2	3	0	3	6	29	35	38
2015 Q3	1	0	1	3	33	36	37
2015 Q4	2	0	2	7	35	42	44
2016 Q1	2	0	2	1	24	25	27
2016 Q2	2	0	2	4	41	45	47
2016 Q3	3	0	3	2	19	21	24
2016 Q4	2	0	2	2	24	26	28
2017 Q1	0	0	0	7	33	40	40
2017 Q2	0	0	0	1	27	28	28
2017 Q3	1	0	1	2	33	35	36
2017 Q4	3	0	3	1	30	31	34
2018 Q1	2	0	2	0	30	30	32
2018 Q2	3	0	3	0	34	34	37
2018 Q3	1	0	1	0	18	18	19
2018 Q4	6	0	6	2	27	29	35
							542

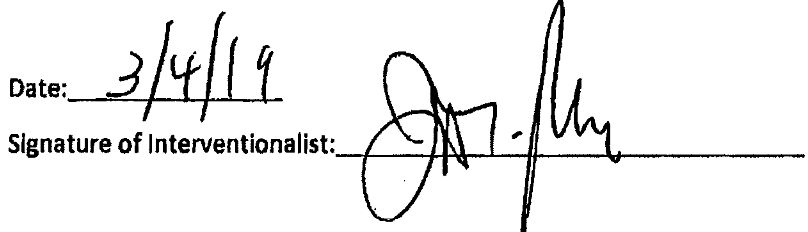
Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/4/19

Signature of Interventionalist:



Interventionalist: Dr. David Thiemann

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	2	0	2	9	17	26	28
2015 Q2	3	0	3	2	19	21	24
2015 Q3	4	0	4	3	17	20	24
2015 Q4	1	0	1	2	11	13	14
2016 Q1	3	0	3	2	12	14	17
2016 Q2	2	0	2	3	8	11	13
2016 Q3	3	0	3	4	9	13	16
2016 Q4	1	0	1	4	15	19	20
2017 Q1	2	0	2	3	14	17	19
2017 Q2	3	0	3	1	9	10	13
2017 Q3	3	0	3	0	7	7	10
2017 Q4	4	0	4	5	18	23	27
2018 Q1	7	0	7	1	11	12	19
2018 Q2	1	0	1	2	14	16	17
2018 Q3	2	0	2	10	25	35	37
2018 Q4	5	0	5	1	11	12	17
							315

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/4/2019

Signature of Interventionalist: David R T[illegible]

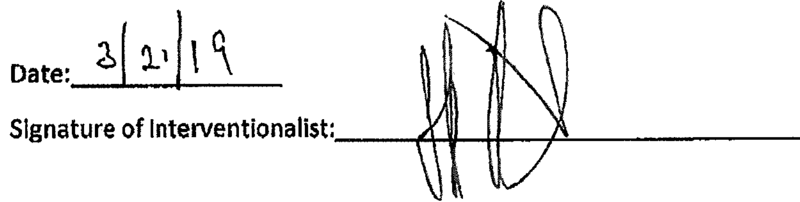
Interventionalist: Dr. Jeffrey Trost

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	2	0	2	4	19	23	25
2015 Q2	4	0	4	5	29	34	38
2015 Q3	9	0	9	6	22	28	37
2015 Q4	2	0	2	3	29	32	34
2016 Q1	3	0	3	11	22	33	36
2016 Q2	5	0	5	4	31	35	40
2016 Q3	9	0	9	6	30	36	45
2016 Q4	2	0	2	4	20	24	26
2017 Q1	6	0	6	8	26	34	40
2017 Q2	6	0	6	3	26	29	35
2017 Q3	4	0	4	2	35	37	41
2017 Q4	4	0	4	5	32	37	41
2018 Q1	9	0	9	4	19	23	32
2018 Q2	4	0	4	7	17	24	28
2018 Q3	8	0	8	6	24	30	38
2018 Q4	4	0	4	4	20	24	28
							564

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/21/19

Signature of Interventionalist:

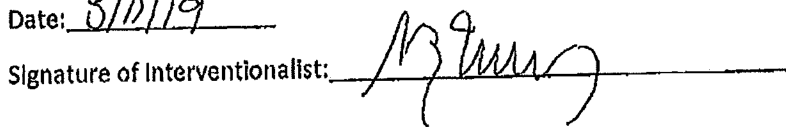
Interventionalist: Dr. Stephen Williams

Quarter Ending	PCI Cases at Applicant Hospital			PCI Cases at Other Hospitals			Total PCI Cases – All Hospitals
	pPCI	npPCI	Total	pPCI	npPCI	Total	
2015 Q1	0	0	0	8	28	36	36
2015 Q2	0	0	0	13	21	34	34
2015 Q3	0	0	0	12	15	27	27
2015 Q4	0	0	0	13	13	26	26
2016 Q1	0	0	0	5	23	28	28
2016 Q2	0	0	0	9	14	23	23
2016 Q3	0	0	0	9	9	18	18
2016 Q4	0	0	0	2	26	28	28
2017 Q1	0	0	0	12	20	32	32
2017 Q2	0	0	0	8	17	25	25
2017 Q3	2	0	2	8	28	36	38
2017 Q4	2	0	2	6	13	19	21
2018 Q1	4	0	4	13	20	33	37
2018 Q2	7	0	7	6	23	29	36
2018 Q3	1	0	1	7	20	27	28
2018 Q4	4	0	4	12	27	39	43
							480

Source of Data: NCDR Physician Dashboard, HCGH PCI Spreadsheet

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: 3/11/19

Signature of Interventionalist:

ATTACHMENT A

Organizations that have achieved The Gold Seal of Approval® from The Joint Commission®

Howard County General Hospital, Inc.

HCO ID: 6273
5755 Cedar Lane
Columbia , MD, 21044

ATTACHMENT A

Activity as of:

4/16/2019
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/22/2016

Last Full Survey Date
2/28/2019

Last On-Site Survey Date
4/12/2019

3/28/2019
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/22/2016

Last Full Survey Date
2/28/2019

Last On-Site Survey Date
2/28/2019

3/27/2019
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/22/2016

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

3/13/2019
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/22/2016

Last Full Survey Date
2/28/2019

Last On-Site Survey Date
2/28/2019

7/1/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/22/2016

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

6/14/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

ATTACHMENT A

5/25/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

5/20/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/26/2013

Last On-Site Survey Date
4/26/2013

5/17/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

ATTACHMENT A

5/12/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/26/2013

Last On-Site Survey Date
4/26/2013

4/29/2016
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/21/2016

Last On-Site Survey Date
4/21/2016

10/22/2013
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
4/27/2013

Last Full Survey Date
4/26/2013

Last On-Site Survey Date
4/26/2013

ATTACHMENT A

6/10/2013
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

Effective Date
5/14/2010

Last Full Survey Date
4/26/2013

Last On-Site Survey Date
4/26/2013

5/10/2013
Quality Report

Accreditation Programs
Hospital

Accreditation Decision
Accredited

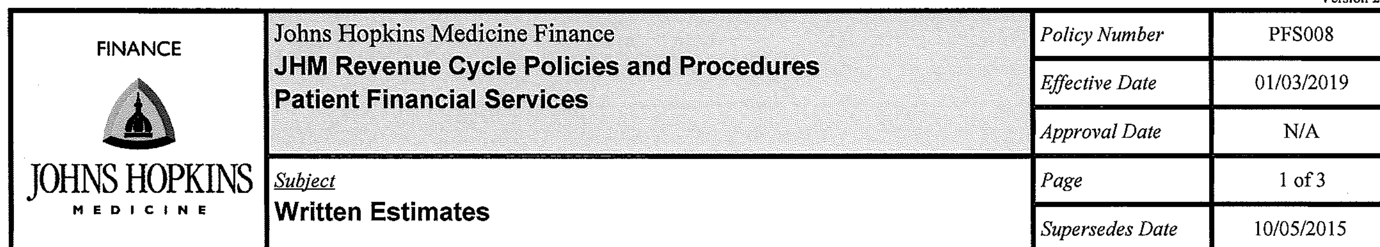
Effective Date
5/14/2010

Last Full Survey Date
5/13/2010

Last On-Site Survey Date
5/13/2010

ATTACHMENT B

Version 2.0



FINANCE JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine Finance **JHM Revenue Cycle Policies and Procedures Patient Financial Services**	*Policy Number*	PFS008
		Effective Date	01/03/2019
		Approval Date	N/A
	Subject **Written Estimates**	*Page*	1 of 3
		Supersedes Date	10/05/2015

This document applies to the following Participating Organizations:

Howard County General Hospital

Johns Hopkins Bayview Medical Center

Suburban Hospital

The Johns Hopkins Health System Corporation

The Johns Hopkins Hospital

Keywords: estimates, written estimates

Table of Contents	Page Number
I. PURPOSE	1
II. PROCEDURES	1
III. RESPONSIBILITIES	2
IV. REFERENCE	3
V. SPONSOR	3
VI. REVIEW CYCLE	3
VII. APPROVAL	3
Appendix A: Maryland COMAR 10.37.10.26	Click Here
Appendix B: Written Estimate Letter - Templates	Click Here

I. PURPOSE

A. To establish a standard practice for providing a written estimate to current or scheduled patients upon the request of the patient, based on Johns Hopkins Medicine protocol and in compliance with Maryland law.

II. PROCEDURES

A. Overview

1. Estimates are not intended for individuals "shopping" around for medical services pricing. In those instances, individuals shall be referred to the Johns Hopkins Medicine website for a list of average costs for the top inpatient/ outpatient services (See Policy No. PFS064 Hospital Service Charges) or to the Maryland Health Services Cost Review Commission website at http://www.hscrc.state.md.us to access similar information for all Maryland Hospitals via the "Maryland Hospitals Performance Evaluation Guide" and the "The Maryland Hospital Pricing Guide." This guide lists the top 15 procedures across Maryland hospitals.
2. Individuals requesting estimates for services not yet scheduled shall be informed that once they are scheduled for medical services an estimate can be provided upon request.
3. Written cost estimates shall be provided upon request to patients scheduled for, or currently undergoing, services within 5 business days. Estimates may be given verbally, however if the patient requests the estimate in writing, a written estimate letter shall be provided to the patient within the above timeframe.

B. Inpatient/Outpatient Cost Estimates (Scheduled Services)

1. Financial Counseling staff or entity designee shall process the estimate request.
2. Estimator's responsibilities:
   a. Obtain detailed information regarding the scheduled inpatient or outpatient admission including diagnosis codes (ICD-10), procedure codes (CPT), length of procedure, length of stay, level of care, treating physician, anesthesia needs, special equipment needs, etc.
   b. Obtain recent average cost information for similar services through the Epic Hospital Billing or Professional Billing Account Query Reports, DataMart inpatient/outpatient reports, Epic Enterprise Fee Schedules, or directly from the JHHS Casemix Department. If no historic account information is available, Medicare fee schedules can be used accessible through the Craneware Online Reference Toolkit, or CMS.gov.

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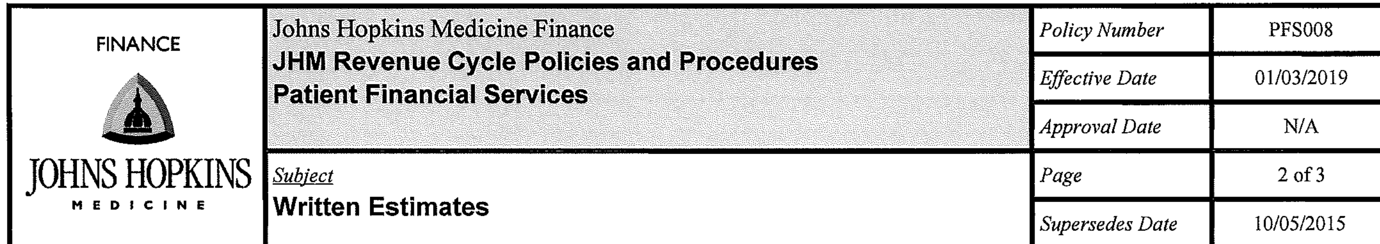

3. Inpatient or outpatient estimates for non-Maryland facilities shall be obtained via the resources stated above, however, if commercial insurance is involved, current negotiated payor fee schedule amounts shall be included in the estimate calculation.
   a. Calculate the patient's estimated cost using the following information as applicable:
   b. Patient Information following patient identification policy
   c. Date(s) of Service
   d. Estimated length of stay
   e. Average room and board charge per day for inpatient cases
   f. Supplies, Pharmacy, Ancillary charges
   g. Operating Room charges if applicable
   h. Visit type
   i. Requested procedures
   j. Anesthesia charges
   k. In the event the patient has insurance, Inpatient Financial Clearance uses estimated charge/day based on the medical service the patient is admitted. The patient's insurance copay/deductible/coinsurance amounts are used to determine the patient's out-of-pocket responsibility.
4. Contact the patient and provide a copy of the written estimate directly to the patient or via the patient's preferred method of delivery.
5. In the event the patient expresses a need for financial assistance for the planned services, provide financial assistance information and contacts.

C. Written Estimates for Patients Currently Receiving Treatment
   1. Upon receipt of a written estimate request from a patient currently receiving treatment, staff members shall immediately forward the request to the designated department to obtain the estimate.
   2. Calculate the patient's estimated costs as outlined above in section B.
   3. Written estimates for patients receiving hospital based services shall exclude professional fees.
   4. Provide the patient with the estimate letter in person or via the patient's preferred method of delivery.
   5. A written estimate for a patient currently in treatment shall be provided within five (5) business days or less if feasible.

III. RESPONSIBILITIES

A. Inpatient/Outpatient clinical and administrative staff members who receive requests for cost estimates shall immediately forward all such requests to the JHM entity designated department/point of contact responsible for providing cost estimates.

B. Designated Department
   1. Designated departments may include, however are not limited to Access Services, Admissions, Patient Access, Financial Clearance, Scheduling, etc. Designated roles within these departments may include Financial Counselors, Financial Clearance Coordinators, Billing Coordinators, Physician's Office Managers, or other individuals designated to provide such information for any of the Johns Hopkins Medicine entities.
   2. Individuals responsible for providing patient requested estimates shall verify the services being rendered or to be rendered to the patient, calculate the estimate, create the estimate letter, provide the written estimate to the patient, document in the Epic Account Notes, Epic Benefit Collection form and scan all estimate information and patient communications to Epic Media Manager.
   3. Seek out verification of calculations with a manager when necessary.

C. Designated Department Manager/Supervisor
   1. Ensure designated individuals within the department maintain responsibility for receiving, generating, and communicating estimate requests in an accurate and timely manner. Managers/Supervisors shall be available to review estimate calculations for accuracy when necessary.

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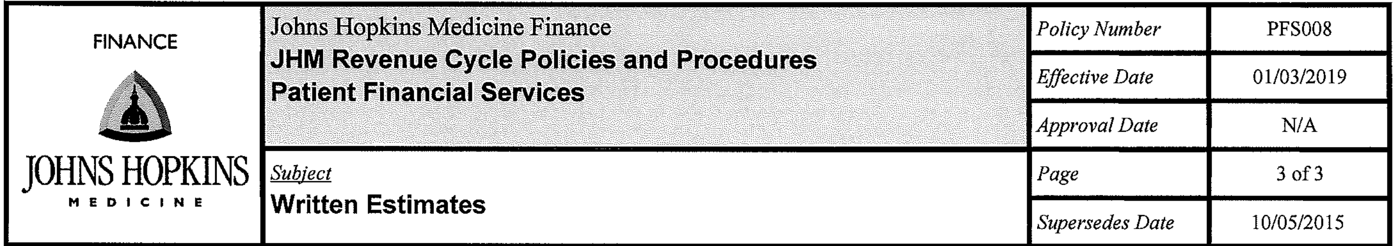
ATTACHMENT B



FINANCE JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine Finance **JHM Revenue Cycle Policies and Procedures Patient Financial Services**	*Policy Number*	PFS008
		Effective Date	01/03/2019
		Approval Date	N/A
	Subject **Written Estimates**	*Page*	3 of 3
		Supersedes Date	10/05/2015

IV. REFERENCE

1. The Johns Hopkins Health System Corporation (JHHS) Finance Policies and Procedures Manual
   - Policy No. PFS056 - Handling Customer Communications
   - Policy No. PASADT003 – Inpatient Admission, Financial Clearance, & Patient Liability
   - Policy No. PFS064 - Hospital Service Charges
2. Maryland Annotated Code, Health General Article, Section 19-350; Code of Maryland Regulations COMAR 10.37.10.26B

V. SPONSOR

- Vice President, JHHS Revenue Cycle

VI. REVIEW CYCLE

Three (3) years

VII. APPROVAL

Electronic Signature(s)	Date
Mike Larson SVP FIN/CFO-JHHS & VP FIN/CFO-JHHC, Exec JHHS Finance	01/10/2019

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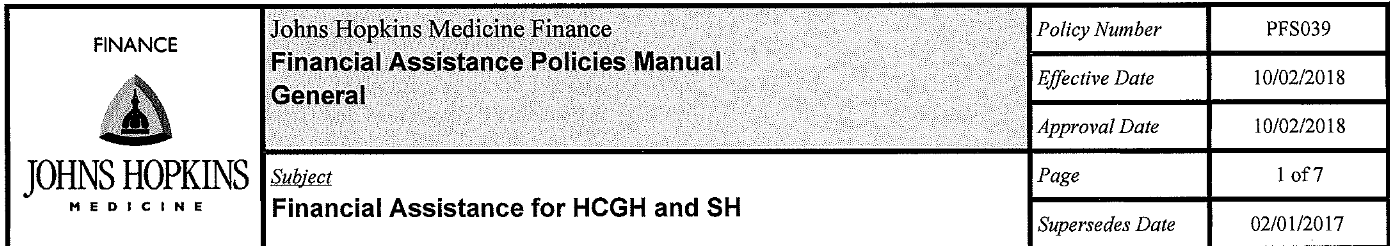
ATTACHMENT C

Version 5.0



FINANCE JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine Finance **Financial Assistance Policies Manual** **General**	*Policy Number*	PFS039
		Effective Date	10/02/2018
		Approval Date	10/02/2018
	Subject **Financial Assistance for HCGH and SH**	*Page*	1 of 7
		Supersedes Date	02/01/2017

This document applies to the following Participating Organizations:

Howard County General Hospital   Johns Hopkins Community Physicians   Suburban Hospital

Keywords: assistance, financial

Table of Contents	Page Number
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III. DEFINITIONS	2
IV. PROCEDURES	3
V. REFERENCE	5
VI. RESPONSIBILITIES– HCGH, SH	6
VII. SPONSOR	6
VIII. REVIEW CYCLE	7
IX. APPROVAL	7
Appendix A: Financial Assistance Program Eligibility Guidelines	Click Here
Appendix B: Free or Reduced Cost Care Financial Assistance Grid	Click Here
Appendix C: Presumptive Financial Assistance Eligibility	Click Here
Appendix D: Medical Financial Hardship Assistance Guidelines	Click Here
Appendix E: Medical Hardship Financial Grid	Click Here
Appendix F: Financial Assistance for Chase Brexton Patients (HCGH only)	Click Here
Appendix G: Financial Assistance for Healthy Howard Patients (HCGH only)	Click Here
Appendix H: Financial Assistance for Montgomery County and Locally Based Programs for Low Income Uninsured Patients (SH only)	Click Here
Appendix I: Maryland State Uniform Financial Assistance Application - Exhibit A	Click Here
Appendix J: Patient Financial Services Patient Profile Questionnaire - Exhibit B	Click Here
Appendix K: Medical Financial Hardship Application - Exhibit C	Click Here

I. POLICY

This policy applies to The Johns Hopkins Health System Corporation (JHHS) following entities: Howard County General Hospital (HCGH) and Suburban Hospital (SH).

II. PURPOSE

A. JHHS is committed to providing financial assistance to patients 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 the Johns Hopkins Medical Institutions to provide Financial Assistance based on indigence or excessive Medical Debt for patients who meet specified financial criteria and request such assistance. The purpose of the following policy statement is to describe how applications for Financial Assistance can be made, the criteria for eligibility, and the steps for processing each application.

C. JHHS hospitals will publish the availability of Financial Assistance on a yearly basis in their local newspapers, and will post notices of availability at patient registration sites, Admissions/Business Office the Billing Office, and at the emergency department within each facility. Notice of availability will be posted on each hospital website, will be mentioned during oral communications, and will also be sent to patients on patient bills. A Patient Billing and Financial

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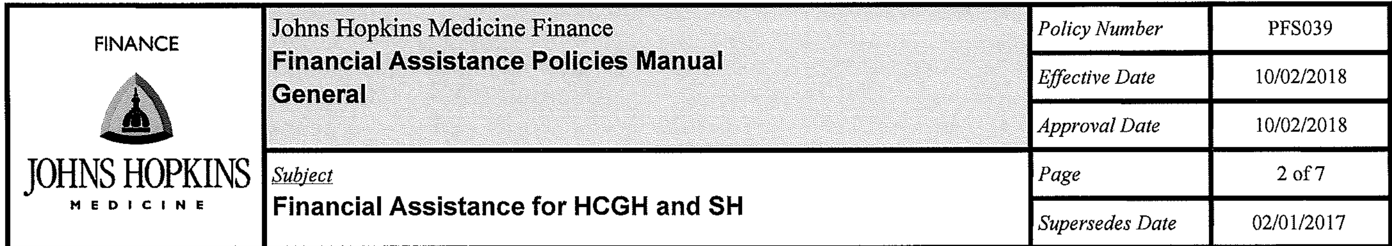

Assistance Information Sheet will be provided to inpatients before discharge and will be available to all patients upon request.

D. Financial Assistance may be extended when a review of a patient's individual financial circumstances has been conducted and documented. Review for Medical Financial Hardship Assistance shall include a review of the patient's existing medical expenses and obligations (including any accounts placed in bad debt) and any projected medical expenses. Financial Assistance Applications and medical Financial Hardship Assistance may be offered to patients whose accounts are with a collection agency and will apply only to those accounts on which a judgment has not been granted so long as other requirements are met.

E. **FINANCIAL ASSISTANCE FOR PHYSICIANS PROVIDING CARE NOTICE:**
Attaches as EXHIBIT D is a list of physicians that provide emergency and medically necessary care as defined in this policy at HCGH and SH. The list indicates if the doctor is covered under this policy. If the doctor is not covered under this policy, patients should contact the physician's office to determine if the physician offers financial assistance and if so what the physicians's financial assistance policy provides.

III. DEFINITIONS

Medical Debt	Medical Debt is defined as out of pocket expenses for medical costs resulting from medically necessary care billed by the JHHS hospital to which the application is made. Out of pocket expenses do not include co-payments, co-insurance and deductibles unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Medical Debt does not include those hospital bills for which the patient chose to be registered as Voluntary Self Pay(opting out of insurance coverage, or insurance billing)
Liquid Assets	Cash, securities, promissory notes, stocks, bonds, U.S. Savings Bonds, checking accounts, savings accounts, mutual funds, Certificates of Deposit, life insurance policies with cash surrender values, accounts receivable, pension benefits or other property immediately convertible to cash. A safe harbor of $150,000 in equity in patient's primary residence shall not be considered an asset convertible to cash. Equity in any other real property shall be subject to liquidation. Liquid Assets do not include retirement assets to which the Internal Revenue Service has granted preferential tax treatment as a retirement account, including but not limited to, deferred compensation plans qualified under the Internal Revenue Code or non qualified deferred compensation plans.
Immediate Family	If patient is a minor, immediate family member is defined as mother, father, unmarried minor siblings, natural or adopted, residing in the same household. If patient is an adult, immediate family member is defined as spouse or natural or adopted unmarried minor children residing in the same household.
Medically Necessary Care	Medical treatment that is absolutely necessary to protect the health status of a patient, and could adversely affect the patient's condition if omitted, in accordance with accepted standards of medical practice and not mainly for the convenience of the patient. Medically necessary care for the purposes of this policy does not include elective or cosmetic procedures.
Family Income	Patient's and/or responsible party's wages, salaries, earnings, tips, interest, dividends, corporate distributions, rental income, retirement/pension income, Social Security benefits and other income as defined by the Internal Revenue Service, for all members of Immediate Family residing in the household
Supporting Documentation	Pay stubs; W-2s; 1099s; workers' compensation, Social Security or disability award letters; bank or brokerage statements; tax returns; life insurance policies; real estate assessments and credit bureau reports, Explanation of Benefits to support Medical Debt.

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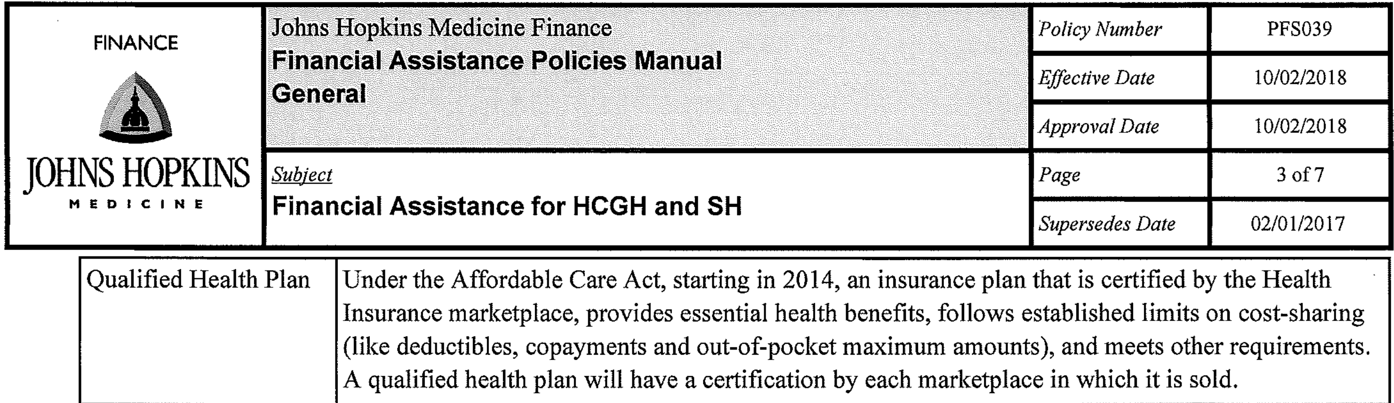

Qualified Health Plan	Under the Affordable Care Act, starting in 2014, an insurance plan that is certified by the Health Insurance marketplace, provides essential health benefits, follows established limits on cost-sharing (like deductibles, copayments and out-of-pocket maximum amounts), and meets other requirements. A qualified health plan will have a certification by each marketplace in which it is sold.

IV. PROCEDURES

A. An evaluation for Financial Assistance can begin in a number of ways:
   1. For example:
      a. A patient with a self-pay balance due notifies the self-pay collector or collection agency that he/she cannot afford to pay the bill and requests assistance.
      b. A patient presents at a clinical area without insurance and states that he/she cannot afford to pay the medical expenses associated with their current or previous medical services.
      c. A physician or other clinician refers a patient for Financial-Assistance evaluation for either inpatient or outpatient services.

B. Each Clinical or Business Unit will designate a person or persons who will be responsible for taking Financial Assistance applications. These staff can be Financial Counselors, Self-Pay Collection Specialists, Administrative staff, Customer Service, etc.

C. Designated staff may meet with patients who request Financial Assistance to determine if they meet preliminary criteria for assistance.
   1. All hospital applications will be processed within two business days and a determination will be made as to probable eligibility. To facilitate this process each applicant must provide information about family size and income, as defined by Medicaid regulations. To help applicants complete the process, a statement of conditional approval will be provided that will list the paperwork required for a final determination of eligibility.
   2. Applications received will be sent to the JHHS Revenue Cycle Management Department for review; a written determination of probable eligibility will be issued to the patient.
   3. At Howard County General Hospital (HCGH), complete applications with all supporting documentation submitted at the hospital are approved via the appropriate signature authority process. Once approved and signed off on, the approved applications will be sent to the JHHS Revenue Cycle Management Department's to mail patient a written determination of eligibility.

D. To determine final eligibility, the following criteria must be met:
   1. The patient must apply for Medical Assistance or insurance coverage through a Qualified Health Plan and cooperate fully with the Medical Assistance team or its' designated agent, unless the financial representative can readily determine that the patient would fail to meet the eligibility requirements. The Patient Profile Questionnaire (Exhibit B) is used to determine if the patient must apply for Medical Assistance. In cases where the patient has active Medical Assistance pharmacy coverage or QMB coverage, it would not be necessary to reapply for Medical Assistance unless the financial representative has reason to believe that the patient may be awarded full Medical Assistance benefits.
   2. All insurance benefits must have been exhausted.

E. To the extent possible, there will be one application process for all of the Maryland hospitals of JHHS. The patient is required to provide the following:
   1. A completed Financial Assistance Application (Exhibit A) and Patient Profile Questionnaire (Exhibit B).
   2. A copy of their most recent Federal Income Tax Return (if married and filing separately, then also a copy of spouse's tax return and a copy of any other person's tax return whose income is considered part of the family income as defined by Medicaid regulations).

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3. A copy of the three (3) most recent pay stubs (if employed) or other evidence of income of any other person whose income is considered part of the family income as defined by Medicaid regulations.
4. A Medical Assistance Notice of Determination (if applicable).
5. Proof of disability income (if applicable).
6. Reasonable proof of other declared expenses.
7. Non-U.S. citizens must complete the Financial Assistance Application (Exhibit A). In addition, the Financial Counselor shall contact the U.S. Consulate in the patient's country of residence. The U.S. Consulate should be in a position to provide information on the patient's net worth. However, the level of detail supporting the patient's financial strength will vary from country to country. After obtaining information from the U.S. Consulate, the Financial Counselor shall meet with the Director, Revenue Cycle and/or CFO (HCGH) or Director of RCM and/or CFO Suburban Hospital (SH) to determine if additional information is necessary.
8. If unemployed, reasonable proof of unemployment such as statement from the Office of Unemployment Insurance, a statement from current source of financial support, etc...

F. A patient can qualify for Financial Assistance either through lack of sufficient insurance or excessive Medical Debt. Medical Debt is defined as out of pocket expenses excluding copayments, coinsurance and deductibles for medical costs billed by a JHHS hospital, unless the patient purchased insurance through a Qualified Health Plan and meets eligibility requirements. Once a patient has submitted all the required information, the Financial Counselor will review and analyze the application and forward it to the Revenue Cycle Management Department for final determination of eligibility based on JHMI guidelines. At HCGH, the Financial Counselor will forward to Director, Revenue Cycle for review and final eligibility based upon JHMI guidelines.
   1. If the application is denied, the patient has the right to request the application be reconsidered. The Financial Counselor will forward the application and attachments for reconsideration to the CFO (HCGH) or Director PFS and CFO (SH) for final evaluation and decision.
   2. If the patient's application for Financial Assistance is based on excessive Medical Debt or if there are extenuating circumstances as identified by the Financial Counselor or designated person, the Financial Counselor will forward the application and attachments to the Director of Revenue Cycle and CFO (HCGH) or Director PFS and CFO (SH). This committee will have decision-making authority to approve or reject applications. It is expected that an application for Financial Assistance reviewed by the Director of Revenue Cycle and CFO (HCGH) or Director RCM and CFO (SH) will have a final determination made no later than 30 days from the date the application was considered complete. The Director of Revenue Cycle and CFO (HCGH) or Director RCM and CFO (SH) will base their determination of financial need on JHHS guidelines.

G. Each clinical department has the option to designate certain elective procedures for which no Financial Assistance options will be given.

H. Services provided to patients registered as Voluntary Self Pay do not qualify for Financial Assistance.

I. A department operating programs under a grant or other outside governing authority (i.e.: Psychiatry Program) may continue to use a government-sponsored application process and associated income scale.

J. Once a patient is approved for Financial Assistance, Financial Assistance coverage shall be effective for the month of determination and the following six (6) calendar months. If patient is approved for a percentage allowance due to financial hardship it is recommended that the patient makes a good-faith payment at the beginning of the Financial Assistance period. Upon a request from a patient who is uninsured and whose income level falls within the Medical Financial Hardship Income Grid set forth in Appendix B, JHHS shall make a payment plan available to the patient. Any payment schedule developed through this policy will ordinarily not last longer than two years. In extraordinary circumstances and with the approval of the designated manager a payment schedule may be extended.

K. Presumptive Financial Assistance Eligibility. There are instances when a patient may appear eligible for financial assistance, but there is no financial assistance form on file. Often there is adequate information provided by the patient or other sources, which could provide sufficient evidence to provide the patient with financial assistance. In the event there is no evidence to support a patient's eligibility for financial assistance, JHHS reserves the right to use outside

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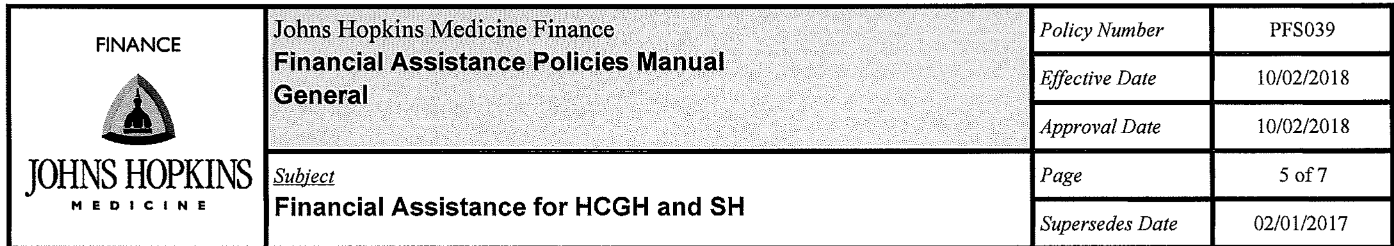

agencies in determining estimated income amounts for the basis of determining financial assistance eligibility and potential reduced care rates. Once determined, due to the inherent nature of presumptive circumstances, the only financial assistance that can be granted is either a partial a 100% writeoff of the account balance dependent upon income and FPL amounts. Presumptive Financial Assistance Eligibility shall only cover the patient's specific date of service and shall not be effective for a six (6) month period. Presumptive eligibility may be determined on the basis of individual life circumstances. Unless otherwise eligible for Medicaid or CHIP, patients who are beneficiaries/recipients of the means-tested social service programs listed by the Health Services Cost Review Commission in COMAR 10.37.10.26 A-2 are deemed Presumptively Eligible for free care provided the patient submits proof of enrollment within 30 days of date of service. Such 30 days may be extended to 60 days if patient or patients representative requests an additional 30 days. Appendix A-1 provides a list of life circumstances in addition to those specified by the regulations listed above that qualify a patient for Presumptive Eligibility.

L. Financial Assistance Applications may only be submitted for/by patients with open and unpaid hospital accounts.

M. Patients who indicate they are unemployed and have no insurance coverage shall be required to submit a Financial Assistance Application (Exhibit A) unless they meet Presumptive Financial Assistance Eligibility criteria (see Appendix A-1). If patient qualifies for COBRA coverage, patient's financial ability to pay COBRA insurance premiums shall be reviewed by the Financial Counselor and recommendations shall be made to Director of Revenue Cycle and CFO (HCGH) or Director RCM and CFO (SH). 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.

N. Patients who receive coverage on a Qualified Health Plan and ask for help with out of pocket expenses (co-payments and deductibles) for medical costs resulting from medical necessary care shall be required to submit a Financial Assistance Application if the patient is at or below 200% of Federal Poverty Guidelines.

O. If a patient account has been assigned to a collection agency, and patient or guarantor requests financial assistance or appears to qualify for financial assistance, the collection agency shall notify RCM and shall forward the patient/ guarantor a financial assistance application with instructions to return the completed application to RCM for review and determination and shall place the account on hold for 45 days pending further instruction from RCM.

P. Beginning October 1, 2010, if within a two (2) year period after the date of service a patient is found to be eligible for free care on the date of service (using the eligibility standards applicable on the date of service), the patient shall be refunded amounts received from the patient/guarantor exceeding $25. If hospital documentation demonstrates the lack of cooperation of the patient or guarantor in providing information to determine eligibility for free care, the two (2) year period herein may be reduced to 30 days from the date of initial request for information. If the patient is enrolled in a means-tested government health care plan that requires the patient to pay-out-of pocket for hospital services, then patient or guarantor shall not be refunded any funds that would result in patient losing financial eligibility for health coverage.

Q. This Financial Assistance policy does not apply to deceased patients for whom a decedent estate has or should be opened due to assets owned by a deceased patient. Johns Hopkins will file a claim in the decedents' estate and such claim will be subject to estate administration and applicable Estates and Trust laws.

R. Actions JHHS hospitals may take in the event of non-payment are described in a separate billing and collections policy (PFS046). To obtain a free copy of this policy, please contact Customer Service at 1-855-662-3017 (toll free) or send an email to pfscs@jhmi.edu or visit a Financial Counselor in the Admission Office of any JHHS Hospital.

V. REFERENCE

JHHS Finance Policies and Procedures Manual

- Policy No.PFS120 - Signature Authority: Patient Financial Services
- Policy No.PFS034 - Installment Payments

Charity Care and Bad Debts, AICPA Health Care Audit Guide

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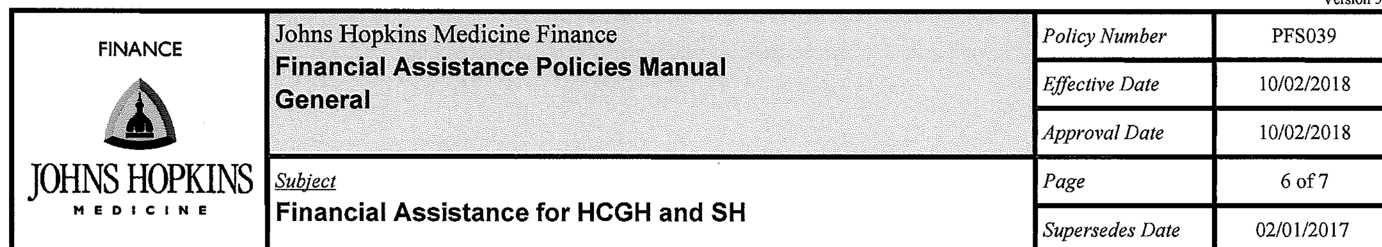
ATTACHMENT C



FINANCE JOHNS HOPKINS MEDICINE	Johns Hopkins Medicine Finance **Financial Assistance Policies Manual General**	*Policy Number*	PFS039
		Effective Date	10/02/2018
		Approval Date	10/02/2018
	Subject **Financial Assistance for HCGH and SH**	*Page*	6 of 7
		Supersedes Date	02/01/2017

Code of Maryland Regulations COMAR 10.37.10.26, et seq
Maryland Code Health General 19-214, et seq
Federal Poverty Guidelines (Updated annually) in Federal Register

NOTE: Standardized applications for Financial Assistance, Patient Profile Questionnaire and Medical Financial Hardship have been developed. For information on ordering, please contact the Patient Financial Services Department. Copies are attached to this policy as Exhibits A, B and C.

VI. RESPONSIBILITIES– HCGH, SH

A. Financial Counselor (Pre-Admission/Admission/In-House/ Outpatient) Customer Service Collector Admissions Coordinator
Any Finance representative designated to accept applications for
   1. Understand current criteria for Assistance qualifications.
   2. Identify prospective patients; initiate application process when required. As necessary assist patient in completing application or program specific form.
      Financial Assistance
      On the day preliminary application is received, send to Revenue Cycle Management Department's for determination of probable eligibility.
   3. Review preliminary application (Exhibit A), Patient Profile Questionnaire (Exhibit B) and Medical Financial Hardship Application (Exhibit C), if submitted, to make probable eligibility determination. Within two business days of receipt of preliminary application, mail determination to patient's last known address or deliver to patient if patient is currently an inpatient. Notate patient account comments.
   4. If Financial Assistance Application is not required, due to patient meeting specific criteria, notate patient account comments and forward to Management Personnel for review.
   5. Review and ensure completion of final application.
   6. Deliver completed final application to appropriate management.
   7. Document all transactions in all applicable patient accounts comments.
   8. Identify retroactive candidates; initiate final application process.

B. Management Personnel (Supervisor/Manager/Director)
   1. Review completed final application; monitor those accounts for which no application is required; determine patient eligibility; communicate final written determination to patient within 30 business days of receiving completed application. If patient is eligible for reduced cost care, apply the most favorable reduction in charges for which patient qualifies.
   2. Advise ineligible patients of other alternatives available to them including installment payments, bank loans, or consideration under the Medical Financial Hardship program if they have not submitted the supplemental application, Exhibit C. [Refer to Appendix B - Medical Financial Hardship Assistance Guidelines.]
   3. Notices will not be sent to Presumptive Eligibility recipients.

C. Financial Management Personnel (Senior Director/Assistant Treasurer or affiliate equivalent)
CP Director and Management Staff
   1. Review and approve Financial Assistance applications and accounts for which no application is required and which do not write off automatically in accordance with signature authority established in JHHS Finance Policy No. PFS120- Signature Authority: Patient Financial Services.

VII. SPONSOR

- CFO (HCGH, SH)
- Director of Revenue Cycle (HCGH)
- Director, PFS (SH)

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VIII. REVIEW CYCLE

Two (2) years

IX. APPROVAL

Revision History:

5/1/2019 - Changes made to financial grids in Appendix A and Appendix B.

Electronic Signature(s)	Date
Mike Larson SVP Finance/Chief Financial Officer, JHHS; VP Finance/ Chief Financial Officer, JHHC; Exec. JHHS FIN	10/02/2018

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ATTACHMENT D -- Charity Care for Maryland Hospitals in 2018
Taken from file provided by e-mail on 5/15/19 by Brett McCone of M.H.A. -- Excel file "Sch_rev5pda_fy18_v01", tab "RE"
"Charity Care" taken from Column L ("CHARUNC")
"Total Operating Expenses" taken from Colum AA ("Tot_Exps")
Sorted by "Category" (regulated, unregulated or total) and then by charity care percentage

Base Year	Hospital Number	Hospital Name	Category	Charity Care	Total Expenses	Charity Care as a % of Total Expenses	Rank	Percentile
2018	213300	Mt. Washington Peds	REGULATE	101	51,657	0.2%	1	1
2018	210033	Carroll Co Hospital Cntr	REGULATE	416	179,888	0.2%	2	3
2018	210044	GBMC	REGULATE	1,642	372,375	0.4%	3	5
2018	210023	Anne Arundel Medical Cntr	REGULATE	3,924	490,791	0.8%	4	7
2018	210035	UM-Charles Regional	REGULATE	971	113,933	0.9%	5	9
2018	210012	Sinai Hospital	REGULATE	5,643	596,332	0.9%	6	11
2018	210040	Northwest Hospital Cntr	REGULATE	2,067	188,598	1.1%	7	13
2018	210030	UM-SRH at Chestertown	REGULATE	460	40,472	1.1%	8	15
2018	210064	Levindale	REGULATE	505	43,649	1.2%	9	17
2018	210009	Johns Hopkins	REGULATE	26,475	2,045,293	1.3%	10	19
2018	210088	UM-Queen Anne's ED	REGULATE	87	6,656	1.3%	11	21
2018	210018	MedStar Montgomery	REGULATE	1,848	135,513	1.4%	12	23
2018	210032	Union Hospital of Cecil Co	REGULATE	1,815	127,785	1.4%	13	25
2018	210002	UMMC	REGULATE	18,572	1,245,985	1.5%	14	28
2018	210037	UM-SRH at Easton	REGULATE	2,421	156,725	1.5%	15	30
2018	210001	Meritus Medical Cntr	REGULATE	4,106	253,102	1.6%	16	32
2018	210022	Suburban	REGULATE	4,363	261,991	1.7%	17	34
2018	210063	UM-St. Joseph Med Cntr	REGULATE	5,307	311,529	1.7%	18	36
2018	210049	UM-Upper Chesapeake	REGULATE	4,313	250,715	1.7%	19	38
2018	210010	UM-SRH at Dorchester	REGULATE	689	38,031	1.8%	20	40
2018	**210048**	**Howard County General**	**REGULATE**	**4,598**	**249,731**	**1.8%**	**21**	**42**
2018	210045	McCready Memorial	REGULATE	291	15,792	1.8%	22	44
2018	210024	MedStar Union Memorial	REGULATE	6,328	342,650	1.8%	23	46
2018	210015	MedStar Franklin Square	REGULATE	7,344	396,609	1.9%	24	48
2018	210019	Peninsula Regional	REGULATE	6,606	336,127	2.0%	25	50
2018	210043	UM-BWMC	REGULATE	6,845	336,519	2.0%	26	52
2018	210058	UM-ROI	REGULATE	2,258	106,249	2.1%	27	54
2018	218992	UM-Shock Trauma	REGULATE	3,485	162,982	2.1%	28	56
2018	210062	MedStar Southern MD	REGULATE	4,844	214,663	2.3%	29	58
2018	210038	UMMC - Midtown	REGULATE	3,962	173,682	2.3%	30	60
2018	210006	UM-Harford Memorial	REGULATE	1,903	83,338	2.3%	31	62
2018	210056	MedStar Good Samaritan	REGULATE	4,954	210,839	2.3%	32	64
2018	210005	Frederick Memorial	REGULATE	6,162	253,917	2.4%	33	66
2018	210028	MedStar St. Mary's	REGULATE	3,735	142,379	2.6%	34	68
2018	210034	MedStar Harbor Hospital Cntr	REGULATE	3,821	142,342	2.7%	35	70
2018	210061	Atlantic General	REGULATE	2,438	80,338	3.0%	36	72
2018	210008	Mercy Medical Cntr	REGULATE	14,632	450,636	3.2%	37	74
2018	210029	JH Bayview	REGULATE	18,783	565,883	3.3%	38	76
2018	214000	Sheppard Pratt	REGULATE	4,488	135,204	3.3%	39	79
2018	210055	UM-Laurel Regional	REGULATE	2,860	82,741	3.5%	40	81
2018	210003	UM-Prince George's Hospital	REGULATE	9,287	240,415	3.9%	41	83
2018	210027	Western Maryland	REGULATE	9,857	243,236	4.1%	42	85
2018	210039	Calvert Health Med Cntr	REGULATE	5,233	115,202	4.5%	43	87
2018	210051	Doctors Community	REGULATE	8,858	185,982	4.8%	44	89
2018	210017	Garrett Co Memorial	REGULATE	2,551	47,330	5.4%	45	91
2018	210065	HC-Germantown	REGULATE	5,062	90,521	5.6%	46	93
2018	210004	Holy Cross	REGULATE	25,604	378,841	6.8%	47	95
2018	210011	St. Agnes Hospital	REGULATE	21,652	318,726	6.8%	48	97
2018	210333	UM-Bowie Health Cntr	REGULATE	1,243	15,944	7.8%	49	99
2018	213300	Mt. Washington Peds	TOTAL	101	58,629	0.2%	1	1
2018	210033	Carroll Co Hospital Cntr	TOTAL	547	263,906	0.2%	2	3
2018	210044	GBMC	TOTAL	1,711	504,347	0.3%	3	5

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"Charity Care" taken from Column L ("CHARUNC")
"Total Operating Expenses" taken from Colum AA ("Tot_Exps")
Sorted by "Category" (regulated, unregulated or total) and then by charity care percentage

Base Year	Hospital Number	Hospital Name	Category	Charity Care	Total Expenses	Charity Care as a % of Total Expenses	Rank	Percentile
2018	210023	Anne Arundel Medical Cntr	TOTAL	3,955	530,969	0.7%	4	7
2018	210035	UM-Charles Regional	TOTAL	971	119,860	0.8%	5	9
2018	210012	Sinai Hospital	TOTAL	6,361	764,960	0.8%	6	11
2018	210040	Northwest Hospital Cntr	TOTAL	2,067	248,190	0.8%	7	13
2018	210030	UM-SRH at Chestertown	TOTAL	475	46,259	1.0%	8	15
2018	210009	Johns Hopkins	TOTAL	26,475	2,396,322	1.1%	9	17
2018	210032	Union Hospital of Cecil Co	TOTAL	1,822	164,243	1.1%	10	19
2018	210018	MedStar Montgomery	TOTAL	1,848	165,450	1.1%	11	21
2018	210088	UM-Queen Anne's ED	TOTAL	87	6,672	1.3%	12	23
2018	210064	Levindale	TOTAL	1,019	77,726	1.3%	13	25
2018	210002	UMMC	TOTAL	18,572	1,358,279	1.4%	14	28
2018	210015	MedStar Franklin Square	TOTAL	7,344	518,888	1.4%	15	30
2018	210024	MedStar Union Memorial	TOTAL	6,611	449,182	1.5%	16	32
2018	210022	Suburban	TOTAL	4,386	295,311	1.5%	17	34
2018	210001	Meritus Medical Cntr	TOTAL	4,719	314,735	1.5%	18	36
2018	210037	UM-SRH at Easton	TOTAL	2,714	180,601	1.5%	19	38
2018	210063	UM-St. Joseph Med Cntr	TOTAL	5,281	335,049	1.6%	20	40
2018	210049	UM-Upper Chesapeake	TOTAL	4,313	262,866	1.6%	21	42
2018	210048	Howard County General	TOTAL	4,598	265,393	1.7%	22	44
2018	210010	UM-SRH at Dorchester	TOTAL	704	40,095	1.8%	23	46
2018	210038	UMMC - Midtown	TOTAL	3,962	223,093	1.8%	24	48
2018	210019	Peninsula Regional	TOTAL	7,605	427,362	1.8%	25	50
2018	210056	MedStar Good Samaritan	TOTAL	4,954	259,073	1.9%	26	52
2018	210045	McCready Memorial	TOTAL	326	16,956	1.9%	27	54
2018	210062	MedStar Southern MD	TOTAL	4,844	247,678	2.0%	28	56
2018	214000	Sheppard Pratt	TOTAL	4,488	229,099	2.0%	29	58
2018	210043	UM-BWMC	TOTAL	6,845	344,997	2.0%	30	60
2018	210061	Atlantic General	TOTAL	2,568	127,458	2.0%	31	62
2018	210005	Frederick Memorial	TOTAL	6,974	340,036	2.1%	32	64
2018	210058	UM-ROI	TOTAL	2,258	109,216	2.1%	33	66
2018	210034	MedStar Harbor Hospital Cntr	TOTAL	3,821	183,508	2.1%	34	68
2018	218992	UM-Shock Trauma	TOTAL	3,485	163,948	2.1%	35	70
2018	210006	UM-Harford Memorial	TOTAL	1,903	87,719	2.2%	36	72
2018	210028	MedStar St. Mary's	TOTAL	3,984	162,219	2.5%	37	74
2018	210029	JH Bayview	TOTAL	18,957	632,548	3.0%	38	76
2018	210008	Mercy Medical Cntr	TOTAL	14,632	483,817	3.0%	39	79
2018	210055	UM-Laurel Regional	TOTAL	2,860	91,189	3.1%	40	81
2018	210003	UM-Prince George's Hospital	TOTAL	9,287	285,839	3.2%	41	83
2018	210027	Western Maryland	TOTAL	10,490	321,987	3.3%	42	85
2018	210051	Doctors Community	TOTAL	8,858	242,017	3.7%	43	87
2018	210039	Calvert Health Med Cntr	TOTAL	5,547	132,711	4.2%	44	89
2018	210017	Garrett Co Memorial	TOTAL	2,678	58,741	4.6%	45	91
2018	210065	HC-Germantown	TOTAL	4,839	100,707	4.8%	46	93
2018	210011	St. Agnes Hospital	TOTAL	23,955	452,576	5.3%	47	95
2018	210333	UM-Bowie Health Cntr	TOTAL	1,243	21,275	5.8%	48	97
2018	210004	Holy Cross	TOTAL	31,486	431,925	7.3%	49	99
2018	210065	HC-Germantown	UNREGULATED	(223)	10,187	-2.2%	1	1
2018	210063	UM-St. Joseph Med Cntr	UNREGULATED	(26)	23,520	-0.1%	2	3
2018	210056	MedStar Good Samaritan	UNREGULATED	(0)	48,234	0.0%	3	5
2018	210002	UMMC	UNREGULATED	-	112,294	0.0%	4	7
2018	210003	UM-Prince George's Hospital	UNREGULATED	-	45,424	0.0%	5	9
2018	210006	UM-Harford Memorial	UNREGULATED	-	4,381	0.0%	6	11

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Sorted by "Category" (regulated, unregulated or total) and then by charity care percentage

Base Year	Hospital Number	Hospital Name	Category	Charity Care	Total Expenses	Charity Care as a % of Total Expenses	Rank	Percentile
2018	210008	Mercy Medical Cntr	UNREGULATED	-	33,181	0.0%	7	13
2018	210009	Johns Hopkins	UNREGULATED	-	351,029	0.0%	8	15
2018	210015	MedStar Franklin Square	UNREGULATED	-	122,279	0.0%	9	17
2018	210018	MedStar Montgomery	UNREGULATED	-	29,938	0.0%	10	19
2018	210034	MedStar Harbor Hospital Cntr	UNREGULATED	-	41,166	0.0%	11	21
2018	210035	UM-Charles Regional	UNREGULATED	-	5,927	0.0%	12	23
2018	210038	UMMC - Midtown	UNREGULATED	-	49,411	0.0%	13	25
2018	210040	Northwest Hospital Cntr	UNREGULATED	-	59,593	0.0%	14	28
2018	210043	UM-BWMC	UNREGULATED	-	8,478	0.0%	15	30
2018	**210048**	**Howard County General**	**UNREGULATED**	**-**	**15,662**	**0.0%**	**16**	**32**
2018	210049	UM-Upper Chesapeake	UNREGULATED	-	12,151	0.0%	17	34
2018	210051	Doctors Community	UNREGULATED	-	56,036	0.0%	18	36
2018	210055	UM-Laurel Regional	UNREGULATED	-	8,448	0.0%	19	38
2018	210058	UM-ROI	UNREGULATED	-	2,967	0.0%	20	40
2018	210062	MedStar Southern MD	UNREGULATED	-	33,015	0.0%	21	42
2018	210088	UM-Queen Anne's ED	UNREGULATED	-	16	0.0%	22	44
2018	210333	UM-Bowie Health Cntr	UNREGULATED	-	5,331	0.0%	23	46
2018	213300	Mt. Washington Peds	UNREGULATED	-	6,972	0.0%	24	48
2018	214000	Sheppard Pratt	UNREGULATED	-	93,895	0.0%	25	50
2018	218992	UM-Shock Trauma	UNREGULATED	-	966	0.0%	26	52
2018	210032	Union Hospital of Cecil Co	UNREGULATED	7	36,458	0.0%	27	54
2018	210044	GBMC	UNREGULATED	69	131,972	0.1%	28	56
2018	210022	Suburban	UNREGULATED	23	33,320	0.1%	29	58
2018	210023	Anne Arundel Medical Cntr	UNREGULATED	32	40,178	0.1%	30	60
2018	210033	Carroll Co Hospital Cntr	UNREGULATED	131	84,019	0.2%	31	62
2018	210029	JH Bayview	UNREGULATED	174	66,665	0.3%	32	64
2018	210030	UM-SRH at Chestertown	UNREGULATED	15	5,788	0.3%	33	66
2018	210024	MedStar Union Memorial	UNREGULATED	282	106,532	0.3%	34	68
2018	210061	Atlantic General	UNREGULATED	130	47,120	0.3%	35	70
2018	210012	Sinai Hospital	UNREGULATED	717	168,628	0.4%	36	72
2018	210010	UM-SRH at Dorchester	UNREGULATED	15	2,064	0.7%	37	74
2018	210027	Western Maryland	UNREGULATED	632	78,751	0.8%	38	76
2018	210005	Frederick Memorial	UNREGULATED	813	86,119	0.9%	39	79
2018	210001	Meritus Medical Cntr	UNREGULATED	613	61,633	1.0%	40	81
2018	210019	Peninsula Regional	UNREGULATED	999	91,234	1.1%	41	83
2018	210017	Garrett Co Memorial	UNREGULATED	127	11,411	1.1%	42	85
2018	210037	UM-SRH at Easton	UNREGULATED	294	23,877	1.2%	43	87
2018	210028	MedStar St. Mary's	UNREGULATED	248	19,840	1.3%	44	89
2018	210064	Levindale	UNREGULATED	514	34,077	1.5%	45	91
2018	210011	St. Agnes Hospital	UNREGULATED	2,303	133,850	1.7%	46	93
2018	210039	Calvert Health Med Cntr	UNREGULATED	314	17,509	1.8%	47	95
2018	210045	McCready Memorial	UNREGULATED	35	1,164	3.0%	48	97
2018	210004	Holy Cross	UNREGULATED	5,882	53,084	11.1%	49	99

ATTACHMENT E
HCAHPS Results for Maryland Hospitals for Questions on which HCGH is listed as "Below Average"
in the Maryland Hospital Performance Evaluation Guide as of 5/29/19
Question: Patients who reported that staff "Always" explained about medicines before giving it to them
HCAHPS Data downloaded from Medicare website on 5/29/19 by J. Dunn (data covers period from 7/1/17 - 6/30/18)

Provider ID	Hospital Name	HCAHPS Answer PERCENT	HCAHPS Rank in MD (1 = lowest)	HCAHPS Percentile in MD
210064	LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	37	1	1
210055	UNIVERSITY OF MD LAUREL REGIONAL HOSPITAL	51	2	3
210003	UNIVERSITY OF MD PRINCE GEORGE'S HOSPITAL CTR	52	3	5
210004	HOLY CROSS HOSPITAL	53	4	7
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	55	5	10
210065	HOLY CROSS GERMANTOWN HOSPITAL	55	6	12
21020F	VA MARYLAND HEALTHCARE SYSTEM - BALTIMORE	55	7	14
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	57	8	16
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	57	9	18
210022	SUBURBAN HOSPITAL	57	10	20
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	57	11	22
210012	SINAI HOSPITAL OF BALTIMORE	58	12	24
210032	UNION HOSPITAL OF CECIL COUNTY	59	13	27
210001	MERITUS MEDICAL CENTER	60	14	29
210019	PENINSULA REGIONAL MEDICAL CENTER	60	15	31
210051	DOCTORS' COMMUNITY HOSPITAL	60	16	33
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	60	17	35
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	60	18	37
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	61	19	39
210023	ANNE ARUNDEL MEDICAL CENTER	61	20	41
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	61	21	44
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	61	22	46
210005	FREDERICK MEMORIAL HOSPITAL	62	23	48
210011	SAINT AGNES HOSPITAL	62	24	50
210013	BON SECOURS HOSPITAL	62	25	52
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	62	26	54
210040	NORTHWEST HOSPITAL CENTER	62	27	56
210043	UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	62	28	59
210044	GREATER BALTIMORE MEDICAL CENTER	62	29	61
210048	**HOWARD COUNTY GENERAL HOSPITAL**	**62**	**30**	**63**
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	62	31	65
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	63	32	67
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	63	33	69
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	63	34	71
210034	MEDSTAR HARBOR HOSPITAL	63	35	73
210060	FORT WASHINGTON HOSPITAL	63	36	76
210028	MEDSTAR SAINT MARY'S HOSPITAL	64	37	78
210039	CALVERT HEALTH MEDICAL CENTER	64	38	80
210061	ATLANTIC GENERAL HOSPITAL	64	39	82
210009	JOHNS HOPKINS HOSPITAL, THE	65	40	84
210024	MEDSTAR UNION MEMORIAL HOSPITAL	65	41	86
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	65	42	88
210033	CARROLL HOSPITAL CENTER	65	43	90
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	67	44	93
210017	GARRETT COUNTY MEMORIAL HOSPITAL	68	45	95
210008	MERCY MEDICAL CENTER INC	71	46	97
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	80	47	99
210058	UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	Not Available		
21010F	VA MARYLAND HEALTHCARE SYSTEM - PERRY POINT	Not Available		
213300	MOUNT WASHINGTON PEDIATRIC HOSPITAL	Not Available		
213301	KENNEDY KRIEGER INSTITUTE	Not Available		

ATTACHMENT F

HCAHPS Results for Maryland Hospitals for Questions on which HCGH is listed as "Below Average"
in the Maryland Hospital Performance Evaluation Guide as of 5/29/19

Question: Patients who reported that YES, they were given information about what to do during their recovery at home

HCAHPS Data downloaded from Medicare website on 5/29/19 by J. Dunn (data covers period from 7/1/17 - 6/30/18)

Provider ID	Hospital Name	HCAHPS Answer PERCENT	HCAHPS Rank in MD (1 = lowest)	HCAHPS Percentile in MD
210064	LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	76	1	1
210003	UNIVERSITY OF MD PRINCE GEORGE'S HOSPITAL CTR	79	2	3
210004	HOLY CROSS HOSPITAL	81	3	5
210060	FORT WASHINGTON HOSPITAL	81	4	7
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	81	5	10
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	82	6	12
210055	UNIVERSITY OF MD LAUREL REGIONAL HOSPITAL	83	7	14
210065	HOLY CROSS GERMANTOWN HOSPITAL	83	8	16
21020F	VA MARYLAND HEALTHCARE SYSTEM - BALTIMORE	83	9	18
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	84	10	20
210022	SUBURBAN HOSPITAL	84	11	22
210034	MEDSTAR HARBOR HOSPITAL	84	12	24
210011	SAINT AGNES HOSPITAL	85	13	27
210012	SINAI HOSPITAL OF BALTIMORE	85	14	29
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	85	15	31
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	86	16	33
210023	ANNE ARUNDEL MEDICAL CENTER	86	17	35
210032	UNION HOSPITAL OF CECIL COUNTY	86	18	37
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	86	19	39
210039	CALVERT HEALTH MEDICAL CENTER	86	20	41
210051	DOCTORS' COMMUNITY HOSPITAL	86	21	44
210033	CARROLL HOSPITAL CENTER	87	22	46
210040	NORTHWEST HOSPITAL CENTER	87	23	48
210043	UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	87	24	50
210048	**HOWARD COUNTY GENERAL HOSPITAL**	**87**	**25**	**52**
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	87	26	54
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	87	27	56
210001	MERITUS MEDICAL CENTER	88	28	59
210005	FREDERICK MEMORIAL HOSPITAL	88	29	61
210008	MERCY MEDICAL CENTER INC	88	30	63
210009	JOHNS HOPKINS HOSPITAL, THE	88	31	65
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	88	32	67
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	88	33	69
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	88	34	71
210044	GREATER BALTIMORE MEDICAL CENTER	88	35	73
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	88	36	76
210013	BON SECOURS HOSPITAL	89	37	78
210019	PENINSULA REGIONAL MEDICAL CENTER	89	38	80
210024	MEDSTAR UNION MEMORIAL HOSPITAL	89	39	82
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	89	40	84
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	89	41	86
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	90	42	88
210028	MEDSTAR SAINT MARY'S HOSPITAL	90	43	90
210061	ATLANTIC GENERAL HOSPITAL	90	44	93
210017	GARRETT COUNTY MEMORIAL HOSPITAL	91	45	95
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	91	46	97
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	91	47	99
210058	UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	Not Available		
21010F	VA MARYLAND HEALTHCARE SYSTEM - PERRY POINT	Not Available		
213300	MOUNT WASHINGTON PEDIATRIC HOSPITAL	Not Available		
213301	KENNEDY KRIEGER INSTITUTE	Not Available		

ATTACHMENT G

HCAHPS Results for Maryland Hospitals for Questions on which HCGH is listed as "Below Average"
in the Maryland Hospital Performance Evaluation Guide as of 5/29/19

Question: Patients who reported that they "Always" received help as soon as they wanted

HCAHPS Data downloaded from Medicare website on 5/29/19 by J. Dunn (data covers period from 7/1/17 - 6/30/18)

Provider ID	Hospital Name	HCAHPS Answer PERCENT	HCAHPS Rank in MD (1 = lowest)	HCAHPS Percentile in MD
210064	LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	25	1	1
210003	UNIVERSITY OF MD PRINCE GEORGE'S HOSPITAL CTR	47	2	3
21020F	VA MARYLAND HEALTHCARE SYSTEM - BALTIMORE	49	3	5
210065	HOLY CROSS GERMANTOWN HOSPITAL	54	4	7
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	55	5	10
210055	UNIVERSITY OF MD LAUREL REGIONAL HOSPITAL	55	6	12
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	55	7	14
210004	HOLY CROSS HOSPITAL	56	8	16
210012	SINAI HOSPITAL OF BALTIMORE	57	9	18
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	57	10	20
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	57	11	22
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	58	12	24
210005	FREDERICK MEMORIAL HOSPITAL	59	13	27
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	59	14	29
210044	GREATER BALTIMORE MEDICAL CENTER	59	15	31
210060	FORT WASHINGTON HOSPITAL	59	16	33
210011	SAINT AGNES HOSPITAL	60	17	35
210028	MEDSTAR SAINT MARY'S HOSPITAL	60	18	37
210043	UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	60	19	39
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	61	20	41
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	61	21	44
210032	UNION HOSPITAL OF CECIL COUNTY	61	22	46
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	61	23	48
210048	**HOWARD COUNTY GENERAL HOSPITAL**	**61**	**24**	**50**
210051	DOCTORS' COMMUNITY HOSPITAL	61	25	52
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	62	26	54
210009	JOHNS HOPKINS HOSPITAL, THE	62	27	56
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	62	28	59
210019	PENINSULA REGIONAL MEDICAL CENTER	63	29	61
210024	MEDSTAR UNION MEMORIAL HOSPITAL	63	30	63
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	63	31	65
210033	CARROLL HOSPITAL CENTER	63	32	67
210034	MEDSTAR HARBOR HOSPITAL	63	33	69
210001	MERITUS MEDICAL CENTER	64	34	71
210022	SUBURBAN HOSPITAL	64	35	73
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	64	36	76
210039	CALVERT HEALTH MEDICAL CENTER	64	37	78
210008	MERCY MEDICAL CENTER INC	65	38	80
210040	NORTHWEST HOSPITAL CENTER	66	39	82
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	66	40	84
210013	BON SECOURS HOSPITAL	67	41	86
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	67	42	88
210061	ATLANTIC GENERAL HOSPITAL	67	43	90
210023	ANNE ARUNDEL MEDICAL CENTER	69	44	93
210017	GARRETT COUNTY MEMORIAL HOSPITAL	71	45	95
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	75	46	97
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	80	47	99
210058	UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	Not Available		
21010F	VA MARYLAND HEALTHCARE SYSTEM - PERRY POINT	Not Available		
213300	MOUNT WASHINGTON PEDIATRIC HOSPITAL	Not Available		
213301	KENNEDY KRIEGER INSTITUTE	Not Available		

COMPLICATION RATE FOR PATIENTS WITH KNEE/HIP REPLACEMENT

These steps have been implemented, or are planned for implementation, at HCGH to reduce complication rate for patients having total joint replacement:

* Implement Evidence Based Pathway for total joint patients beginning with H and Hct, and Hgb A1C parameters
* Provide education to providers on EBP and standard treatment to prevent post –op anemia and prevent blood transfusion post operatively
* Standardize collection of pre-operative labs and cancel cases if not at or greater than outlined standards
* Implement ERAS pathway on all total joint patients.
* Standardize post operative care of total joint patients

* Standardized pre-operative instructions provided to offices of PCP's (see next 2 pages)

I can provide a more-detailed update if MHCC staff require it for the review of our npPCI application.

Orthopaedic Surgery

Preparing for Orthopaedic Surgery

Once you have been told by your doctor that you may need total joint or other orthopaedic surgical procedures, you can start doing some things right away to help assure you have the best possible outcome. It is never too soon to start preparing. This handout is designed to assist you on your journey as you prepare for surgery.

EXERCISE

The better shape you are in before surgery, the easier recovery will be after surgery, even if it is difficult for you to exercise now due to an injury or pain. Pre-habilitation (or pre-hab for short) is the term used for preoperative exercise programs. These programs should start at least six weeks prior to surgery. Preoperative exercises help increase your tolerance and flexibility before surgery and decrease mobility problems after surgery.

Exercises that help strengthen your upper and lower body are the most beneficial. Talk to your physician about exercise programs including working with a physical therapist or doing exercises on your own. Be sure to discuss your preoperative exercise program with your orthopaedic surgeon and your primary care physician.

DIET

If you are overweight, it is important to try and lose weight prior to surgery. Extra weight adds stress to your joints, making it more difficult for you to move both before and after surgery. Talk with your primary care physician about information on weight loss programs and exercise. All diet pills need to be stopped at least 14 days prior to surgery.

Your body needs additional protein and nutrients after surgery. Taking multivitamins, eating well-balanced meals and staying hydrated in the weeks or months prior to surgery will help with wound healing.

STOP SMOKING

Smoking can increase your risks from anesthesia and surgery. Smoking can lead to a longer time in the hospital by increasing your chances of developing a wound infection, pneumonia, a heart attack or stroke. Smoking also slows down the healing of you bones by decreasing your blood circulation. If you smoke, talk to your physician about local resources to help you quit.

VISIT YOUR PRIMARY CARE PHYSICIAN

It is very important that any health problems or medical conditions are addressed prior to surgery, especially with a heart and lung assessment. Be sure to review all of your medications, both over the counter and prescription (including pain medications) with your physician. Be sure to take your medications on a regular basis and adhere to any dietary restrictions.

You should visit with your primary care physician as soon as you learn you are having surgery to screen for chronic diseases and discuss how to optimize those conditions prior to surgery. This can happen months prior to surgery and should include a discussion on diet, exercise, nutrition and weight loss if applicable. A preoperative assessment with history and physical should be conducted by your primary care physician within 30 days of your surgery.

HOWARD COUNTY GENERAL HOSPITAL

JOHNS HOPKINS MEDICINE

DIABETES

Surgery can add stress to your body and affect your blood sugar. Please work with your primary care physician or endocrinologist to make sure your diabetes is optimally controlled, with an HbA1c less than eight. Uncontrolled blood sugars can increase your chances of developing infections, slow down your healing and prolong your hospital stay.

ANEMIA

Total joint replacements, as with all operations, will involve some blood loss. Be sure your primary care physician checks your blood levels as soon as you start contemplating joint surgery. All patients with anemia (low iron levels) should be evaluated and optimized. For females, the hemoglobin should be above 12 and above 13 for males. This will help speed up your recovery and reduce your need for a blood transfusion after surgery.

VISIT OTHER MEDICAL SPECIALISTS

If you see any other medical specialists, you should make an appointment so they know you are planning on having total joint surgery. Some conditions may need to be optimized prior to surgery or additional tests may be needed. Sometimes, medication—such as blood thinners—will need to be adjusted as you get closer to your surgical date.

DENTAL EXAMS

Significant dental conditions may need to be resolved prior to surgery. Bacteria from your mouth can enter your bloodstream and cause an infection in your new joint. If you have problems with cavities, bleeding, sores or infections in your mouth, please have these treated by your dentist as soon as possible. Your orthopaedic surgeon may require a dental exam as part of your preoperative clearance. If you already visit the dentist for routine cleanings every six months, you do not need an additional visit. Routine dental cleanings are recommended but should not be scheduled within two weeks of surgery.

INSURANCE COVERAGE

Check with your insurance company to review your coverage. Often there are deductibles or copayments that will need to be paid prior to having this procedure.

ADDITIONAL HELP AT HOME

You are typically in the hospital overnight after orthopaedic surgery. You will need additional help at home when you are discharged from the hospital. Start enlisting the help of neighbors, friends and family who will be available to help you with doctor and physical therapy appointments, preparing meals and household chores after surgery. You may have to schedule your surgery during a time when someone will be able to stay with you after surgery until you are able to manage on your own. Home care agencies and transportation services are also available, however they are not covered by insurance. If you live or work in Howard County, please feel free to contact our Member Care Support Network at **410-720-8788**. Outside of Howard County, contact Maryland Access Point, **410-313-5980**, for information on home care and transportation.

You are only in the hospital for a short time, usually overnight. Having your health optimized prior to surgery will help you with the immediate post-operative hospitalization and with your recovery in the months after surgery.

MORE INFORMATION ABOUT TOTAL JOINT SURGERY

If you are planning on having Total Joint Surgery in the near future but want to learn more about the procedure and what to expect, attend one of our orientation classes. Call **410-740-7780** to schedule an appointment.

To speak with the Joint Academy Coordinator, call **410-720-8000**.

ATTACHMENT I
HCAHPS Results for Maryland Hospitals for Questions on which HCGH is listed as "Below Average"
in the Maryland Hospital Performance Evaluation Guide as of 5/29/19
Measure: Outpatients who got cardiac imaging stress tests before low-risk outpatient surgery
HCAHPS Data downloaded from Medicare website on 5/29/19 by J. Dunn (data covers period from 7/1/16 - 6/30/17)

Provider ID	Hospital Name	SCORE in Medicare Data	Rank in MD (worst to best)	Percentile Rank in MD
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	11.1	1	1
210061	ATLANTIC GENERAL HOSPITAL	7.4	2	5
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	7.0	3	9
210048	HOWARD COUNTY GENERAL HOSPITAL	6.6	4	12
210024	MEDSTAR UNION MEMORIAL HOSPITAL	6.3	5	16
210034	MEDSTAR HARBOR HOSPITAL	6.3	6	20
210032	UNION HOSPITAL OF CECIL COUNTY	6.2	7	24
210008	MERCY MEDICAL CENTER INC	5.8	8	27
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	5.8	9	31
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	5.8	10	35
210019	PENINSULA REGIONAL MEDICAL CENTER	5.7	11	39
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	5.6	12	42
210043	UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	5.6	13	46
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	5.6	14	50
210011	SAINT AGNES HOSPITAL	5.4	15	54
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	5.4	16	58
210012	SINAI HOSPITAL OF BALTIMORE	5.1	17	61
210009	JOHNS HOPKINS HOSPITAL, THE	5.0	18	65
210017	GARRETT COUNTY MEMORIAL HOSPITAL	4.7	19	69
210044	GREATER BALTIMORE MEDICAL CENTER	4.4	20	73
210039	CALVERT HEALTH MEDICAL CENTER	4.3	21	76
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	4.2	22	80
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	4.0	23	84
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	3.8	24	88
210040	NORTHWEST HOSPITAL CENTER	3.8	25	91
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	3.6	26	95
210033	CARROLL HOSPITAL CENTER	3.3	27	99
210001	MERITUS MEDICAL CENTER	Not Available		
210003	UNIVERSITY OF MD PRINCE GEORGE'S HOSPITAL CTR	Not Available		
210004	HOLY CROSS HOSPITAL	Not Available		
210005	FREDERICK MEMORIAL HOSPITAL	Not Available		
210013	BON SECOURS HOSPITAL	Not Available		
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	Not Available		
210022	SUBURBAN HOSPITAL	Not Available		
210023	ANNE ARUNDEL MEDICAL CENTER	Not Available		
210028	MEDSTAR SAINT MARY'S HOSPITAL	Not Available		
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	Not Available		
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	Not Available		
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	Not Available		
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	Not Available		
210051	DOCTORS' COMMUNITY HOSPITAL	Not Available		
210055	UNIVERSITY OF MD LAUREL REGIONAL HOSPITAL	Not Available		
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	Not Available		
210058	UNIV OF MD REHABILITATION & ORTHOPAEDIC INSTITUTE	Not Available		
210060	FORT WASHINGTON HOSPITAL	Not Available		
210064	LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	Not Available		
210065	HOLY CROSS GERMANTOWN HOSPITAL	Not Available		
213300	MOUNT WASHINGTON PEDIATRIC HOSPITAL	Not Available		
213301	KENNEDY KRIEGER INSTITUTE	Not Available		

ATTACHMENT J

5755 Cedar Lane
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HOWARD COUNTY
GENERAL HOSPITAL
JOHNS HOPKINS MEDICINE

May 15, 2019

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

Dear Ms. Fleck:

We are writing as part of the application by Howard County General Hospital for a Certificate of Conformance for Non-Primary Percutaneous Coronary Intervention.

As requested by Question 15 of that application, Howard County General Hospital commits 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 Intervention (ACCF/AHA/SCAI) for Percutaneous Coronary Intervention. Howard County General Hospital recognizes that, 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.

Howard County General Hospital also commits (as requested by Question 23 of the application) that our hospital will provide *primary* PCI services in accord with the requirements for *primary* PCI programs established by the Maryland Health Care Commission.

Sincerely,

Steven C. Snelgrove
President and Chief Executive Officer

Peter V. Johnston, M.D.
HCGH Medical Director
Interventional Cardiology

Attachment K -- HCGH CCL room downtimes, 7/1/13 - 12/31/18

Room	Date		Duration	Reason
	Begin	End	(Hours)	Unavailable
CCL 2 (GEHC)	**12/20/2018 14:00**	**12/20/2018 15:00**	**1.0**	**Per GE Healthcare service ticket, "Lateral Chiller Fluid Low"**
CCL 2 (GEHC)	**12/20/2018 14:00**	**12/20/2018 15:00**	**1.0**	**Per GE Healthcare service ticket, "Lateral Chiller Fluid Low"**
CCL 1 (Philips)	**11/29/2018 8:00**	**11/29/2018 16:00**	**8.0**	**Preventive maintenance for the 2nd half of CY 2018**
CCL 1 (Philips)	**11/7/2018 18:30**	**11/7/2018 19:30**	**1.0**	**Per Philips service ticket, field change order to upgrade system to rel 8.2.30.5**
CCL 2 (GEHC)	**10/11/2018 10:00**	**10/11/2018 16:30**	**6.5**	**Preventive Maintenance for Room 2 for 2nd half of CY 2018**
CCL 2 (GEHC)	**9/18/2018 10:00**	**9/18/2018 11:00**	**1.0**	**Per GE Healthcare service ticket, "issue with frontal image not being displayed on monitor"**
CCL 2 (GEHC)	**9/17/2018 12:00**	**9/17/2018 15:00**	**3.0**	**Per GE Healthcare service ticket, "issue with frontal image not being displayed on monitor"**
CCL 1 (Philips)	**8/11/2018 17:00**	**8/11/2018 18:00**	**1.0**	**Per Philips service ticket, "Someone hit the emergency power button accidentally, needs to reboot the room."**
CCL 2 (GEHC)	**7/9/2018 18:15**	**7/9/2018 19:35**	**1.3**	**Per GE Healthcare service ticket, "lateral tube collimator power failure"**
CCL 2 (GEHC)	**7/9/2018 14:01**	**7/9/2018 14:25**	**0.4**	**Per GE Healthcare service ticket, "lateral tube collimator power failure"**
CCL 1 (Philips)	**5/15/2018 13:45**	**5/15/2018 15:30**	**1.8**	**Corrective maintenance, per Philips service ticket**
CCL 1 (Philips)	**5/11/2018 8:15**	**5/11/2018 8:45**	**0.5**	**Per Philips service ticket, "loud beeping in equipment room"**
CCL 2 (GEHC)	**2/21/2018 12:30**	**2/21/2018 14:30**	**2.0**	**Per GEHC service ticket, "tableside controller for c-arm seems to have a short in it; fails intermittently"**
CCL 2 (GEHC)	**2/7/2018 12:30**	**2/7/2018 14:00**	**1.5**	**Per GEHC service ticket, "tableside controller for c-arm seems to have a short in it; fails intermittently"**
CCL 2 (GEHC)	**2/7/2018 8:26**	**2/7/2018 8:59**	**0.5**	**Per GEHC service ticket, "tableside controller for c-arm seems to have a short in it; fails intermittently"**
CCL 2 (GEHC)	**1/24/2018 10:40**	**1/24/2018 14:00**	**3.3**	**Water leak into CCL 2 from an area of the hospital above CCL 2**
CCL 2 (GEHC)	**1/23/2018 14:25**	**1/23/2018 16:00**	**1.6**	**Water leak into CCL 2 from an area of the hospital above CCL 2**
CCL 2 (GEHC)	**11/13/2017 11:00**	**11/13/2017 15:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**11/6/2017 9:00**	**11/6/2017 10:15**	**1.3**	**Per GE Healthcare service ticket, a tube change was conducted (work stated 11/3; work completed 11/6)**
CCL 2 (GEHC)	**11/3/2017 10:15**	**11/3/2017 16:30**	**6.2**	**Per GE Healthcare service ticket, a tube change was conducted (work stated 11/3; work completed 11/6)**
CCL 2 (GEHC)	**10/2/2017 11:00**	**10/2/2017 15:30**	**4.5**	**Low air flow to cooling unit**
CCL 2 (GEHC)	**7/20/2017 8:00**	**7/20/2017 16:30**	**8.5**	**Lose monitor when boom is moved into certain positions**

Attachment K -- HCGH CCL room downtimes, 7/1/13 - 12/31/18

Room	Date Begin	Date End	Duration (Hours)	Reason Unavailable
CCL 1 (Toshiba)	**6/23/2017 10:00**	**6/23/2017 12:00**	**2.0**	**Per Toshiba service ticket, lab down due to "several tube and sensor errors"**
CCL 2 (GEHC)	**4/19/2017 8:00**	**4/19/2017 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**4/11/2017 15:40**	**4/11/2017 17:00**	**1.3**	**Chiller low on fluid; side-to-side movement difficult with table**
CCL 1 (Toshiba)	**3/21/2017 15:00**	**3/22/2017 9:00**	**18.0**	**Replace fluoroscopy footswitch**
CCL 1 (Toshiba)	**2/22/2017 8:00**	**2/22/2017 12:00**	**4.0**	**Preventive Maintenance**
CCL 1 (Toshiba)	**2/14/2017 16:00**	**2/22/2017 8:00**	**184.0**	**Handle of patient table was damaged by stretcher and had to be replaced**
CCL 2 (GEHC)	**1/9/2017 14:00**	**1/9/2017 15:00**	**1.0**	**Per GE Healthcare service ticket, "AP Ref Monitor Won't Power Up"**
CCL 2 (GEHC)	**11/3/2016 8:00**	**11/3/2016 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**10/10/2016 9:00**	**10/10/2016 21:00**	**12.0**	**Water leak into CCL 2 from an area of the hospital above CCL 2**
CCL 1 (Toshiba)	**9/16/2016 9:00**	**9/16/2016 17:30**	**8.5**	**Repair of broken foot switch cover**
CCL 2 (GEHC)	**9/8/2016 7:00**	**9/8/2016 20:00**	**13.0**	**Water leak into CCL 2 from an area of the hospital above CCL 2**
CCL 1 (Toshiba)	**4/27/2016 15:00**	**4/28/2016 9:00**	**18.0**	**Repair related to a power issue ("unit blanks out", per Toshiba service ticket)**
CCL 2 (GEHC)	**4/7/2016 8:00**	**4/7/2016 12:00**	**4.0**	**Preventive Maintenance**
CCL 1 (Toshiba)	**3/17/2016 8:00**	**3/17/2016 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**12/3/2015 14:30**	**12/3/2015 16:30**	**2.0**	**Service to resolve chiller issue identified by staff on 11/30/15**
CCL 2 (GEHC)	**12/1/2015 8:00**	**12/1/2015 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**11/4/2015 14:20**	**11/4/2015 16:00**	**1.7**	**Repair related to issue with handle for table**
CCL 2 (GEHC)	**10/22/2015 9:00**	**10/22/2015 12:30**	**3.5**	**Repair related to c-arm not returning to home position**
CCL 1 (Toshiba)	**9/25/2015 15:00**	**9/25/2015 16:00**	**1.0**	**Unable to move c-arm**
CCL 2 (GEHC)	**9/22/2015 9:30**	**9/22/2015 12:00**	**2.5**	**Repair related to problem with audio in CCL room**
CCL 2 (GEHC)	**8/17/2015 15:30**	**8/17/2015 17:00**	**1.5**	**Repair related to monitor (per service ticket, "AP Live Monitor Down")**
CCL 1 (Toshiba)	**6/30/2015 13:45**	**6/30/2015 16:00**	**2.3**	**Computer issue ("screens not coming up", per Toshiba service ticket)**

Attachment K -- HCGH CCL room downtimes, 7/1/13 - 12/31/18

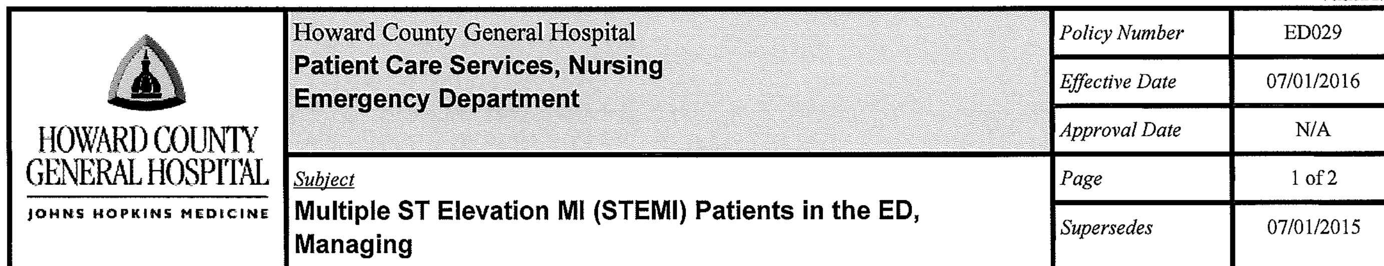
Room	Date Begin	Date End	Duration (Hours)	Reason Unavailable
CCL 2 (GEHC)	**4/24/2015 8:00**	**4/24/2015 12:00**	**4.0**	**Preventive Maintenance**
CCL 1 (Toshiba)	**2/5/2015 8:00**	**2/5/2015 12:00**	**4.0**	**Preventive Maintenance**
CCL 1 (Toshiba)	**12/29/2014 8:00**	**12/29/2014 16:30**	**8.5**	**Replacement of uninterruptible power supply (UPS) that services CCL 1**
CCL 2 (GEHC)	**12/2/2014 14:00**	**12/3/2014 12:00**	**22.0**	**Water leak into CCL 2 from an area of the hospital above CCL 2**
CCL 2 (GEHC)	**12/1/2014 8:00**	**12/1/2014 9:00**	**1.0**	**Repair related to monitor (per service ticket, "Touch Display Inoperable")**
CCL 2 (GEHC)	**11/28/2014 11:15**	**11/28/2014 13:15**	**2.0**	**Repair related to monitor (per service ticket, "Touch Display Inoperable")**
CCL 2 (GEHC)	**11/6/2014 13:45**	**11/6/2014 14:45**	**1.0**	**Repair related to table (per service ticket, "Locking handle came off the rail controller")**
CCL 2 (GEHC)	**10/29/2014 9:51**	**10/29/2014 16:31**	**6.7**	**Preventive Maintenance**
CCL 1 (Toshiba)	**10/14/2014 9:30**	**10/14/2014 10:30**	**1.0**	**Dose Rate Adjustment by vendor (Toshiba)**
CCL 2 (GEHC)	**8/5/2014 8:00**	**8/8/2014 12:00**	**76.0**	**Major repair -- no power to table -- 100-pin cable had to be delivered to HCGH from factory in France**
CCL 2 (GEHC)	**8/1/2014 8:00**	**8/1/2014 16:30**	**8.5**	**Power supply issue that affected our ability to move the patient table**
CCL 2 (GEHC)	**6/20/2014 15:30**	**6/20/2014 16:30**	**1.0**	**Error code; equipment returned to normal operation after re-boot**
CCL 2 (GEHC)	**4/28/2014 8:00**	**4/28/2014 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**4/4/2014 14:08**	**4/7/2014 10:00**	**67.9**	**Fluoroscopy not working; low voltage power supply replaced**
CCL 2 (GEHC)	**3/6/2014 9:58**	**3/6/2014 16:00**	**6.0**	**Chiller Shut-Down on lateral head; repairs done by GE Healthcare**
CCL 1 (Toshiba)	**2/4/2014 8:00**	**2/4/2014 12:00**	**4.0**	**Preventive Maintenance**
CCL 2 (GEHC)	**11/5/2013 13:00**	**11/5/2013 14:00**	**1.0**	**Room locked-up during a case; repairs done by GE Healthcare**
CCL 2 (GEHC)	**10/23/2013 8:00**	**10/23/2013 12:00**	**4.0**	**Preventive Maintenance**
CCL 1 (Toshiba)	**9/13/2013 8:55**	**9/13/2013 10:00**	**1.1**	**Power issue ("no power to CCL 1", per Toshiba service ticket)**

Attachment L -- HCGH PCI Patients and DTB Times, 1/1/15 - 6/30/19

Quarter Ending	# of STEMI Patients	# of STEMI Pts Receiving PCI	STEMI Pts with DTB <90 minutes			Data Source
			# with DTB <90 minutes	% <90	Rolling 8 Quarters	
CY15 Q1	18	18	10	56%		NCDR Registry
CY15 Q2	28	28	25	89%		NCDR Registry
CY15 Q3	29	27	21	78%		NCDR Registry
CY15 Q4	24	24	22	92%		NCDR Registry
CY16 Q1	22	22	14	64%		NCDR Registry
CY16 Q2	21	21	14	67%		NCDR Registry
CY16 Q3	29	28	22	79%		NCDR Registry
CY16 Q4	27	27	25	93%	78%	NCDR Registry
CY17 Q1	23	23	14	61%	79%	NCDR Registry
CY17 Q2	22	19	17	89%	78%	NCDR Registry
CY17 Q3	25	25	18	72%	77%	NCDR Registry
CY17 Q4	24	22	16	73%	75%	NCDR Registry
CY18 Q1	42	40	30	75%	76%	NCDR Registry
CY18 Q2	24	24	15	63%	75%	HCGH Log
CY18 Q3	19	19	15	79%	75%	HCGH Log
CY18 Q4	32	32	27	84%	75%	HCGH Log
CY19 Q1	22	22	16	73%	76%	HCGH Log
CY19 Q2 (as of 5/20/19)	15	15	13	87%	75%	HCGH Log

ATTACHMENT M, 1of2

Version 2.0



HOWARD COUNTY GENERAL HOSPITAL JOHNS HOPKINS MEDICINE	Howard County General Hospital **Patient Care Services, Nursing Emergency Department**	*Policy Number*	ED029
		Effective Date	07/01/2016
		Approval Date	N/A
	Subject **Multiple ST Elevation MI (STEMI) Patients in the ED, Managing**	*Page*	1 of 2
		Supersedes	07/01/2015

Keywords: ED, manage STEMI

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I. PURPOSE

To provide for optimum management and treatment of multiple ST Elevation MI (STEMI) patients in the Emergency Department and managing a STEMI patient when another emergency is occupying the Cardiovascular Lab (Cath Lab).

II. POLICY

In the event a STEMI patient presents to the ED during Cath Lab on-call hours, and the Cath Lab is involved in another emergency case, best effort will be made to bring the STEMI to the Cath Lab in a timely manner.

III. PROCEDURE

A. If multiple patients with STEMI who are candidates for primary PCI present to the ED at the same time, the Interventional Cardiologist and ED physician will decide the order in which the patients are taken to the catheterization laboratory. If it is expected that there will be a significant delay (>90 minutes) until primary PCI can be provided to the additional patient(s), the patient(s) awaiting treatment will be emergently transferred to a PCI-capable hospital or be administered fibrinolytics as deemed appropriate by the Interventional Cardiologist and ED physician.

B. If both catheterization laboratories are in use when a STEMI patient eligible for primary PCI arrives in the ED, any elective procedures will be discontinued as soon as possible so that the STEMI patient may be brought to the catheterization laboratory. If it is expected that there will be a significant delay (>90 minutes) until primary PCI can be provided to the patient, they will be emergently transferred to a PCI-capable hospital or be administered fibrinolytics as deemed appropriate by the Interventional Cardiologist and ED physician.

C. If the Cath Lab on-call team is caring for an emergency in the Cath Lab and a STEMI patient presents to the ED, the Interventional Cardiologist and ED physician will decide if the STEMI patient can be cared for at HCGH or if in the best interest of the patient, the patient should be transferred to PCI-capable hospital.

D. In all STEMI cases the Hopkins Access Line (HAL) 410-955-9444 will be notified to activate the HCGH Heart Attack Team (HAT). If the on-call nurses and techs are with another patient, HAL will be notified by the on-call team. The on-call techs will discuss time frames with the Interventional Cardiologist. The Interventional Cardiologist and ED physician will decide the disposition of the patient. If it is decided that the patient will be moved, suitable transfer arrangements will be made. In most cases, HAL will be notified to activate the Johns Hopkins Hospital HAT team and arrange for emergency transfer.

E. Emergent STEMI cases will take priority over scheduled cases in the Cardiovascular Lab.

IV. SUPPORTIVE INFORMATION

Sponsoring Department:

- Emergency Department

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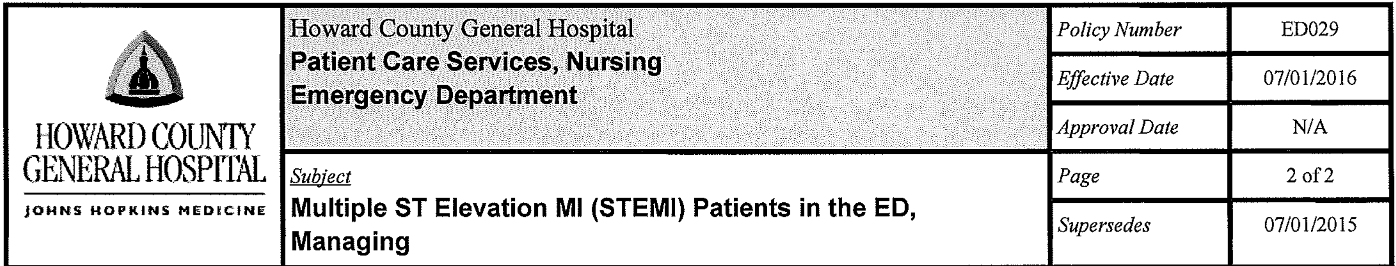

Howard County General Hospital **Patient Care Services, Nursing** **Emergency Department**	*Policy Number*	ED029
	Effective Date	07/01/2016
	Approval Date	N/A
Subject **Multiple ST Elevation MI (STEMI) Patients in the ED, Managing**	*Page*	2 of 2
	Supersedes	07/01/2015

Related Policies:

- C-02.0: Care of the PCI Patient (Percutaneous Coronary Intervention)
- ED042: Triage

References:

1. Bagai, A, Jollis, J, Dauerman, H, et al. (2013) Emergency department bypass for ST-segment-elevation-myocardial infarction patients identified with a prehospital electrocardiogram.Circulation 128:352-359.
2. Naidu, S, Rao, S Blankenship, J, Cavendish, J, et al. (2012) Clinical expert consensus statement on best practices in the cardiac catherization laboratory: Society for cardiovascular angiography and interventions. 2012:1-9.

V. APPROVALS

Electronic Signature(s)	Date
Edward Heise Director Emergency Services	03/17/2017

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Attachment N -- HCGH Continuing Education Related to PCI Services (7/1/13 thru 12/31/18)

Care Area	Type / Topic of Activity	Approximate Date	Audience	CEU* Approved Y/N	# Credits	Internal Program Y/N	External Program Y/N
IRCV	Fluoroscopy training (Biannual in December)	12/15/18	Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/13/18	All new RN hires & current RNs as needed	N		Y	N
IRCV	Stents and Balloons	11/15/18	RN / Tech	N		Y	N
IRCV	Catheters and wires Part I	10/15/18	RN / Tech	N		Y	N
IRCV	Cardiogenic Shock	9/15/18	RN / Tech	N		Y	N
IRCV	Hemochron (Annual in August)	8/15/18	RN	N		Y	N
IRCV	Pathology of Coronary Occlusion	8/15/18	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/14/18	All new RN hires & current RNs as needed	N		Y	N
IRCV	New Philips Injector	7/15/18	RN	N		Y	N
IRCV	ACLS (Biannual renewal)	7/1/18	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	7/1/18	RN / Tech	N		N	Y
IRCV	IABP (Annual in June)	6/15/18	RN / Tech	N		Y	N
IRCV	Moderate Procedural Sedation (Annual in May)	5/1/18	RN	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	4/14/18	All new RN hires & current RNs as needed	N		Y	N
IRCV	Interventional Cath Waveforms	3/15/18	RN	N		Y	N
IRCV	ECG refresher and test	2/15/18	RN / Tech	N		Y	N
IRCV	Radiation Safety	2/15/18	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/13/17	All new RN hires & current RNs as needed	N		Y	N

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Care Area	Type / Topic of Activity	Approximate Date	Audience	CEU* Approved Y/N	# Credits	Internal Program Y/N	External Program Y/N
IRCV	Hemochron (Annual in August)	8/15/17	RN	N		Y	N
IRCV	New Single Chamber temporary transvenous pacemaker	8/15/17	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/14/17	All new RN hires & current RNs as needed	N		Y	N
IRCV	ACLS (Biannual renewal)	7/1/17	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	7/1/17	RN / Tech	N		N	Y
IRCV	IABP (Annual in June)	6/15/17	RN / Tech	N		Y	N
IRCV	Moderate Procedural Sedation (Annual in May)	5/1/17	RN	N		Y	N
IRCV	12 Lead ECGs and MI variants	4/15/17	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	4/14/17	All new RN hires & current RNs as needed	N		Y	N
IRCV	Capnography and the new GE system	3/15/17	RN / Tech	N		Y	N
IRCV	Sheath Pull, Hemostasis and Groin Management	2/15/17	RN / Tech	N		Y	N
IRCV	SICD Devices—Boston Scientific	1/15/17	RN / Tech	N		Y	N
IRCV	Fluoroscopy training (Biannual in December)	12/15/16	Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/13/16	All new RN hires & current RNs as needed	N		Y	N
IRCV	Capnography and Moderate Sedation	11/15/16	RN / Tech	N		Y	N
IRCV	MacLab Training from GE for Techs	11/15/16	Tech	N		Y	N
IRCV	Catheters and Wires in Coronary Angiography	11/15/16	RN / Tech	N		Y	N
IRCV	Hemochron (Annual in August)	8/15/16	RN	N		Y	N

Attachment N -- HCGH Continuing Education Related to PCI Services (7/1/13 thru 12/31/18)

Care Area	Type / Topic of Activity	Approximate Date	Audience	CEU* Approved Y/N	# Credits	Internal Program Y/N	External Program Y/N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/14/16	All new RN hires & current RNs as needed	N		Y	N
ICU	Post PCI Care bulletin board and education (Summer 2016)	7/1/16	All ICU Staff	N		Y	N
IRCV	ACLS (Biannual renewal)	6/30/16	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	6/30/16	RN / Tech	N		N	Y
IRCV	IABP (Annual in June)	6/15/16	RN / Tech	N		Y	N
IRCV	Moderate Procedural Sedation (Annual in May)	5/1/16	RN	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	4/14/16	All new RN hires & current RNs as needed	N		Y	N
IRCV	New Medtronic Dual Chamber temporary transvenous Pacemaker	3/15/16	RN / Tech	N		Y	N
IRCV	ICD Discriminators	2/15/16	RN / Tech	N		Y	N
IRCV	Policy updates for Sterile Field, Back Table and Skin Prep	1/15/16	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/14/15	All new RN hires & current RNs as needed	N		Y	N
IRCV	Temporary Transvenous pacing	11/15/15	RN / Tech	N		Y	N
IRCV	Hemochron (Annual in August)	8/15/15	RN	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/15/15	All new RN hires & current RNs as needed	N		Y	N
IRCV	ACLS (Biannual renewal)	7/1/15	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	7/1/15	RN / Tech	N		N	Y
IRCV	IABP (Annual in June)	6/15/15	RN / Tech	N		Y	N
IRCV	Moderate Procedural Sedation (Annual in May)	5/1/15	RN	N		Y	N

Attachment N -- HCGH Continuing Education Related to PCI Services (7/1/13 thru 12/31/18)

Care Area	Type / Topic of Activity	Approximate Date	Audience	CEU* Approved Y/N	# Credits	Internal Program Y/N	External Program Y/N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	4/15/15	All new RN hires & current RNs as needed	N		Y	N
IRCV	Pharmacy—Contrast Media and Propofol	1/15/15	RN / Tech	N		Y	N
IRCV	Fluoroscopy training (Biannual in December)	12/15/14	Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/14/14	All new RN hires & current RNs as needed	N		Y	N
ICU	IABP education and competency (Fall 2014)	10/15/14	All ICU staff	N		Y	N
IRCV	Safe Radiation Practices	10/1/14	RN / Tech	N		Y	N
IRCV	Sheep Heart Dissection	9/15/14	RN / Tech	N		Y	N
IRCV	Hemochron (Annual in August)	8/15/14	RN	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/15/14	All new RN hires & current RNs as needed	N		Y	N
IRCV	D-STAT Band use	7/15/14	RN / Tech	N		Y	N
IRCV	ACLS (Biannual renewal)	7/1/14	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	7/1/14	RN / Tech	N		N	Y
IRCV	IABP (Annual in June)	6/15/14	RN / Tech	N		Y	N
IRCV	Moderate Procedural Sedation (Annual in May)	5/1/14	RN	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	4/15/14	All new RN hires & current RNs as needed	N		Y	N
IRCV	Biventricular Pacer self-study article and test	3/1/14	RN	N		Y	N
IRCV	Cardiac Rhythm Devices	3/1/14	RN	N		Y	N
IRCV	Angiography for nurses	2/1/14	RN	N		Y	N

Attachment N -- HCGH Continuing Education Related to PCI Services (7/1/13 thru 12/31/18)

Care Area	Type / Topic of Activity	Approximate Date	Audience	CEU* Approved Y/N	# Credits	Internal Program Y/N	External Program Y/N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	12/14/13	All new RN hires & current RNs as needed	N		Y	N
IRCV	Contrast Media	11/15/13	RN / Tech	N		Y	N
IRCV	Radial Artery Approach to PIC including TR band removal	9/15/13	RN / Tech	N		Y	N
IRCV	Hemochron (Annual in August)	8/15/13	RN	N		Y	N
IRCV	Therapeutic Hypothermia	8/15/13	RN / Tech	N		Y	N
ICU and ED	Review of AHA algorithms for ACS. Review of Lifepak functionality and response to Codes	8/15/13	All new RN hires & current RNs as needed	N		Y	N
IRCV	ACLS (Biannual renewal)	7/1/13	RN / Tech	N		N	Y
IRCV	BLS (Biannual renewal)	7/1/13	RN / Tech	N		N	Y
ICU and ED	Acute Coronary Syndromes (done at every Orientation to ICU)	On-Going	Newly graduated RN and new RN hires	N		Y	N
ICU	TR Band and D-STAT Band (done at every Orientation to ICU)	On-Going	Newly graduated RN and new RN hires	N		Y	N

PATIENT TRANSFER AGREEMENT
BETWEEN
THE JOHNS HOPKINS HOSPITAL
AND
HOWARD COUNTY GENERAL HOSPITAL, INC.

This **PATIENT TRANSFER AGREEMENT** is made this 11th day of April 2019, by and between **THE JOHNS HOPKINS HOSPITAL** (herein called "JHH") and **HOWARD COUNTY GENERAL HOSPITAL, INC.** herein called ("Facility").

WHEREAS, JHH and Facility desire by means of this Agreement, to insure continuity of care and treatment appropriate to the needs of the patients of JHH and Facility (hereinafter referred to collectively as "patients"), utilizing the knowledge and other resources of both facilities in a coordinated and cooperative manner to improve the health and care of patients.

NOW, THEREFORE, THIS AGREEMENT WITNESSETH: That in consideration of the mutual advantages accruing to the parties hereto, JHH and Facility hereby covenant and agree with each other as follows:

I. <u>JHH AND FACILITY AGREE</u>:

A. To the timely transfer of patients between their facilities, as hereinafter provided, wherein the party seeking to transfer a patient is referred to as the "Transferring Facility" and the party receiving a patient is referred to as the "Receiving Facility." Transfers may occur upon the recommendation of an attending physician who is a member of the medical staff of the Receiving Facility that such transfer is medically appropriate and a determination that the Receiving Facility has adequate resources and personnel to meet the needs of the patient. Once approved, the transfer shall occur as promptly as possible under the circumstances.

- The foregoing notwithstanding, if the patient to be transferred is a patient of Facility receiving primary percutaneous coronary intervention ("PCI) or non-primary PCI, for any required additional care at JHH, including emergent or elective cardiac surgery or PCI, JHH agrees to receive the unconditional transfer of such patient.

B. That, prior to transferring a patient where the Receiving Facility is JHH, Facility shall contact JHH via the 24 hour Hopkins Access Line ("HAL Line"), to arrange for the transfer. The HAL Line is accessed by calling 410-955-9444 or 1-800-765-JHHS (5447).

C. That the Transferring Facility shall make available through the electronic medical record of each patient to the Receiving Facility at the time of transfer an abstract of pertinent medical and other information necessary to continue the patient's treatment without interruption and provide essential identifying information including (to the extent available), but not

necessarily limited to:

- Patient's name, address, telephone number, if known, and age and telephone number of the next of kin;
- Patient's third party billing data;
- History of the injury or treatment;
- Condition on admission;
- Vital signs pre-transfer and at the time of transfer;
- Treatment provided to patient, including medications given and route of administration;
- Laboratory and X-ray findings, including files (if available);
- Fluids given, by type and volume;
- Name, address, and phone number of physician referring patient;
- Name of physician to whom patient is to be transferred; and
- Name of physician who has been contacted about patient.

The Transferring Facility will supplement the information as necessary for the maintenance of the patient at Receiving Facility.

D. Both parties agree to maintain the confidentiality of the medical information so as to comply with all state and federal laws, rules and regulations regarding the confidentiality of patient records. As may be applicable , both parties agree to comply with the Health information Technology Clinical Health Act of 2009 (the "HITECH Act"), the Administrative Simplification provisions of the Health insurance Portability and Accountability Act of 1996, as codified at 42 USC §1320d through d-8("HIPAA") and any current and future regulations promulgated under either the HITECH Act or HIPAA, including without limitation the federal privacy regulations contained in 45 C.F.R. Parts 160 and 164 (the "Federal Privacy Regulations"), the federal security standards contained in 45 C.F.R. Parts 160, 162, and 164 (the "Federal Security Regulations"), and the federal standards for electronic transactions contained in 45 C.F.R. Parts 160 and 162 (the "Federal Electronic Transactions Regulations"), all as may be amended from time to time, and collectively referred to herein as "HIPAA Requirements".

E. That the Transferring Facility shall have responsibility for obtaining the patient's consent to the transfer to the Receiving Facility prior to the transfer, if the patient is competent. In the event that a patient with an emergency medical condition has not been stabilized prior to transfer, the Transferring Facility will obtain the patient's informed consent that the medical benefit of the transfer outweighs the risk of the transfer. If the patient is not competent, the Transferring Facility shall attempt to obtain consent from any reasonably available legally responsible person acting on the behalf of the patient. Nothing in this Agreement shall restrict a patient's freedom of choice to choose to be transferred to an institution other than one that is a party to this Agreement.

F. That the Transferring Facility shall have the responsibility for arranging transportation of the patient to the Receiving Facility. The Receiving Facility's responsibility for

the patient's care shall begin when the patient arrives at Receiving Facility, unless special arrangements are made for Receiving Facility personnel to accompany the patient during the transfer.

G. That each party shall arrange for appropriate and safe handling of patients' valuables in accordance with its policies, and that Transferring Facility shall arrange for the transport of patient's valuables to Receiving Facility when the patient is transferred.

H. That clinical records of a patient transferred shall contain evidence that the patient was transferred.

I. That the transfer procedure is made known to the patient care personnel of each of the parties.

J. That the Transferring Facility will promptly readmit to its facility for further care and treatment, if medically appropriate, any patient transferred to the other when the reason for transfer has been resolved, and the patient is within its service capability, and the patient has agreed to or requested the transfer.

K. That neither party shall use the name of the other in any promotional or advertising material without the prior written approval of the other party.

L. That governing bodies of each institution shall have exclusive control of their policies, management, assets and affairs of their respective institutions.

M. That neither party assumes liability for any debts or other obligations for the other party's action.

II. EACH PARTY REPRESENTS AND WARRANTS UPON EXECUTION AND THROUGHOUT THE TERM OF THIS AGREEMENT THAT:

A. It is an acute care hospital licensed by the state in which it is located and accredited by the Joint Commission;

B. All medical professionals providing services to patients at its facility are licensed in their profession by the state in which it is located and credentialed by its Medical Staff, and that services provided to patients shall be within the scope of said medical professional's privileges;

C. It shall perform the services required hereunder in accordance with: (i) all applicable federal, state, and local laws, rules and regulations, including but not limited to the Emergency Medical Treatment and Active Labor Act ("EMTALA"); and (ii) all applicable standards of the Joint Commission and any other relevant accrediting organizations;

D. It has, and shall maintain throughout the term of this Agreement, all appropriate

federal and state licenses and certifications which are required in order to perform the services required hereunder; and

E. Neither it nor any of its staff is sanctioned or excluded from any federally funded health care programs as provided in Sections 1128 and 1128A of the Social Security Act (42 U.S.C. 1320a-7a).

III. **BILLING**:

Bills incurred with respect to services performed by either party for patient care shall be collected by the institution rendering such services directly from the patient, third party insurance coverage, or other sources normally billed by the institution. No clause of this Agreement shall be interpreted to require either party to compensate the other for services rendered to a patient transferred under this Agreement.

IV. **TERM**:

A. This Agreement shall be effective from the date first set forth above, and shall continue in effect for a period of one (1) year thereafter (Initial Term"). This Agreement shall renew automatically for additional successive one (1) year periods (each a "Renewal Term"), upon the expiration of the Initial Term, or a subsequent Renewal Term, subject to the termination provisions herein. Either party may terminate this Agreement at any time, without cause, by giving sixty (60) days written notice to the other party. However, if either party shall breach any of the representations and warranties set forth in Section II hereof, the breaching party shall be given thirty (30) days to cure the breach, after the non-breaching party gives written notice describing such breach. Such notice of breach shall specify with reasonable particularity the nature and extent of the breach complained of in order to enable a cure. If the breaching party is unable to cure the breach within the thirty (30) day following written notice, this Agreement shall terminate at the completion of the thirty (30) days cure period.

V. **GENERAL**:

A. This Agreement may be modified or amended from time to time by mutual written agreement of the parties, and any such modification or amendment shall be attached to and become part of this Agreement.

B. An executed copy of this Agreement with all amendments, if any, shall be kept in the administrative file of each of the parties for reference.

C. Nothing in this Agreement shall be construed as limiting the rights of either party to affiliate or contract with any other institution, while this Agreement is in effect.

D. This Agreement is subject to all requirements of Maryland law and any regulations issued pursuant hereto and that where the Agreement is in conflict with the provision of the law or the regulations, the same shall be deemed to conform with the law and the regulations.

E. All notices hereunder by either party to the other shall be in writing, delivered

personally, by certified or registered mail, return receipt requested, or by Federal Express or Express Mail, and shall be deemed to have been duly given when delivered personally or when deposited in the United States mail, postage prepaid, addressed as follows:

If to JHH:
The Johns Hopkins Hospital
Attention: Vice President, Medical Affairs
600 N. Wolfe Street
Baltimore, MD 21287

If to Facility:
Howard County General Hospital, Inc.
Attn: John Dunn
5755 Cedar Lane
Columbia, MD 21044

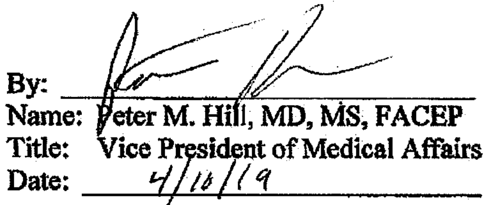
Each with a copy to:
The Johns Hopkins Health System Corporation
Attention: General Counsel
733 N. Broadway, Suite 102
Baltimore, MD 21205

Or to such other persons as either party may from time to time designate by written notice to the other.

(Signatures Appear on the Following Page)

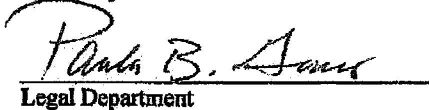
IN WITNESS WHEREOF, The Johns Hopkins Hospital and Howard County General Hospital, Inc. have executed this Agreement by their duly authorized representatives.

THE JOHNS HOPKINS HOSPITAL



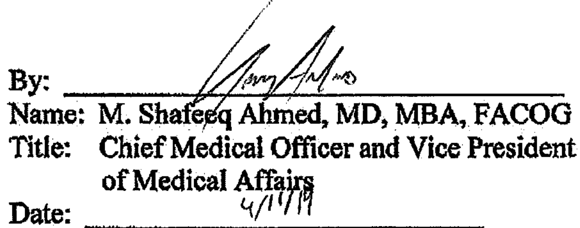
By: ______________________
Name: Peter M. Hill, MD, MS, FACEP
Title: Vice President of Medical Affairs
Date: 4/16/19

This Agreement has been reviewed by The Johns Hopkins Health System Corporation Legal Department.



Legal Department

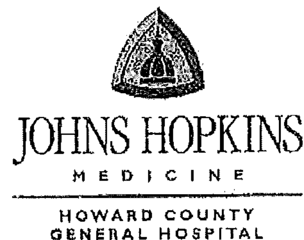
HOWARD COUNTY GENERAL HOSPITAL, INC.



By: ______________________
Name: M. Shafeeq Ahmed, MD, MBA, FACOG
Title: Chief Medical Officer and Vice President of Medical Affairs
Date: 4/11/19

ATTACHMENT P

5755 Cedar Lane
Columbia, Maryland 21044
410-740-7890
410-740-7990 (TDD)
www.hcgh.org



April 5, 2017

Mr. James Scheulen, MBA, PA-C
Chief Administrative Officer for Emergency Services and Capacity Management
Johns Hopkins Medicine
1830 Bldg., Suite 6-100
Baltimore, MD 21287

Dear Jim:

Since September, 2003, Howard County General Hospital (HCGH) has provided primary percutaneous coronary intervention (PCI) – first, via the Atlantic C-PORT registry; and, since early 2006, via a Maryland Health Care Commission (MHCC) waiver to perform primary PCI without on-site cardiac surgery capability. The waiver requires that we provide documentation that HCGH has executed a formal, written agreement with an advanced cardiac life support emergency medical services provider that guarantees arrival of a ground ambulance within 30 minutes of a request for patient transport.

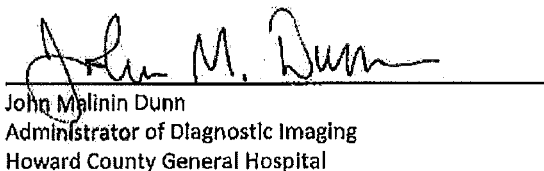
The last signed agreement between Johns Hopkins Lifeline and HCGH was in 2007. We are now preparing our September 2017 application for renewal of the waiver and thought it would be a good time to get this agreement updated and resigned. Specifically, we are requesting your agreement to the following terms:

- Johns Hopkins Lifeline is a provider of advanced cardiac life support emergency medical transportation services.
- Johns Hopkins Lifeline will provide for an air or ground ambulance to respond to HCGH within 30 minutes of receipt by Johns Hopkins Lifeline of a request from HCGH.

If you would like any changes made to these terms, please let me know (e-mail is jdunn5@jhmi.edu, and phone is 410-884-4549). If the agreement is acceptable as is, please sign on the line below and e-mail back to me.

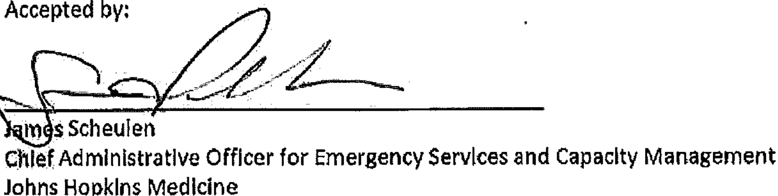
Jim, thank you very much, and I look forward to hearing from you.

Sincerely,



John Malinin Dunn
Administrator of Diagnostic Imaging
Howard County General Hospital

Accepted by:



James Scheulen
Chief Administrative Officer for Emergency Services and Capacity Management
Johns Hopkins Medicine