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June 11, 2013

VIA HAND DELIVERY

Office of the Attorney General
55 Elm Street, P.O. Box 120
Hartford, CT 06141-0120
Attn: Gary W. Hawes, AAG

Office of Health Care Access, Dept. of Public Health
410 Capitol Avenue
Hartford, CT 06134
Attn: Steven W. Lazarus

Re: GWHN and Vanguard – Responses to Completeness Questions re: Certificate of Need Application for a Joint Venture

Dear Messrs. Hawes and Lazarus:

In your May 23, 2013 letter you posed certain questions to Greater Waterbury Health Network, Inc. ("GWHN") and Vanguard Health Systems, Inc. ("Vanguard"), in response to their May 3, 2013 application for approval of a Certificate of Need (the "Application"). GWHN and Vanguard hereby submit their responses to those questions. At your request, one copy has been hand delivered to Mr. Hawes' office and seven copies have been hand delivered to Mr. Lazarus' office. In addition, each office has received an equal number of electronic versions.

Please note that Travis Messina has replaced Rob Jay as Vanguard's primary point of contact. Mr. Messina's title is Director, Development, his phone number is 615-665-6052, and his email address is tmessina@vanguardhealth.com.

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If you have any questions or need anything further, please contact me at (203) 784-3108. Thank you for your assistance in this matter.

Very truly yours,

CARMODY & TORRANCE LLP

By _____
Ann H. Zucker

AHZ:ag
Enclosures

cc: Darlene Stromstad
Greater Waterbury Health Network, Inc.

John J. Faldetta, Jr.
Travis Messina
Vanguard Health Systems, Inc.

APPLICATION FOR APPROVAL OF JOINT VENTURE

Greater Waterbury Health Network, Inc. ("GWHN") and Vanguard Health Systems, Inc. ("Vanguard") (collectively, the "Applicants") hereby respectfully submit to the Attorney General and the Commissioner of the Department of Public Health the following responses to completeness questions dated May 23, 2012 regarding the application for approval of their joint venture under Conn. Gen. Stat § 19a-486 et seq. (the "Application").

1. **With respect to Vanguard Health System, Inc.'s experiences with new models of payment related to health care reform as mentioned on page 12 of the Application, please provide information on the specific payment adjustments that were made to Vanguard-owned hospitals under the Medicare Value-Based Purchasing Program ("VBP") for federal fiscal year ("FY") 2013. As part of this response, please identify those Vanguard hospitals that are receiving an upward payment adjustment as a result of the VBP program and those that are receiving a downward adjustment. Please also identify the percentage payment adjustment for each hospital under the VBP program and comment generally on the performance scoring of Vanguard hospitals under the VBP program in each of the states where they operate.**

   Vanguard is committed to transforming the quality of hospital care. This commitment is illustrated by the number of hospitals receiving positive payment adjustments as a result of the VBP program. Note that Baptist Health System is a five-hospital system and MetroWest includes two hospitals, though each system has a single Medicare provider number. As illustrated in the table below, 10 Vanguard hospitals received upward payment adjustments while 13 received downward adjustments, of which, six have been owned by Vanguard for three years or less. While Vanguard strived to have more of its hospitals achieve upward adjustments, the impact of those receiving downward adjustments is minimal. As noted below, all but two of the hospitals receiving downward adjustments experienced an impact of less than 0.2%. Note that performance is not concentrated within select markets. Michigan, Massachusetts, Illinois and Texas had hospitals receive both upward and downward adjustments. Vanguard is confident that this supports its belief that the quality initiatives that have been implemented are producing results, irrespective of market, and such quality incentives will produce results in the remaining hospitals within each respective market.

	Number of Hospitals	CMS Certification Number (CCN)	Final FY 2013 Hospital VBP Adjustment Factor
Upward Adjustments			
Texas			
Baptist Health System	5	450058	1.0015
Illinois			
Westlake	1	140240	1.0010
MacNeal	1	140054	1.0006
Massachusetts			
MetroWest	2	220175	1.0004
Michigan			
Sinai Grace	1	230024	1.0010
Downward Adjustments			
Illinois			
West Suburban	1	140049	0.9998
Weiss	1	140082	0.9978
Michigan			
Detroit Receiving	1	230273	0.9996
Huron Valley	1	230277	0.9993
Harper-Hutzel	2	230104	0.9984
Massachusetts			
Saint Vincent	1	220176	0.9993
Arizona			
Phoenix Baptist	2	030030	0.9991
Maryvale	1	030001	0.9990
Arrowhead Hospital	1	030094	0.9986
West Valley Hospital	1	030110	0.9986
Paradise Valley	1	030083	0.9982
Texas			
Valley Baptist - Brownsville	1	450028	0.9974
Valley Baptist - Harlingen	1	450033	0.9961

2. Please clarify whether the $10.1 million in savings in surgical implants, $1.2 million in gain share payments to participating physicians and $3.9 million in savings to Medicare relate to savings achieved by Baptist Health System as a result of its participation in the CMS ACE Demonstration Project. To the extent these are not the savings achieved by Baptist, please quantify the savings it has achieved in each of the categories listed from

the onset of the project. Also, please discuss any specific strategies from this Demonstration Project that Vanguard will incorporate at the Hospital.

The amounts listed do entirely relate to Baptist Health System ("Baptist") in San Antonio. The $10.1 million in savings (now at $11.2 million as Baptist is saving approximately $500,000 or more per quarter) is a direct result of Baptist's participation in the ACE Demonstration Project. The collaboration with Baptist physicians through the project has enabled Baptist to achieve these savings. These savings allowed Baptist to distribute $3.9 million discount in Medicare reimbursement (now $4.5 million) and pay the $1.2 million in gain share payments to the physicians (now $1.3 million). Baptist has taken many of the lessons learned from this program, including transparency and full collaboration, and has applied them to other service lines via management agreements or increased effectiveness of existing medical directorships. Baptist has been sharing its experiences and knowledge with the other Vanguard markets, thus positioning these markets to participate in the next phase of bundled payments known as BPPI. Baptist has even applied to expand its Bundled Payment to include 30 days post discharge for the diagnosis of Congestive Heart Failure. Vanguard intends to share these experiences and practices with GWHN, just as it has with the other Vanguard facilities.

3. **Please provide a more extensive discussion of the specific achievements of Vanguard hospitals in improving the quality, accessibility and the cost-effectiveness of health care in connection with the following initiatives described at page 858 of the Application and of Vanguard's future plans to implement the initiatives at the Hospital:**

Vanguard has developed extensive knowledge as a result of its participation in the various CMS programs described below. Consistent with current practice, Vanguard will utilize lessons learned in its facilities throughout the country, including the Hospital.

a. CMS Pioneer ACO in Detroit and the 2 CMS Shared Savings ACOs in Chicago and San Antonio;

ACO achievements in Vanguard Markets (dates reflect program start dates):

- 1/1/12 – Michigan Pioneer ACO – No official results, however, our most recent Q4 report from CMS indicates that the program is achieving per participant savings; the official CMS reconciliation report is due to Vanguard in mid-July.
- 7/1/12 – two Medicare Shared Savings Program ("MSSP") ACOs; TX, IL – No measureable performance to date. First performance year is not recognized until July 2014.
- 1/1/13 – two MSSP Shared Savings ACOs; AZ, MA – No measureable performance to date. First performance year is not recognized until December 2013.

b. CMS Community Based Care Transition Program in Massachusetts;

Care transitions occur when a patient moves from one health care provider or setting to another. Hospitals have served as the focal point of efforts to reduce readmissions by focusing on those components for which they have direct responsibility, including the

quality of care during the hospitalization and the discharge planning process. However, it is clear that there are multiple factors along the care continuum that impact readmissions, and identifying the key drivers of readmissions for a hospital and its downstream providers is the first step towards implementing the appropriate interventions necessary for reducing readmissions. The Community Based Care Transition Program ("CCTP") seeks to correct these deficiencies by encouraging a community to collaborate to improve quality, reduce cost, and improve patient experience. The CCTP is part of the Partnership for Patients, a nationwide public-private partnership that aims to reduce preventative errors in hospitals by 40 percent and reduce hospital readmissions by 20 percent. Vanguard has partnered with the Area Agency on Aging (AAA) for this Care Transition Program around three key conditions: MI, CHF and Pneumonia.

c. CMS Innovation grant in Chicago; and

Imaging Advantage LLC was approved for a CMS Innovation Grant in Chicago, to which Vanguard is a partner. Imaging Advantage's Project Abstract is "The Right Exam, at the Right Time, Read by the Right Radiologist". The project's goals are to further CMS's three-part aim (an interpretation of IHI's Triple Aim) of better care for individuals, better health for populations and slower growth in costs through improvements in care by reengineering the hospital-based radiology service delivery model. To achieve these goals, Imaging Advantage and its partners will design and implement workflow and infrastructure innovations, integrate radiologists in the entire patient-care experience and provide ongoing training to a significant number of physicians and support personnel in states with elevated displaced worker populations (Arizona, California, Illinois, Massachusetts, Michigan, Ohio, Oregon and Texas), with an emphasis on curtailing outsourcing of high-tech health care I.T. jobs. Vanguard also will deploy RealTime QA®, an innovative program designed to address issues and resolve discrepancies while the patient is still present in the hospital, clinic or imaging center. Vanguard believes that this project will create a new standard of hospital-based patient care and demonstrate that high-quality, low-cost care can be delivered without regard to a patient's socio-economic status or geography. This initiative projects a reduction of healthcare costs of $75 million over the 3 year term of the project, with a target population of approximately 28 million lives.

d. Dual-Eligible risk in other markets.

Vanguard manages dual-eligible risk in the Arizona Market. Vanguard's Abrazo Advantage Health Plan ("AAHP") currently participates in the Dual-Eligible Demonstration Program in Arizona. AAHP, a Medicare Advantage HMO under contract with the Centers for Medicare and Medicaid, has served dually eligible members since 2006. In October 2012, CMS completed an onsite review of the plan's execution of the model of care resulting in the highest possible score of "Superior". This score represents the achievement of the standard of care delivered to this population.

4. **Pursuant to Section 8.14 of the Contribution Agreement, it is a condition precedent to Vanguard's obligation to perform that the Connecticut corporate practice of medicine statute be amended to allow stock corporations and other for-profit entities to own medical foundations that employ physicians. Please explain why the proposal is dependent on this particular legislation? Furthermore, will the condition affect access to services for the uninsured or underinsured population?**

Over the past 20 years, healthcare has increasingly been delivered on an outpatient basis. Physicians have become less dependent on hospitals, but hospitals continue to need physicians to provide leadership and be actively involved in clinical initiatives such as quality improvement programs, as well as provide services such as on call coverage. Hospitals have sought new ways to align with physicians, and physicians have sought new models to conduct their practice, especially as the economics of private practice have changed. Additionally, younger physicians increasingly express a preference for a 9-to-5 job with benefits, rather than the traditional independent contractor or entrepreneurial "hang out a shingle" model.

Despite the evolution of medical care and the protection of patients by various regulatory bodies, Connecticut continues to be a state in which the so-called "corporate practice of medicine" is not clearly permitted. Under the legal theory of respondeat superior, the acts of an employee are attributed to the employer; so, the acts of a physician practicing medicine are attributed to the physician's employer. If that employer is not a physician, the employer is violating C.G.S. §20-9 (copy attached as **Exhibit 1**) and is practicing without a license. Connecticut law provides a limited number of exceptions; among them are:

- A federal employee acting in the scope of his or her employment;
- Out of state physicians for 30 days;
- Midwives & APRNs;
- Physician assistants (See C.G.S. §20.9 for the foregoing exceptions);
- Non-profit hospitals (Attorney General Opinion dated December 3, 1954 (copy attached as **Exhibit 2**);
- Practicing through a professional service corporation (C.G.S. § 33-182a et seq.) and limited liability company (C.G.S. §34-119 et seq.)(collectively, **Exhibit 3**); and
- Medical foundations owned by non-profit hospitals (C.G.S. §33-182aa attached as **Exhibit 4**).

Medical foundations, frequently used in other states, have been permitted in Connecticut since 2009. Connecticut's medical foundation statute permits non-profit hospitals to hold membership (ownership) interests in medical foundations. A number of hospitals in Connecticut currently use this arrangement, including The Waterbury Hospital, St. Francis Hospital and The Stamford Hospital.

In order for Vanguard and other for-profit entities to operate hospitals in the Connecticut market as they currently function, they need a way to employ physicians. Simply amending the medical foundation statute to permit for-profit hospitals to hold membership interests will accomplish this goal.

No adverse change, with respect to providing services to the uninsured and underinsured, is anticipated as a result of allowing the Joint Venture, a for-profit entity, to be a member of a medical foundation.

5. **Please clarify how the parties arrived at the 80% / 20% ownership split. If the decision was influenced in part by Vanguard's desires to have the financial results of the Company consolidated with the results of other Vanguard-owned entities, please clarify whether an 80% ownership interest in the minimum ownership percentage that will allow for consolidation.**

   There are several reasons why the parties chose an 80% / 20% ownership of the Joint Venture.

   GWHN's historical operating performance supports a transaction value of $100 million. In order to assure that the post-conversion foundation had adequate assets to satisfy the obligations of GWHN and certain of its affiliates and to ensure that the Joint Venture would be committed to an adequate capital plan, GWHN's board negotiated a 20% interest in the Joint Venture. The value of the Joint Venture is supported by the fairness evaluation prepared by Principle Valuation.

   The Generally Accepted Accounting Principles (GAAP) promulgated by the Financial Accounting Standards Boards (FASB) provide that companies may consolidate into their financial statements those entities that they control. While GAAP does not prescribe a percentage interest as "controlling", the Applicants believe that the proposed transaction will permit the Joint Venture to be consolidated with Vanguard's other holdings.

6. **Please discuss the purpose and intent of having a separate JV Board of Directors and Board of Trustees, and clarify the respective authority of both boards as it pertains to Waterbury Hospital ("Hospital") operations, with specific focus on clinical, quality assurance and patient care matters. Please provide any draft bylaws or policies and procedures that would further delineate the powers and functions of both boards.**

   The governing board for the Joint Venture is known as the "Board of Directors" and constitutes the fiduciary board of the JV. The procedures and responsibilities of the Board of Directors are set forth in the Amended and Restated Operating Agreement for the Joint Venture. The Board of Directors of the Joint Venture appoints the members of the "Board of Trustees", which is an advisory board for the Hospital. Vanguard believes strongly in local governance in its hospitals and its hospitals always have Boards of Trustees to provide local input into the operations and activities of its hospitals. Vanguard views a hospital as a unique community asset serving a special role in its community, driving the company's decision to establish advisory boards throughout the Vanguard system. In this case, the Board of Trustees shall consist of 12 members, with at least six of such members being physicians on the Hospital's active medical staff and the remaining members being local community leaders. Vanguard has found this model ensures continued community and medical staff input into the governance of the local delivery system.

The Board of Trustees has those responsibilities required for governing bodies of hospitals as established by The Joint Commission. Among the responsibilities of the Board of Trustees are the following: (a) participating in the adoption of a vision, mission, and values statement for the Hospital and its related businesses (the "Hospital Businesses"); (b) participating in development and review of operating and capital budgets and facility planning for the Hospital Businesses and advising the Board of Directors with respect to the same; (c) monitoring quality and performance improvement at the Hospital Businesses; (d) granting medical staff privileges and, when necessary and with the advice of counsel, taking disciplinary action consistent with the Hospital's Medical Staff Bylaws; (e) assuring medical staff compliance with Joint Commission requirements; (f) providing advice and consultation regarding physician recruitment efforts; (g) fostering community relationships and identifying service and educational opportunities; and (h) performing such other activities and duties as may be directed or delegated to it by the Board of Directors.

Please see the attached draft of the Board of Trustee Bylaws for the Hospital at **Exhibit 5**.

7. **Were other management structures considered? If so, please summarize the reasons for choosing the bifurcated Board structure and its perceived benefits for the Hospital.**

   This was the management structure that the GWHN Board indicated was the preferred management structure. As Vanguard agreed to this structure, no other management structures were considered.

   The management structure proposed in this transaction conforms to the GWHN's Board's wishes to have local input into the day-to-day operations of the Hospital, especially the medical quality and availability and scope of care

8. **Please clarify the purpose and intent behind the two-for-one voting provision in favor of the Class A Member (i.e., Vanguard) provided in Section 5.1(g) of the Amended and Restated Operating Agreement with respect to approval of the Company's annual operating or capital budget.**

   Vanguard intends and expects to consolidate the financial results of the Joint Venture with the financial results of Vanguard and its other subsidiaries. Pursuant to generally accepted accounting principles, an entity can consolidate the financial results of another entity if, among other things, it has the ability to control such entity's annual operating and capital budgets. Section 5.1(g) of the Amended and Restated Operating Agreement enables Vanguard to control the Joint Venture's annual operating and capital budgets by giving each Vanguard director two votes while the GWHN directors have only one vote.

9. **Please elaborate on the dispute resolution process provided in Section 5.4 of the Amended and Restated Operating Agreement, and explain why the call right extends only to the Class A Member (i.e., Vanguard).**

   The Amended and Restated Operating Agreement defines a "Material Dispute" as a dispute between the Class A Directors (the Vanguard Directors) and the Class B Directors (the GWHN Directors) regarding any of the matters set forth in Section 5.1(e) of the Amended

and Restated Operating Agreement, as a result of which any such item fails to receive the approval of the Joint Venture's Board of Directors at two consecutive Board meetings. A "Material Dispute" is limited to the matters set forth in Section 5.1(e) of the Amended and Restated Operating Agreement as the parties identified those as the most significant matters pertaining to the operation of the Joint Venture. Section 5.4 of the Amended and Restated Operating Agreement provides a mechanism and time periods for the parties to hopefully resolve a Material Dispute. First, senior executives for each of Vanguard and GWHN will meet in an attempt to resolve the dispute. If this meeting does not resolve the dispute, then the Class A Directors and Class B Directors will attempt to resolve the dispute within 30 days, including by participating in a non-binding mediation. It is only after all of these steps that Vanguard may trigger the call right to purchase GWHN's equity interest in the Joint Venture. The call right is not reciprocal because the purpose of Vanguard in entering into the Joint Venture is to own and operate healthcare facilities in the Waterbury, Connecticut area, not simply to buy and sell interests in healthcare facilities for investment purposes. As the owner of a vast majority of the Joint Venture (80%), which will be a consolidated subsidiary of Vanguard, the parties agreed that Vanguard is the more logical party to own all of the equity interests in the event a Material Dispute cannot be resolved.

10. **Please explain why the Right of First Refusal set forth in Section 6.1 of the Amended and Restated Operating Agreement is not reciprocal. In other words, why is WMC the only party permitted to entertain third-party offers to purchase its Membership Interest?**

    In the negotiations between the parties with respect to the Joint Venture's Amended and Restated Operating Agreement, GWHN, as the minority owner, agreed that it would not transfer its membership interest in the Joint Venture to a third party. However, GWHN and WMC agreed that WMC should have such right if WMC received an offer to sell its membership interests in the Joint Venture and GWHN was granted a right of first refusal to purchase WMC's membership interests. The parties mutually agreed to these terms and believe them to be appropriate because WMC would not have agreed to the Joint Venture but for GWHN's strategies, leadership, and community vision. Forcing WMC, the majority owner, to partner with another entity after expending millions of dollars and valuable time on creating the Joint Venture to improve the Hospital with the expectation of GWHN's help and expertise would be inappropriate; therefore GWHN has no right to transfer. Similarly, it would be inappropriate to force GWHN to remain in the Joint Venture with the third party offering to purchase WMC's membership interests; therefore, GWHN is able to prevent such result by exercising its right of first refusal and purchasing WMC's membership interest so that GWHN may be the sole owner of the Joint Venture. The parties mutually agreed that the foregoing concerns were best addressed by allowing WMC the right to transfer and providing GWHN a right of first refusal.

11. **Section 6.1 of the Management Services Agreement has been redacted to remove the amount of the Management Services Fee and this information is also redacted at page 14 of the Application. It is noted, however, that paragraph 10 of the October 29, 2012 letter of intent provides for a management fee equal to two (2%) of the Company's consolidated net revenues. Please confirm the methodology for calculating and/or the**

amount of the Management Services Fee and, if it varies significantly from the Management Services Fee set forth in the letter of intent, explain why the change in the Management Services Fee was made.

The methodology for calculating and/or the amount of the Management Services Fee has not changed from the Letter of Intent.

12. **Please also confirm that the Management Services Fee is within a range consistent with (a) industry standards; and (b) management fees charged by Vanguard to other hospitals to which it provides similar management services. Please provide specific industry practices examples or benchmarks to support your response and the finding in the Fairness Opinion at p. 745 of the Application that the proposed Management Services Fee represents a commercially fair rate.**

    a. Principle Valuation has provided additional detail to the Fairness Evaluation, dated May 1, 2013, in which it describes an industry norm of Management Services Fees in the range of 2-5% of net revenues collected placing Vanguard's fee of 2% at the low end of the industry standard. Please refer to **Exhibit 6**.

    b. Vanguard has the same arrangement pursuant to a Management Services Agreement with respect to Weiss Hospital in Chicago, Illinois, which is a joint venture owned 80.1% by Vanguard, and Valley Baptist Health System, which is a two-hospital system in Harlingen and Brownsville, Texas that is owned by a joint venture for which Vanguard is the 51% owner. The aforementioned hospitals are the only hospitals managed by Vanguard pursuant to similar arrangements.

13. **Please confirm that the reimbursement provided to the Manager with respect to employee salaries, wages and benefit expenses pursuant to Section 6.2 of the Management Services Agreement is consistent with industry practice and provides examples or other support for your answer. Please also explain the functions that employees of the Manager would serve and how they would differ from functions provided by employees of the Hospital.**

    Section 4 of the Management Services Agreement provides that the Manager shall employ all of the employees that work at the healthcare facilities operated by the Joint Venture, including the Hospital. Thus, the function of the employees of the Manager will be all of those reasonable and necessary to operate the Hospital and other healthcare facilities owned by the Joint Venture, including the typical functions performed by a Chief Operating Officer, Chief Executive Officer, Chief Financial Officer, and Chief Nursing Officer, while neither the Hospital nor the Joint Venture will have any employees. Pursuant to the Management Services Agreement, the Manager leases these employees to the Joint Venture. Section 6.2 of the Management Services Agreement provides that the Joint Venture shall reimburse the Manager for all of the out-of-pocket costs incurred by the Manager in employing the employees, including the provision of health, welfare and fringe benefit plans, programs and arrangements to the employees. The Manager is not receiving any premium or mark-up from the Joint Venture in connection with the employment of the employees as it is only passing

through its actual out-of-pocket costs, which we believe to be the industry practice. Vanguard has the same arrangement pursuant to a Management Services Agreements with respect to Weiss Hospital in Chicago, Illinois and Valley Baptist Health System, which is a two-hospital system in Harlingen and Brownsville, Texas that is owned by a joint venture for which Vanguard is the 51% owner.

14. In the introduction and elsewhere in the Application and the proposed Amended and Restated Operating Agreement, reference is made to "the commitment of the JV to expend no less than $55 million on capital items and the development and improvement of ambulatory services in the greater Waterbury community." (see e.g., Application pps. 5, 15; Section 2.7 of the Operating Agreement). However the Applicants state on page 20 of the Application under the heading of "Capital Commitment" that "Vanguard is committed to contributing $55 Million over 7 years towards capital improvements for maintaining the Hospital campus and enhancing ambulatory services in the Greater Waterbury community." Contrast this with Section 3.8 of the Proposed Amended and Restated Operating Agreement, which provides that Vanguard will extend to the Company a $55 million Line of Credit.

In light of the foregoing, please clarify the following:

a. What financial projections have the Applicant's produced that would support the ability of the JV's operations to fund the $55 million amount and what assumptions support these projections.

The financial projections provided in the initial application illustrate three years of performance. This model produces cash flow from operations of approximately $21.6 million over the three year period, utilizing the assumptions as described in the response to question 35 of the initial application. The projections also assume a deployment of the $55 million capital commitment over seven years. Under the aforementioned assumptions, the JV will have a balance of $13.6 million on the line of credit by the end of its third fiscal year. Vanguard is highly confident this will take place by year 7 of the JV.

b. Does Vanguard intend to contribute $55 million to the JV, or is Vanguard merely acting as a source of financing for the JV's working capital needs?

Vanguard is acting as a source of financing and will provide a $55 million line of credit to the JV to be drawn against as needed to fund working capital and various capital expenditures.

c. Assuming the latter, how do the terms of the contemplated promissory note, including, without limitation the rate of interest charged by Vanguard (Vanguard's weighted average cost of indebtedness for borrowed money adjusted quarterly) compare to other available sources of financing?

The interest rate shall be a floating rate *per annum* which is equal to Vanguard's weighted average *per annum* interest rate paid from time to time on all of its indebtedness for borrowed money (excluding capital leases). The floating rate of interest shall be recalculated as of the first day after each Quarterly Payment Date. Vanguard's access to capital markets provides extremely competitive rates, which are directly passed to the JV without markup. The Applicants believe that the terms provided to the JV by Vanguard are significantly more favorable than what could be obtained by the entity on a stand-alone basis.

15. **Section 3.2 of the Amended and Restated Operating Agreement allows the Manager to make additional capital calls of the Members in the event that additional borrowing by the Company would cause its Consolidated Leverage Ratio to exceed 4.00:1.00 (which would prohibit the Company from accessing the Line of Credit). Based on anticipated capital needs and the projected financial performance of the JV, what is the likelihood that the limit on the Consolidated Leverage Ratio will be implicated?**

    Based on the financial projections provided, there is an extremely low likelihood that the Consolidated Leverage Ratio limit will be exceeded. According to the financial projections, the highest Consolidated Leverage Ratio that the JV produces is 1.5x. This occurs in year 3.

16. **The Purchase Price for the GWHN Assets, as provided in Section 1.2(b) of the Contribution Agreement, is $45 Million +/- the amount by which the net book value of the GWHN Net Working Capital varies from $6.8 million, minus the agreed upon value of certain liabilities assumed by the Company (i.e., asbestos abatement, pension liability, capital lease obligations, among others). These liabilities, as shown on the Pro Forma provided on page 17 of the Application, total $12.946 million. Pursuant to Section 12.8 of the Contribution Agreement, GWHN is required to maintain an indemnity reserve of at least $7.5 million for three years following the Closing and $5.0 million for two additional years thereafter. Taking into consideration these factors, the cash consideration received by and/or available to GWHN will be significantly less than $45 Million. In addition, GWHN will retain liabilities of approximately $45.777 million and will also have limitations on the use of its non-current assets following the transaction, according to the Pro Forma. Seen in this light, please reconcile the foregoing with the Applicants' statement on page 18 of the Application that "[a]s a result of becoming a member of the JV, GWHN will be financially sound with reduced expenses, retired debt and the necessary resources to fund its pension obligations."**

    The attachment accompanying this document illustrates how "GWHN will be financially sound with reduced expenses, retired debt and the necessary resources to fund its pension obligations." See **Exhibit 7.**

    The cash Purchase Price is $45 million. For purposes of this preliminary assessment set forth in **Exhibit 7**, GWHN Net Working Capital is assumed to be at the agreed upon $6.8 million, though the Purchase Price will be adjusted at the time of Closing based on GWHN's actual Net Working Capital at that time.

From this number, the book value of assumed liabilities will be subtracted. As of September 30, 2012, the book value of liabilities was as follows:

- Accrued Pension Liability: $3,139,000 Current Portion ("CP") + $5,906,712 Non-Current Portion ("NCP") = $9,045,712
- Asbestos Abatement: $2,785,468 (NCP)
- Capital Lease Obligations: $461,461 (CP) + $1,105,261 (NCP) = $1,566,722

These liabilities being assumed by the Joint Venture sum to $13,397,902.

Further deducted from the $45 million Purchase Price is the amount reflecting GWHN's ownership stake in the Joint Venture or 20% of $31.602 million.

Subtracted from this amount will be fees related to the transaction, including advisor fees (investment banker fees, lawyer fees, etc.) and Medical Tail Insurance and Loss Portfolio Transfer Coverage, assumed to be approximately $14.1 million.

The cumulative net cash proceeds received from this transaction amount to approximately $11.182 million.

In addition to this $11.182 million, GWHN has various liquid and illiquid assets and liabilities that are excluded from the assets and liabilities being sold or assumed as a part of the transaction.

As of September 30, 2012, GWHN had approximately $42.858 million of unrestricted cash and liquid investments on its balance sheet, shown on page 2 of **Exhibit 7**. These funds will together with the $11.182 million cash consideration received at Closing, be used to pay off approximately $29.139 million of liabilities not being assumed by the joint venture. **Following the payoff of such liabilities, GWHN will retain approximately $23.270 million of unrestricted cash.**

In addition to the unrestricted cash and liquid investments, GWHN had approximately $151.636 million of restricted funds and illiquid assets at September 30, 2012, $62.472 million of which will be retained by GWHN. Despite the restricted nature of many of these assets (funds held in trust, donor-specified use funds, etc.), they are projected to earn approximately $1.5 million each year, earnings which can be used to further support GWHN, its mission, and its management of ongoing expenses and liabilities. Total assets retained by GWHN following Closing will be approximately $91.872 million.

With regard to liabilities, GWHN will retain approximately $45.778 million of liabilities. Of these liabilities, approximately $29.139 million will be paid off at Closing, leaving $16.639 million of liabilities remaining in GWHN following the Closing of the Transaction.

From a solvency perspective, GWHN will retain Net Assets of approximately $75.233 million.

While GWHN will be required to maintain an indemnity reserve of $7.5 million for three years following the Closing and $5.0 million for two additional years thereafter, with $23.270 million of unrestricted cash at Closing, GWHN will have sufficient cash to meet this

indemnity reserve requirement. Additionally, its restricted funds will yield approximately $1.5 million each year which will further support GWHN, its mission, and its management of ongoing expenses and liabilities.

17. **Please clarify what pension obligations are being retained by GWHN and how they differ from those being assumed by the JV post-Closing. Please also clarify the amount of the pension obligation being retained by GWHN and the anticipated annual expenditure necessary to fund such obligation.**

    On or prior to the closing, GWHN will freeze the Waterbury Hospital Cash Balance Retirement Plan. The JV will become the new sponsor of The Waterbury Hospital Cash Balance Retirement Plan. Annual contributions to the Plan are expected to be approximately $1.1 million although such amount may vary based on a number of actuarial factors.

    The JV will become a participating employer in the New England Health Care Employees Pension Fund and will be responsible for all contributions with respect to employees covered by the Fund after the closing applicable to service after the closing.

    Upon the closing, GWHN intends to withdraw as a participating employer from the Connecticut Health Care Associates Pension Fund. GWHN has been informed by the Fund that there will be a withdrawal liability due to such withdrawal which is expected to be approximately $17 million. The annual expenditure necessary to fund such obligation owed by GWHN after the closing is approximately $2,300,000.

18. **Please provide information on the asbestos abatement liability being assumed by the JV, including the extent of asbestos abatement necessary at the Hospital, the status of remediation efforts and estimated completion dates for the remediation work to be completed if the CON is granted and if the CON is not granted.**

    Asbestos was used extensively as insulation and fireproofing material in many facilities, including hospitals. In the 1970s, federal agencies, including the Environmental Protection Agency and the Occupational Safety and Health Administration, began to regulate the exposure and removal of asbestos and related substances. When buildings containing these substances are renovated, significant care must be taken to comply with these regulations.

    In 2001, recognizing the widespread use of this material, the Financial Accounting Standards Board (FASB) began to require that entities reserve funds for these costs on their balance sheets. This liability would come into play only when and if renovations are commenced in areas where there is asbestos. Consequently, GWHN has reserved $2.7 million for asbestos containment/remediation. No funds need be expended until projects contemplating the disturbance of asbestos-containing materials are planned. No such work is underway nor is any planned for the immediate future; GWHN reserves for this possibility pursuant to FASB rules.

19. **Applicants state on page 18 of the Application that "[a]s a Vanguard hospital, the Hospital will enjoy economies of scale." In addition, on page 15 of the Application, Applicants state that "Vanguard's purchasing power allows Vanguard to keep supply costs low." Please reconcile these statements with the Financial Attachment 1(C), which**

shows substantial projected increases in the "Supplies and Drugs" line item in each of the FYs 2014-2016 if the CON is granted as compared to the same costs projected if the CON is not granted.

For the purposes of projecting the "Supply and Drugs" line item under the with CON scenario, the overarching assumption is that the magnitude of the expense will grow as adjusted discharges grow with an annual inflation factor of 2%. The Applicants contend that this is a conservative assumption and that the JV could realize significant cost savings above and beyond those projected on the Financial Attachments.

The Applicants' Supplies and Drugs account includes several expenses that are not incurred by the Hospital on a stand-alone basis. Additional expenses will be incurred because the JV will be a for profit entity and cannot take advantage of certain programs available to tax exempt hospitals: these items include 340b pricing (reduced pricing on certain supplies only available to tax-exempt healthcare providers)and additional expenses related to sales tax. Additionally, in an effort to reduce operating expenses, the supply expense will increase as a result of insourcing various outsourced services such as dietary, transportation, and environmental services.

These items amount to $3.7M of additional expense and are summarized as follows:

Supplies and Drugs Normalizing Adjustments

Supplies and Drugs FY2012	$35,006,526
Normalizing Adjustments	
340b Pricing	$531,084
Sales Tax	$745,126
Supplies related to insourcing of dietary, transport, and EVS	$2,414,457
Total Adjustments	$3,690,668
Adjusted Supplies and Drugs Expense	$38,697,194

After deducting these adjustments from the FY2012 projected "Supplies and Drugs" expense line item, the expense grows 6.4% between FY2014 and FY2016, whereas Revenue from Operations grows 6.5%. Revenue growing at a faster rate than expense demonstrates how Vanguard will provide the JV with access to group purchasing arrangements allowing the JV to be financially sustainable into the future.

20. At page 20 of the Application, Applicants state that "[f]ollowing the JV closing, the JV Board, Hospital leadership and community physicians will engage in an assessment and planning process for the prioritization of capital investments that best secure the Hospital's future and meets the changing needs of the Waterbury community." Reference is also made to page 312 of the Application which identifies a preliminary 5-year capital plan that was in the process of being prepared in November 2010 with approximately $88.6 million of capital needs identified. Please provide a copy of this

capital plan and a listing of the $50 million in near-term capital improvements identified by Kaufman Hall referenced at page 21 of the Application, and identify in order of priority and by estimated dollar amount the capital projects on which Applicants believe the proposed $55 million capital commitment should be spent. If the Applicants have not reached agreement on these matters, please identify in order of priority and by estimated dollar amount the capital projects on which GWHN's present management team believes the proposed $55 million capital commitment should be spent.

Page 312 of the Application is a page from a PricewaterhouseCoopers ("PWC") presentation that is clearly marked "Draft" and provides its financial analysis of Waterbury Hospital. The bulleted statement on page 312, referred to in the above question, is a reflection on the overlapping work by Kaufman Hall that was in process at the time of the PWC draft report. The scope of the Kaufman Hall engagement was to identify the Hospital's capital needs. The listing of capital needs identified by Kaufman Hall is located at page 296 of the Application.

The Applicants believe that these proposals are now out of date, particularly in light of the adoption of recent federal health care legislation and, therefore in 2013, have limited relevance to planning for the greater Waterbury service area going forward. Current data shows significant decreases in ***inpatient*** care and increases in ***outpatient*** care. Proposed investments in information technology are underway although additional investment is needed.

While an outside consultant has not been retained for an additional study, the Applicants currently believe the $55 million in capital commitment should be spent in the following priority areas:

- Investment in building outpatient space;
- Physician recruiting and retention;
- Providing physicians with the tools they need in their own practice space;
- Continuation in upgrading information technology to link the various locations together;
- Replacement and upgrade of some specific technology and equipment at the Hospital campus directly.

Note that the allocation of capital is subject to changing market dynamics, as the JV aims to invest capital in a manner that is most advantageous to the community.

21. **The proposed $55 million capital commitment over 7 years is also to be spent in a manner to enhance ambulatory services in the Greater Waterbury community. Please elaborate on the ambulatory service strategy for GWHN discussed at page 846 of the Application and identify in order of priority the specific ambulatory services in Waterbury on which Applicants believe the proposed $55 million capital commitment should be spent. If the Applicants have not reached agreement on these matters, please identify in order of priority the specific ambulatory services in Waterbury on which GWHN's present management team believe the proposed $55 million capital commitment should be spent.**

The Applicants are in the process of developing a comprehensive ambulatory services strategy. The Applicants' initial vision calls for the development of a robust primary care platform that will result in strengthening relationships with specialists, and development of an accessible ambulatory network of services.

At this time, the Hospital has completed a medical staff development plan of its primary service area that identifies physician demand over the next five years. Projected physician need is primarily based on expected retirements. No decisions have been made about the specific recruitment or retention strategy, other than to continue the Hospital's commitment to a primary care teaching environment.

The Hospital's service area has been reviewed to catalogue existing services and potential needs. No determination has been made on location or levels of services to be provided.

No decisions have been made about capital investments. However, the JV's priority is maintaining a strong, competent medical staff, and ensuring they can deliver high quality care in appropriate environments. Because the Hospital does have a presence in several outpatient markets, capital will probably be invested in physicians, equipment and information technology before being invested in outpatient "bricks and mortar".

22. Please provide copies and/or drafts of the community health needs assessment that GWHN began preparing in FY2012 with St. Mary's Hospital that is referenced at page 892 of the Application and provide an estimate of how many months after closing it will take to prepare the community needs study referenced at page 61 of the Application. Please provide any other community health needs assessments or studies of the Greater Waterbury area that Vanguard or GWHN have produced and/or participated in since 2010.

The Greater Waterbury Community Health Improvement Partnership is a collaborative effort of several community organizations, to include the Hospital and Saint Mary's Hospital to conduct a Community Health Needs Assessment ("CHNA"). This effort will ultimately meet the Hospitals' IRS 990 Schedule H requirements and the Waterbury Health Department's accreditation requirements.

The goals of CHNA are as follows:

- Identify community health needs and priorities within the Greater Waterbury Area;
- Provide a platform for collaboration between organizations to address sources of poor health outcomes and inequity;
- Provide a baseline measure of key health indicators and monitor trends in health status for Waterbury residents; and
- Inform health policy and strategies for developing and implementing a comprehensive community health improvement plan.

The time line and proposal from Halloran Consulting are attached as **Exhibit 8**.

The Applicants have not produced any other community health needs assessments at this time.

23. Reference is made on page 26 of the Application to an increase in the cash purchase price and a reduction in the capital commitment pledge in response to certain changes in the business condition of GWHN (not mentioned on page 26, but worth noting is that Net Working Capital target was also substantially reduced from $14.5 Million to $6.8 Million). Please elaborate further as to how and to what extent the business terms of the transaction have changed since the October 29, 2012 letter of intent was executed by the parties and include specific information that addresses the following:

a. Has the financial condition of GWHN stabilized, or do Applicants anticipate that further adjustment to the business terms may be necessary?

The business terms of the transaction, in the aggregate, have not changed as the total amount of capital involved with the transaction is still $100 million ($45 million purchase price / $55 million capital commitment). There have been no other changes to the terms of the transaction other than the reallocation of funds from the capital commitment to the purchase price and the Applicants do not anticipate any additional changes to the terms of the transaction. Furthermore, the Applicants feel the financial condition of GWHN is in similar condition when compared to the time that the Letter of Intent was negotiated.

b. Why was the Net Working Capital target reduced?

There are several reasons for the reduction in the Net Working Capital target. The first is a timing difference. The $14.3 million figure was based upon the combined balance sheets for June 30, 2012, as that was the most recent data available at the time the Letter of Intent was negotiated. The $6.8 million figure is based upon consolidated trial balances as of September 30, 2012. As a result of the 2012 financial audit, GWHN management determined that accounts receivable required a write-down of approximately $7 million due to the perceived uncollectability of the related accounts. In addition, inventory was written up by $2.4 million to more accurately reflect its value. The second reason for the change is due to a change in methodology. The $14.3 million figure was calculated based upon 100% ownership in each of the affiliated entities, whereas the $6.8 million figure was calculated based upon the JV's actual ownership in each of its affiliated entities.

c. With reference to page 26 of the Application, how is the payment reduction of $11 million over the next 3 years calculated? Please provide supporting data for this calculation.

The $11 million calculation was extracted from page 17 of the *Proposed FY2014 – FY 2015 Budget: Issue Briefs* released on February 6, 2013 by Governor Dannel P. Malloy.

d. What changes have been made to the business terms of the proposed JV and the post-closing plans for the Hospital to account for the changes in hospital funding contained in the state biennial budget for 2014 and 2015?

No changes have been made to the business terms of the proposed JV as a result of the changes in hospital funding contained in the state biennial budget for 2014 and 2015. The post-closing plans accounted for the reduction of funding and have incorporated the cuts into the financial projections. Despite the reduction in funding, the operations still enable the JV to produce positive financial performance going forward.

24. Section 17(c) of the October 29, 2012 letter of intent between the parties has been redacted. Please provide a summary of the redacted text so it can be determined whether an unredacted copy of the letter of intent will need to be submitted.

In Section 17(c) of the letter of intent, the parties agreed to limit contacts with another health care institution during the Exclusivity Period, so that both parties could concentrate their respective efforts on completing the transaction at hand. The Exclusivity Period has expired.

25. With respect to the list of GWHN's due diligence items referenced at page 26 of the Application and listed as Exhibit 8, please provide the information supplied by Vanguard and GWHN's findings with respect to the following (note: to the extent the information is deemed confidential and/or privileged, please supply summaries so that it can be determined whether copies of the actual documents will need to be submitted):

a. The organizational matters described in due diligence requests 1.5 and 1.6;

In response to due diligence request 1.5 requesting that Vanguard provide a summary of any planned or anticipated corporate restructuring, Vanguard stated the following: "[n]o planned or anticipated restructuring."

In response to due diligence request 1.6 requesting that Vanguard provide a summary of any planned or anticipated sale, restructuring, or other re-organization of the assets of GWHN, in whole or in part, Vanguard stated the following: "[n]o planned or anticipated sale."

b. The tax matters described in due diligence request 2.1;

In response to due diligence request 2.1 requesting that Vanguard provide a summary of any ongoing audits, investigations, protests, or other matters posing a risk in excess of $100,000, Vanguard responded that the parties could "arrange conference call to discuss if desired."

c. The projected financial statements and description of previously unanticipated future factors/events described in due diligence requests 3.6 and 3.7;

In response to due diligence request 3.6 requesting that Vanguard provide projected financial statements for the next three years, Vanguard stated that it, "does not disclose projected financials."

In response to due diligence request 3.7 requesting that Vanguard provide a description of any previously unanticipated factors/events that are materially impacting, or are expected to materially impact, current or projected operating results, Vanguard stated "none."

d. The licensure and accreditation matters described in due diligence requests 4.1 and 4.2;

In response to due diligence request 4.1, requesting Vanguard to provide a list of sentinel events for each Vanguard hospital during the past two years, as well as a description of the events and the actions taken in response, Vanguard inquired as to whether there was additional data that could be provided in lieu of that specific request in order to fulfill Waterbury's due diligence efforts. GWHN determined that Vanguard had adequately addressed the due diligence topic with its responses to 9.1 and 9.2.

In response to due diligence request 4.2 requesting that Vanguard provide, for each of its hospitals, all institutional licensure and accreditation survey reports, including statements of deficiency and plans of correction for the last three years, Vanguard provided a list of hospitals with their accreditations and recognitions. That list is attached as **Exhibit 9**.

e. The corporate compliance matters described in due diligence requests 5.2-5.2.4;

In response to due diligence request 5.2 requesting that Vanguard provide information on government investigations of Vanguard, Vanguard referred GWHN to pages 70-73 of its Annual Report on Form 10-K for fiscal year 2012 that it filed with the U.S. Securities and Exchange Commission (the "SEC") on 8/24/12. That filing is publicly available on the SEC's website.

In response to due diligence request 5.2.1 requesting that Vanguard provide a list of any material audit, inspection, recoupment action, recovery demand or other investigation, Vanguard stated that no material events have occurred except for those disclosed in Vanguard's filings with the SEC. Vanguard also stated that, during the life of Vanguard, it has not been subject to (a) a Corporate Integrity Agreement ("CIA") or Settlement Agreement with CIA provisions, (b) criminal prosecution of management, or (c) exclusion from Medicare and/or Medicaid.

In response to due diligence request 5.2.2 requesting that Vanguard provide copies of all CIAs or Settlement Agreements that are now in place or are actively being negotiated, Vanguard responded "none" which was an inaccurate response, as Vanguard does have a work plan for compliance. Since the time of these due diligence activities, Vanguard has provided GWHN with its current work plan for compliance.

In response to due diligence request 5.2.3 requesting that Vanguard provide a copy of the current work plan for compliance activities, Vanguard responded "none." Since the time of these due diligence activities, Vanguard has provided GWHN with its current work plan for compliance.

In response to due diligence request 5.2.4 requesting that Vanguard provide information as to any self-disclosures made by Vanguard to the government in the past three years,

Vanguard referred to page 71 of the Form 10-K for fiscal year 2012 that it filed with the SEC on 8/24/12.

f. The litigation matters described in due diligence requests 6.1-6.4;

In response to due diligence requests 6.1 (requesting information on all claims, litigation, arbitration, administrative or other proceedings or investigations currently pending or threatened), 6.2 (requesting information on all claims, litigation, etc. within the last three years), 6.3 (requesting information on all claims, litigation, etc. involving cities, towns, or countries), and 6.4 (requesting information on all claims, litigation, etc. involving class discrimination) Vanguard referred to Item 3, pages 70-73 of the Form 10-K for fiscal year 2012 that it filed with the SEC on 8/24/12.

g. The information system matters described in due diligence request 7.2;

In response to due diligence request 7.2 requesting that Vanguard provide a description of current, committed but not started, and planned information systems projects that will affect interoperability with joint venture information systems or otherwise affect the joint venture, Vanguard responded "none."

h. The quality matters described in due diligence requests 9.1 and 9.2;

In response to due diligence request 9.1 requesting that Vanguard provide copies of comparative performance reports for Vanguard hospitals' key outcome indicators for the last three years, Vanguard provided a page containing four graphs depicting various improvements in quality in Vanguard facilities beginning in 2010. That page is attached at **Exhibit 10**.

In response to due diligence request 9.2 requesting that Vanguard provide all quality data recorded by the Center for Medicare and Medicaid Services under the Hospital Quality Initiative Program and by the Joint Commission under the ORYX Core Measure Performance Measurement System and associated validation results, Vanguard provided a document titled "Hospital Inpatient Quality Reporting (IQR) Program Measures." That document is attached at **Exhibit 10**.

i. The mission and cultural compatibility matters described in due diligence requests 10.1-10.5;

In response to due diligence request 10.1 requesting that Vanguard provide a summary and account of its history of community support and involvement, and engagement in public health initiatives Vanguard provided the document attached at **Exhibit 11**.

In response to due diligence request 10.2 requesting that Vanguard provide a summary and the amount of charity care that it provided for the last three years in Vanguard hospitals, Vanguard referred to pages 28 and 116 of the Form 10-K for fiscal year 2012 that it filed with the SEC on 8/24/12.

In response to due diligence request 10.3 requesting that Vanguard provide a description of outreach programs and services to identify the needs of the poor and medically underserved in Vanguard hospitals, Vanguard provided the document attached at **Exhibit 11**.

Vanguard did not provide a response to due diligence request 10.4 requesting that it provide policies related to collections, discounts, waivers of deductibles and coinsurance, and patient billing rights in Vanguard hospitals.

In response to due diligence request 10.5, Vanguard responded that all of its hospitals have their own policies and procedures, but provided illustrative policies from its MetroWest hospitals. Those policies are attached at **Exhibit 11**.

j. The recent transaction matters described in due diligence requests 11.1-11.3; and,

In response to due diligence request 11.1 requesting that Vanguard provide a list and description of any failed deals to acquire hospitals in the past five years, and why those deals failed, Vanguard responded "none" because the only two transactions that could be in question (Athol and Holy Cross) failed to meet the required closing conditions.

In response to due diligence request 11.2 requesting that Vanguard provide a list of hospitals that it sold within the last ten years, Vanguard provided the response attached at **Exhibit 12**.

In response to due diligence request 11.3 requesting that Vanguard provide a description of its deal with Tufts Medical Center at that time, Vanguard provided the response attached at **Exhibit 12**.

k. The ability to fulfill JV objectives matters described in due diligence requests 12.1 and 12.2.

In response to due diligence request 12.1 requesting that Vanguard provide an assessment of its ability to fulfill the objectives of the Joint Venture, Vanguard provided the response attached at **Exhibit 13**.

In response to due diligence request 12.2 requesting that Vanguard describe its financial ability and commitment to expend significant financial resources to maintain and grow the Joint Venture's competitive position in the marketplace post-transaction, Vanguard provided the response attached at **Exhibit 13**.

26. With respect to the GWHN Task Force Meeting Minutes attached at Exhibit 15 to the Application, please provide information on the following:

a. Vanguard's overall strategy in Connecticut, including its analyses of challenges specific to the Connecticut market and its anticipated methods of addressing those challenges referenced at p. 818 (include information regarding developing regional tertiary care relationships referenced at p. 846 of the Application);

Vanguard has been a high value health care provider in New England for over 8 years, principally in central Massachusetts and the far western suburbs of Boston. Vanguard believes there is a need and an opportunity to develop a high value health care network in Northern Connecticut as we expand within New England. There are several community hospitals within Northern Connecticut that have identified the need for a capital and operating partner to become sustainable in the future and continue to serve their communities. Vanguard has signed letters of intent with two of these community hospitals: Greater Waterbury Health Network and Bristol Hospital and Health Care Group. Vanguard also believes that more community hospitals in Connecticut will need to be part of larger, better capitalized organizations to be sustainable in the future. Vanguard's size, resources and track record affords it the opportunity to partner with other organizations in Northern Connecticut, ultimately creating a clinically integrated, value-based health care network in Northern Connecticut.

b. A summary of the presentation made by Cain Brothers to the GWHN Task Force on the major issues regarding the proposed JV focusing on the Net Working Capital number, certain assumed liabilities, off balance sheet items and the CHCA pension plan as referenced at p. 821 and the resolution of those issues; and

On February 22, 2013, Cain Brothers made a presentation to the GWHN Task Force regarding an update on the proposed JV negotiations, including ongoing Vanguard diligence areas. The presentation highlighted the following:

- Reprisal of some key terms associated with the Letter of Intent signed with Vanguard on October 29, 2012, including the Enterprise Value, Vanguard's capital expenditure commitments, commitment to existing Community Benefit / Uncompensated Care policies, governance rights, and the exclusivity period

- At this time Vanguard had completed a majority of its diligence efforts, but had highlighted some issues that needed to be discussed:
  - Net working capital – As a result of the 2012 financial audit, GWHN management determined that accounts receivable required a write-down of approximately $7 million due to the perceived uncollectability of the related accounts. In addition, inventory was written up by $2.4 million to more accurately reflect its value.
  - CHCA pension – Due to the existing CHCA pension's status as a multi-employer plan, the funded status did not appear on Waterbury Hospital's balance sheet. Given the unfunded liability was estimated at $17.2 million, Vanguard wanted to have a discussion about the potential liability and the assumption of the liability post transaction.
  - Reimbursement environment – Vanguard wanted to discuss the current reimbursement environment in Connecticut, including the perceived risk of a 2.5% revenue cut due to State budgetary constraints.

- Also highlighted were some other outstanding items in the definitive agreement that would still need to be negotiated:

- Termination fee
- Escrow or reserve requirement
- Casualty loss for termination
- Material adverse change clause

- Finally, a revised balance sheet allocation between the GWHN Foundation and the JV was presented, as well as an updated net Foundation assets calculation.

c. The significant A/R write-off referenced at p. 823.

During 2012, the Hospital also determined that patient accounts receivable was overstated by $5,160,000 as of September 30, 2010 and bad debt expense was understated by $2,210,000 for the year ended September 30, 2011, primarily resulting from patient accounts receivable balances due from workers' compensation insurance companies and self-pay patients.

27. Please identify the core services that Vanguard believes are essential to the operation of an effective hospital as is referenced at page 46 of the Application and provide a more extensive discussion on the following:

a. Vanguard's understanding of what constitutes the Hospital's core services as referenced at page 46 of the Application;

Vanguard has benefited from numerous conversations with the local operators at the Hospital and feels it has a solid understanding of the core service lines that GWHN believes are essential to the success of the Hospital. These services include: Emergency Services, Cardiology, Behavioral Health, Women's Services, Orthopedics, Neurosurgery, Urology, Oncology and General Surgery. Vanguard agrees these services are crucial to the surrounding community and looks forward to continuing to provide these services.

While Vanguard does not have a standard template with respect to core services that are essential to the operation of an effective hospital, it does acknowledge that divisions such as an emergency department and general surgery are likely necessary for the viability of any hospital and the services of such divisions are offered in all hospitals owned and operated by Vanguard. Identification of other services that lead to addressing community needs, complying with state regulations, and providing clinical quality and efficiency is conducted on a facility-by-facility basis.

b. Vanguard's commitment to maintaining core, existing service lines of the Hospital for a period of 10 years as referenced at p. 853 of the Application;

Vanguard does not enter markets with the intention of eliminating services. Eliminating service lines without strategy or reason will not create a sustainable, let alone growing, business. However, any successful business must be nimble and able to adapt to market changes. Therefore, Vanguard will not jeopardize the sustainability of the Hospital by refusing to eliminate a service line but Vanguard may also add additional services if the needs of the community so demand. As a result of such community needs and market

demands, it is necessary for Vanguard to reserve the right to consider changes to service line strategies, such as discontinuing a service, if the viability of the Hospital is threatened. To examine the efficiency and necessity of a service, periodic assessments of advancements in technology and care delivery and competitive dynamics will be conducted with the Hospital. Health care is local and those working in the markets know what is best for the community.

c. How long the JV will continue to provide the services currently offered by the Hospital, including its clinics, psychiatric programs and emergency department as represented at page 48 of the Application;

Please see the response to question 27B

d. The impact that the JV's for-profit status will have on the current ownership structure, tax-exempt status and services offered by the Harold Leever Regional Cancer Center, Inc. and the Heart Center of Greater Waterbury, Inc. joint ventures with St. Mary's Hospital; and

The JV's for-profit status will not impact the current ownership of the Harold Leever Regional Cancer Center or the Heart Center of Greater Waterbury. However, due to the for-profit status of the JV, each of the Harold Leever Regional Cancer Center and the Heart Center of Greater Waterbury may convert to for-profit entities when the JV receives an ownership interests in such entities; such matters must still be voted upon by the governing bodies of such entities. The JV is in the process of filing a CON for both of the aforementioned entities. Furthermore, the services will not change and will continue to be provided to the community as both are vital to delivering appropriate care to the community.

e. Clinical services that Vanguard has eliminated at its other hospitals.

Vanguard has eliminated services at other hospitals in response to changes in market dynamics. Specifically, discontinued services at other hospitals include:

Hospital	Service	Commentary
Mission Trail Baptist Hospital	Obstetrics	Low delivery volume; high cost per delivery; implemented action plan to repurpose OB space to better serve the community. Note that Vanguard transferred the service to a nearby hospital (as Baptist is a 5 hospital system with one provider number).
Weiss Memorial Hospital	Obstetrics	The service area was saturated with OB services; low volume and high cost of coverage
MetroWest Medical Center	Skilled Nursing Facility	Low volume coupled with reduced reimbursement rates.

In each case, the decision to eliminate the above services was driven by the goal of maximizing each hospital's resources to best serve their respective communities.

28. Reference is made to page 853 of the Application which contains statements by Vanguard that "at Vanguard hospitals, uninsured patients with incomes below 200% of the Federal Poverty Level are classified as financially indigent and receive free care." Those patients with income between 200% and 500% of the Federal Poverty Level or balances due in excess of 50% of their annual income are classified as "Medically Indigent" and receive 40% to 80% discounts (on a sliding scale basis) on amounts they owe. When comparing the GWHN and Vanguard charity care policies, there are certain components of the GWHN policy which are more favorable to patients than the Vanguard policy and in other cases the Vanguard policy is more favorable to patients than the GWHN policy. Please answer the following with respect to these statements:

a. Will the same Vanguard charity and indigent care policies as referenced above be instituted at the Hospital and, if not, why not?

The Applicants will implement the charity care and indigent care policies that are more favorable to the community. The Vanguard sliding scale is more favorable than the Hospital's sliding scale and will be adopted by the JV. The JV will also adopt the Hospital's 50% uninsured discount, which is more favorable than Vanguard's discount policy. Please see **Exhibit 14** for the current Hospital policy.

b. What measure is used to determine the referenced discounts of between 40% and 80% (e.g., is this a discount of hospital charges or some other measure?)

Both Vanguard and the Hospital measure discounts against charges as set forth in the Charge Master.

c. What are Vanguard's plans with respect to raising the Hospital's charges post-closing?

Vanguard has no current plans to raise the Hospital's charges post-closing, but does on occasion perform comparative rate assessments of the service area.

d. Do the Vanguard charity and indigent care policies only apply to the uninsured?
Yes, the Vanguard policies referenced above apply only to the uninsured. In addition, Vanguard provides financial assistance to insured patients who suffer from financial hardship on case by case basis.

e. What types of financial assistance plans have Vanguard hospitals offered to uninsured patients over 500% of the Federal Poverty Level and/or insured patients who suffer from financial hardship?

Vanguard provides assistance to all uninsured patients based upon a predetermined discount. Vanguard provides assistance to uninsured patients whose income is over 500% of the Federal Poverty Level based on the ratio of Hospital charges owed as a percentage of their total income as follows:

Balance Due	Discount
Balance Due is equal to or greater than 90% patients annual income	80%
Balance Due is equal to or greater than 70% and less than 90% patients annual income	60%
Balance Due is equal to or greater than 50% and less than 70% patients annual income	40%

f. Will the JV offer financial assistance to uninsured patients over 500% of Federal Poverty Level and/or insured patients who suffer from financial hardship?

Yes. Please reference the response to part e.

g. What components of GWHN's charity care policy are more favorable than Vanguard's?

GWHN's 50% discount from Hospital charges to all uninsured patients, regardless of Federal Poverty Level is more favorable.

h. What components of Vanguard's charity care policy are more favorable than GWHN's?

Vanguard's sliding scale discounts are more generous that the Hospital for patients at 225-400% of Federal Poverty Level.

29. With respect to the statement at page 48 of the Application that "[t]he JV will retain and continue to follow charity care and uncompensated care policies as least as favorable to patients as those maintained by GWHN" and the copies of the relevant polices appended to the Application at Exhibit 17, please answer the following questions:

a. Will the JV comply with the requirements of the IRS Code Section 501(r) as set forth at pages 874 and 875 of the Application with respect to its financial assistance policy, limitation on charges and billing and collection activities?

Yes, per paragraph 2.6(c) of the Operating Agreement, the JV shall comply with the requirements of sections 501(r)(3) – (6) of the Code with respect to conducting a community needs health assessment, establishing a written financial assistance policy, limiting amounts charged for emergency and other medically necessary services for those qualifying for financial assistance, and foregoing extraordinary collection actions against an individual before determining whether that individual is eligible for financial assistance.

b. If the answer to the above is no, please explain any differences with respect to the policies the JV will follow in each of these areas.

Not applicable, see response to question 29a.

c. How will the JV's activities in these areas differ from the approach taken by GWHN with respect to the bullet points items set forth at pages 874 and 875?

The JV's activities regarding compliance with sections 501(r)(3) – (6) of the Code with respect to patient billing and collections will not change materially from existing Hospital policy.

d. The transition plan does not mention the development of charity care, financial assistance and uncompensated care policies and procedures. When does the JV anticipate that these would be finalized?

Upon closing, the JV will implement Vanguard's charity care, financial assistance and uncompensated care policies and procedures as defined in the original Application, and further described in response to question 28 above.

30. Reference is made to the statement on page 53 of the Application that one initiative crucial to the long-term success of GWHN is to "[e]nhance the Hospital's medical staff by attracting and retaining physicians through access to available capital" and it is also noted at page 309 of the Application that one of the reasons for the decline in admissions for the Hospital in FY 2010 was loss of business from physicians who aligned with other hospitals and organizations. Please provide specific examples of how Vanguard has been successful in attracting and retaining new physicians at its other hospitals within the first three years of acquiring ownership (note: the discussion at pages 847-848 of the Application is insufficient).

Recruiting talented physicians is vital to Vanguard's success. Vanguard's approach involves three basic steps: assessment, strategy development and plan execution.

Assessment

Community need assessments are an essential part of Vanguard's recruitment planning process. Physician needs assessment data has become increasingly important in developing strategic recruitment plans and in compliance with federal recruiting regulations. To ascertain future physician workforce needs, Vanguard engages an independent party to conduct a community need assessment at least every two years. Currently this effort is coordinated by The Carnahan Group who takes into account a comprehensive evaluation of local physician FTEs, patient demographics, disease incidence and a variety of other factors. Decisions to recruit additional physicians are generally based on one or more of the following:

1. A population to physician ratio that is deficient in serving the healthcare needs of the population in a particular specialty
2. A demand for a particular medical service in the community coupled with a lack of

availability of the service or long waiting periods
3. A designation of the community (or part of the community) as a Health Professional Shortage Area (HPSA)
4. A reasonably expected reduction in the number of physicians of that specialty due to anticipated physician retirements
5. A lack of physicians serving indigent or Medicaid patients within the service area

Strategy Development
During Vanguard's annual strategic planning process, market leaders determine recruitment priorities to support key business objectives. Depending on the situation, recruitment strategies may include recruiting new physicians to the community or acquiring existing medical practices. Acquisitions sometimes make the most sense as physicians already are known in their community and have an established reputation. Regional teams devote considerable time to crafting a compelling value proposition and assessing the financial impact for each new recruit.

When considering Vanguard practice opportunities, candidates have several alignment options. Employment opportunities abound, particularly for primary care physicians, with one of Vanguard's eight medical groups. Vanguard's solid business platform supports all sides of the physician compensation equation; compensation models that are market based, fair and equitable, bonuses which are tied to quality performance metrics, favorable relationships with health plans, economies of scale that reduce expenses, and sophisticated billing and collection systems. This allows Vanguard employed physicians to focus on what they are trained to do – take excellent care of the patients we serve. Further, Vanguard physicians enjoy the security and stability of being part of a Fortune 500 company operating regionally integrated health networks in six urban markets. That means Vanguard has ready access to capital funds for investment in state of the art clinical equipment and facilities. All these advantages and others allow Vanguard physicians to advance IHI's Triple Aim of providing better health and better care at lower cost.

In addition, Vanguard also supports physician recruitment into established independent practices. To qualify for relocation assistance a physician must be relocating his or her medical practice from more than 25 miles outside a Vanguard hospital service area and may not be a current member of the medical staff. The relocation requirement is waived if a physician is still in his or her first year of practice, including residents and fellows; or has been employed full-time by a government entity for at least the previous two years; e.g. Department of Defense, Veterans Administration, Indian Health Service, and Federal or State Bureau of Prisons.

Decisions to acquire, recruit, or relocate a physician are driven by local leadership. Vanguard offers a variety of incentives to attract the best physician talent and routinely refines the overall financial value of our recruitment packages. The goal is to ensure Vanguard remains market-competitive for top recruits without incurring unnecessary expense or sparking bidding wars. Once the number of physicians to recruit is determined and strategy is laid out, a dedicated team of experienced recruiters are engaged to execute the plan.

Execution

Recruiters work with market leadership to identify the critical knowledge, skills, abilities, and experiences needed for job success. From this assessment, ideal candidate profiles are developed for each open position and a rigorous search process is initiated. Recruiting teams have access to sophisticated recruiting technologies to tap the richest sources of recruits. Automated and efficient tools to identify, track, screen, recruit, hire and onboard top candidates effectively are also provided. Vanguard recently developed a next-generation career site with rich video content to better address the interests of prospective recruits. Vanguard's goal is to create the kind of strong first impression and personal connection that encourages physician job-seekers to apply for Vanguard opportunities or refer colleague.

Physician leaders play a key role in every stage of Vanguard's recruitment process - manpower planning, lead generation, site visit interviews, candidate selection, and ultimately, new physician integration. Physicians are engaged in an array of high-yield professional networks designed to cultivate strong personal relationships and contacts that can generate more high-quality recruitment leads over the short and long terms. Peer-to-peer connections are a central component of Vanguard's recruitment strategy. When it comes to recruitment, nothing is more influential than a peer referral when considering job opportunities.

Vanguard's most valuable recruitment asset is the breadth and depth of its graduate medical education programs. Every day more than 1,400 residents and fellows in 65 specialties receive training at a Vanguard facility. Alignment with Vanguard's GME programs is crucial to address Vanguard's physician workforce shortages and several initiatives are underway to promote retention. These include:

- Resident Stipend Packages
- GME Program Coordinators Programs
- Engagement with Chief Residents Council
- Resident Social Functions
- Resident Educational Programs
- New Resident Orientation
- Job Openings on Resident Clinical Portal
- GME Database Development
- Video Testimonials of Recent Recruits & Faculty

Recruiters and administrators are involved in long-term "courtship" recruiting of key residents and fellows early in their training. Relationships are also maintained with desirable candidates from past recruitment efforts, regardless of whether the candidates are actively job-seeking. Contacts are maintained through soft-touch communications and information sharing. Vanguard's goal is to ultimately get candidates to consider accepting a position in the future or to provide additional candidate referrals from his or her network.

All of these initiatives will be implemented into the recruiting process for the JV.

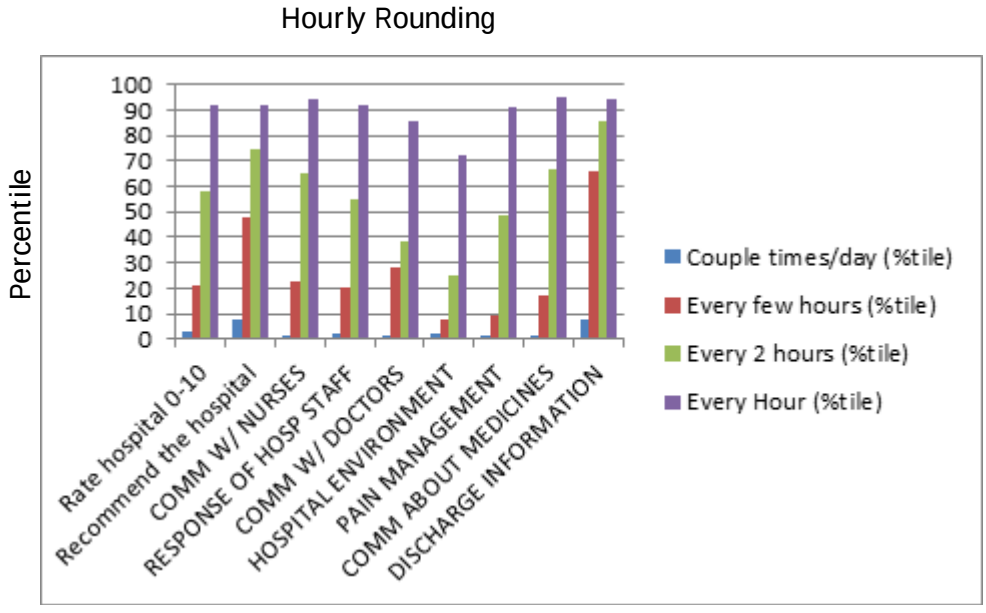
31. Reference is made to the statement on page 53 of the Application that another initiative crucial to the long-term success of GWHN is to "maintain high satisfaction scores by patients, physicians, employees and volunteers." Please provide specific examples of

how Vanguard has achieved high satisfaction scores in these areas at its other hospitals within the first three years of acquiring ownership (note: the discussion on page 848 of the Application is insufficient). Additionally, please explain how Vanguard expects to replicate these successes in this proposal.

Vanguard utilizes a number of techniques to maintain high satisfaction across its base of constituents (patients, employees, etc.). These methodologies were used in Vanguard's other hospitals, including Valley Baptist, DMC Sinai-Grace, and MetroWest Medical Center, following an acquisition and have resulted in meaningful improvements in satisfaction. Below is a list of tactics that Vanguard utilizes, and intends to use in the JV, to improve satisfaction from every person that has an encounter with the Hospital.

Techniques for Patient Satisfaction

1. **Communication.** Communication around delays, treatment, waiting times, etc. are perhaps the most important patient experience metrics for EDs. Nurse Communication is one of Vanguard's keys to higher HCAHPS scores.
2. **Hourly rounding for all care givers, in all facilities as a non-negotiable.** This is all about communication with the patient to ensure Vanguard is keeping them safe, healing them and to simply show Vanguard employees care. Clinicians are taught to not only tell patients (and family members) they will check on them every hour, but to also explain why. They reinforce, "I care about you and I want to be sure you are safe." As a system, Vanguard has seven of the nine HCAHPS domains above the 90th percentile. The following chart illustrates the percentile in which Vanguard ranks for each of the nine HCAHPS domains based upon the frequency of each action during hourly rounding:



3. **Implement Bed side shift handover.** Communication with staff at shift change, next to the patient, to ensure Vanguard employees have clear expectations and nothing slips through the cracks.

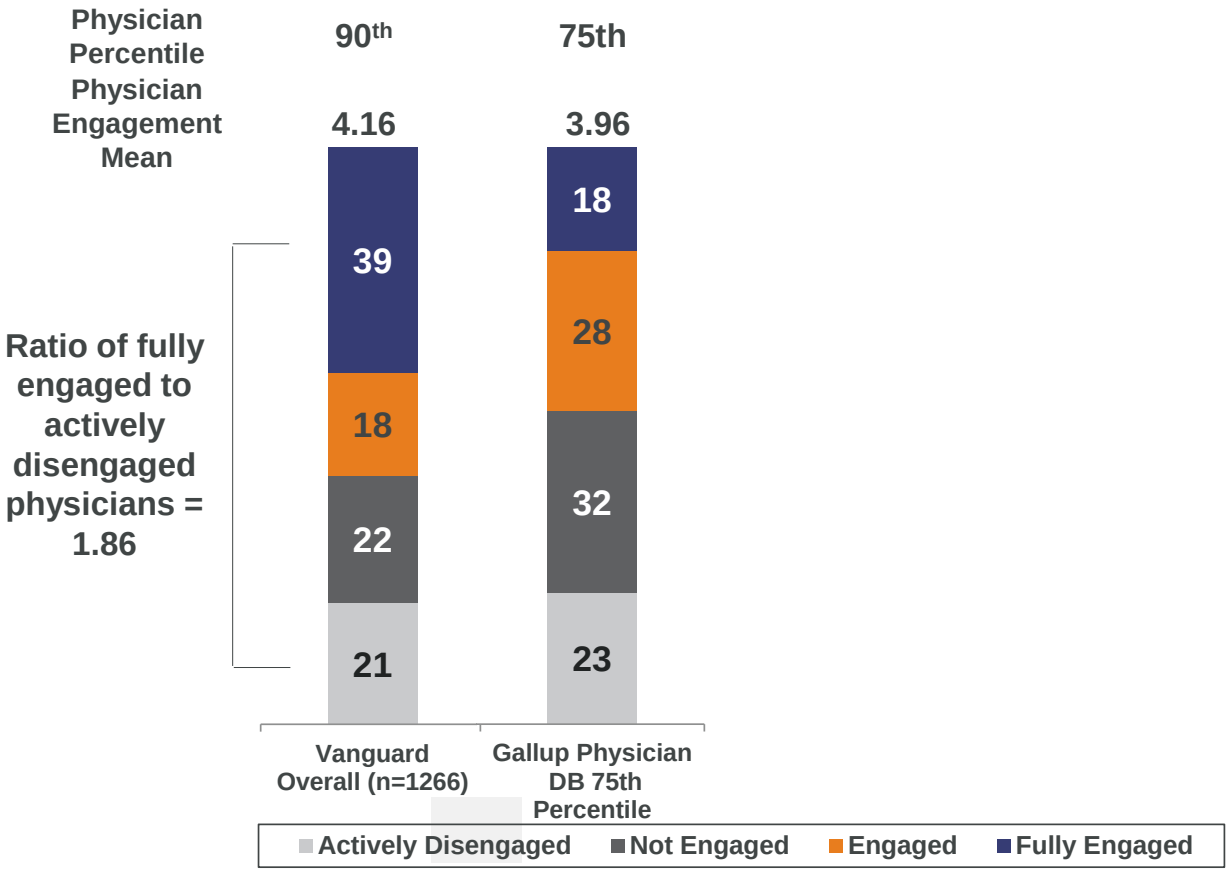
4. **Post Discharge phone calls for all IP, OP and ED patients.** This is communication with the patient after they leave to ensure they know Vanguard employees care, check to see if they have questions (medications, etc.), possible service recovery, and ensure they have a follow up visit.
5. **Weekly Verbatim Review Sessions with staff**. These are an opportunity for recognition around great patient care and accountability for poor performance. Facilities have OP one week, IP one week, ED one week and then the process starts over.
6. **Survey as many patients as possible, in as many methodologies as possible.** Vanguard surveys IP, OP and ED patients via phone with Press Ganey after discharge. Vanguard has placed kiosk and floating iPads for OP and ED; and collects data via iPad from hourly rounding.

Strategies for Employee Engagement

1. **Daily Huddle (or daily email update)**
   - o Quick recap of issues/events
   - o State of the State for the day
2. **1:1 Rounding With Employees**
3. **1:1 Employee Meetings**
   - o What is going right
   - o What could we do better
   - o Assess if employee has tools & equipment needed
   - o Ask if there is anyone they would like to recognize
4. **Employee Recognition**
   - o On the Spot Recognition
     - "Way To Go Cards"
   - o Recognition as part of staff meeting agendas
   - o Department Recognition Board
   - o Understand how each individual likes to be recognized (use recognition profile)
   - o Thank you cards to employees
   - o Always acknowledge high quality performance
5. **Establish a Departmental Employee Engagement Team**
6. **Departmental Status/Progress Report**
   - o Help staff understand their role in communicating needs
   - o Understand and respond to employee issues/needs
   - o Suggestion / opinion / issues box / or communication Board for Department
   - o Develop Accomplishments Board
   - o Close the Loop – communicate reason/rational why something may not happen
   - o Stop light status report for materials and equipment – Red (can't or haven't delivered), Yellow (in progress), Green light (complete)
7. **Goal/Performance Discussions**
   - o Minimum twice a year
   - o Help staff identify skill & knowledge necessary to help them use their talents better
8. **Staff Development**
   - o Departmental Mentors for new hires

- o Team members develop/train other team members
- o Invite guest champions from other Departments to Staff Meeting – drives internal/departmental customer engagement
- o New Hire Peer interviews
- o Purpose statement for the Department
- o Create awareness of how employee's role fits into purpose

Vanguard's successes are evident by the results of its most recent Physician engagement survey from 2010, results below.



32. With respect to the Applicants' answer to Question 20 of the Application at pages 56-57, please provide specific examples from other hospitals owned by Vanguard where it has achieved significant savings in the expense categories set forth in Question 20 within the first three years of acquiring ownership and discuss how the strategies followed at those hospitals could lead to cost savings in these same categories at the Hospital.

The table below illustrates various cost savings Vanguard hospitals have enjoyed in the first three years of partnering with Vanguard.

Health System	Savings	Savings Commentary	Expense Category Effect
Detroit Medical Center	$8M	Insourced the HIM\Coding functions utilizing Vanguards policies and procedures and cost infrastructure	Reduced Business Expense and Other Operating Expense; Increased Salaries & Wages and Fringe Benefits
Detroit Medical Center	$0.5M	Changed billing software vendor to VHS standard	Reduced Business Expense and Other Operating Expense
Detroit Medical Center	$2M	Moved early out self-pay follow-up process to VHS internal structure	Reduced Business Expense and Other Operating Expense; Increased Salaries & Wages and Fringe Benefits
Detroit Medical Center	$0.9M	Moved transcription to VHS vendor and rates	Reduced Business Expense and Other Operating Expense
Westlake Hospital \ West Suburban Hospital	$10M	Insourced all functions being performed by prior owner corporate structure\eliminated duplication	Reduced Business Expense and Other Operating Expense; Increased Salaries & Wages and Fringe Benefits
Westlake Hospital \ West Suburban Hospital	$1M	Move transcription to VHS process\rates	Reduced Business Expense and Other Operating Expense
Valley Baptist Health System	$6M	Insourced the full revenue cycle process	Reduced Business Expense and Other Operating Expense; Increased Salaries & Wages and Fringe Benefits
Valley Baptist Health System	$4M	GPO pricing improvement	Reduced Medical Supplies and Pharmaceuticals
Valley Baptist Health System	$6M	Insourced the IT services	Reduced Business Expense and Other Operating Expense; Increased Salaries & Wages and Fringe Benefits
Valley Baptist Health System	$2M	Renegotiated rates and maximized efficiencies for EVS & Dietary	Reduced Business Expense and Other Operating Expense

The Applicants anticipate leveraging Vanguard's past experience of capitalizing on cost savings by challenging the need to outsource services. Having access to best practices across all Vanguard hospitals will facilitate the insourcing of services without sacrificing the quality of the service provided. Cost savings that the Applicants expect the JV to experience in the first three years are set forth in response to question 39.

33. Reference is made to the IRS Form 990 Report submitted as Exhibit 18 to the CON Application and specifically the Schedule beginning on page 896. Please respond to the following questions with respect to the Hospital continuing to provide services to the uninsured and underinsured:

a. In FY 2011, the Hospital reported a total community health improvement services and community operations benefit cost of $12,823,398 for the programs and services described in the schedule that were provided to 30,230 persons. Please discuss

whether the proposed JV would anticipate incurring an equivalent annual expense (e.g., accounting for inflation, etc.) in support of these same programs and services in each of its first three years of operation of the Hospital. Include in the answer whether the JV would also anticipate serving an equivalent number of persons.

The JV anticipates the provision of total community health improvements to grow with the increasing volume of discharges, as illustrated in our projected financials. However, this cost of care will stay constant as a percentage of the total care provided by the JV. The JV is projecting $14.9 million, $15.4 million and $15.9 million of total community benefit costs for years 1 – 3 of the financial projections, respectively. The JV does not anticipate a material change in the acuity of the population served, therefore, the number of persons served will grow at a proportionate rate.

b. In FY 2011, the Hospital reported a cost of $936,076 in free care. Would the JV anticipate incurring an equivalent annual free care expense in each of its first three years of operation of the Hospital? Please provide an explanation for your answer.

As stated in Section 10 of the Contribution Agreement (and similarly described in Section 6 of the LOI), GWHN and its Affiliates will not be precluded from participating in activities that promote health care services for residents of the communities historically served by GWHN and its Affiliates through the Hospital, specifically operation of indigent or charity care clinics and services and other similar services or programs intended to better serve the health care needs of the community's indigent population. The JV assumes that it will maintain the same proportion of free care expense as a percentage of total care expense and that there will be no change in acuity of the patients served. Therefore, the total cost of free care provided is projected to increase throughout the projected years.

c. Please provide data on the expenses the Hospital incurred in FYs 2011 and 2012 in supporting the following departments, programs and/or services and discuss whether the JV anticipates making similar annual financial commitments in each of its first three years of operation of the Hospital:

1) Waterbury Health Access Program;
2) Waterbury Hospital Center for Behavioral Health;
3) Heart Center of Greater Waterbury;
4) Greater Waterbury Area Family Birthing Center;
5) Evergreen 50 Club; and
6) Waterbury Hospital ID Clinic.

The expenses related to the aforementioned programs or services are detailed in the following table:

Program/Service	FY2012 Cost	FY2011 Cost	FY2012 Grant	FY2011 Grant
Waterbury Health Access Program	$390,725	$410,557	$390,725	$410,557
Waterbury Hospital Center for Behavioral Health	10,577,221	10,356,148	2,137,134	2,136,312
Heart Center of Greater Waterbury	688,000	806,000	-	-
Greater Waterbury Area Family Birthing Center	4,021,251	3,995,529	-	-
Evergreen 50 Club	53,518	52,600	-	-
Waterbury Hospital ID Clinic	2,584,929	2,879,271	1,772,339	2,024,798

The JV intends to make similar expenditures to support these programs in each of the first three years of the operation of the Hospital, contingent upon the availability of the grants associated with these programs. Based upon diligence regarding these grants, there is high level of certainty that the grants will be available to the JV or to Waterbury Foundation. As such, these costs were included in Financial Attachments 1(A) through 1(C) originally submitted in the Application.

34. Please identify the GWHN leaders that are referred to at page 852 of the Application as occupying interim positions and advise on whether the Applicants are planning for these leaders to assume permanent positions with the JV post-closing.

The above referenced page is from Vanguard's initial response to the GWHN CIM. At this time, there are no GWHN leaders occupying interim positions. The JV is committed to a local leadership team and will use all of its resources to recruit and retain highly qualified executives.

35. Please explain the bases and underlying assumptions connected with projected changes from FY 2012 to FY 2014 in the Hospital's inpatient and outpatient population mix for Medicare, Medicaid, Champus, Commercial, Uninsured and Workers Compensation patients as depicted at pages 67 and 68 of the Application.

The inpatient payor mix table on page 67 of the Application incorrectly stated projected payor mix for FYs 2014-2016 based on gross patient revenue while FY 2012 reflected payor mix based on encounters. The corrected table, based on inpatient encounters, is appended below. Please note that FY 2012 has been restated to remove normal newborns. FY2014 is based upon the Hospital's actual experience during the first 5 months of FY2013.

INPATIENT POPULATION EXCLUDING NORMAL NEWBORNS

PAYOR	FY 2012	FY 2014	FY 2015	FY2016
Medicare	51.0%	51.7%	51.7%	51.7%
Medicaid	23.5%	24.1%	24.1%	24.1%
Champus	0.1%	0.1%	0.1%	0.1%
Total Government	**74.6%**	**75.9%**	**75.9%**	**75.9%**
Commercial	22.9%	21.9%	21.9%	21.9%
Uninsured	1.7%	1.4%	1.4%	1.4%
Workers Compensation	0.8%	0.9%	0.9%	0.9%
Total Non-Government	**25.4%**	**24.2%**	**24.2%**	**24.2%**
Total Payor Mix	**100%**	**100%**	**100%**	**100%**

The outpatient population mix table on page 68 of the Application is correct. FY 2014 is based upon FY2013 actual experience. Neither the inpatient table nor the outpatient table was used in any other aspect of the Application.

36. On pages 69 and 70 of the Application, provide the sources upon which the underlying revenue and expense assumptions are based for the projected amounts from FY 2014 to FY 2016 in the Financial Attachments 1A through 1C.

The assumptions originally presented in the Application are marked in *italics* and the sources upon which the assumptions are based are presented in normal font.

FINANCIAL ATTACHMENT 1A:

- *Inpatient Revenue*
  - *Inpatient volumes will decrease 2% each year regardless of payment source.*
    - The decrease in inpatient volume is related to the macro trend of shifting inpatient volume to the outpatient and/or ambulatory setting. Further, lower acuity patients that were traditionally admitted for 1-2 days are now being classified as observation cases, thereby reducing inpatient volume statistics.
  - *1% of non-government patients will shift to other Medical Assistance as a result of healthcare reform.*
    - To demonstrate the effect of the Affordable Care Act as it relates to the Hospital's financials, 1% of non-governmental patients will qualify to participate in the state facilitated insurance exchanges.
  - *Medicare rates are reduced 1.5% annually.*
    - The annual payment reduction reflects past experience as well as the effect of sequestration.
  - *Medicaid rates are reduced 1% annually and do not include the Governor's proposed budget.*
    - The annual payment reduction reflects past experience.
  - *Non-government rates are increased 3% annually.*

        - Based on preliminary discussions with managed care companies, the Hospital will receive 3% annual increases in payment rates from non-governmental payers.

- *Outpatient Revenue*
    - *Outpatient volumes will increase 2% each year regardless of payment source.*
        - As stated in response to the declining inpatient volume above, the Hospital expects to see a continuing shift of inpatient care to the outpatient setting. The admission of patients is expected to be scrutinized more so than the historical norm because of the higher cost structure of inpatient care versus outpatient care. This effort highlights the need to provide the most cost efficient, high quality care.
    - *Medicare rates are reduced 1.5% annually.*
        - The annual payment reduction reflects past experience as well as the effect of sequestration.
    - *Medicaid rates are reduced 1% annually and do not include the impact of the Governor's proposed budget.*
        - The annual payment reduction reflects past experience.
    - *Non-government rates are increased 3% annually.*
        - Based on preliminary discussions with managed care companies, the Hospital will receive 3% annual increases in payment rates.
    - *Bad Debt as a percent of Net Revenue is increased by 0.1% annually for both inpatient and outpatient cases.*
        - The Hospital recognizes the trend in the structure of insurance plans towards larger copays and deductibles. Because the patient responsibility will increase as this trend manifests itself, the Hospital expects an increased exposure to bad debt.
- *EXPENSES:*
    - *Salary and Fringe Benefits are increased 2% annually.*
        - Salaries and Fringe Benefits are a function of both average hourly wage and FTE assumptions. This statement corresponds to merit based increases in the average hourly wage which is in line with historical experience. FTE assumptions are addressed in a subsequent response.
    - *Supplies and drug expense cost per occupied bed are increased 1% annually.*
        - Supplies and Drugs grow as volume changes by utilizing the supplies and drugs per adjusted occupied bed statistic. Pricing in the cost of supplies is addressed by utilizing a 1% annual pricing factor.
    - *Professional/Contracted Services are decreased by $1 million in FY2014 for transaction costs and then increased 1% annually.*
        - Included with the FY2012 audited financial statements are $1M of non-recurring expense related to the costs of this transaction as well as the contemplated transaction between LHP, St. Mary's, and Waterbury. These costs are deducted from the go forward run rate for Professional/Contracted Services. This expense line item is thereafter increased at 1% annually to reflect pricing increases.
    - *Other Operating Expense, Depreciation/Amortization and Interest are increased 1% annually.*

        - The increase in these expense line items is the result of pricing increases.
    - *FTEs are decreased to reflect the shift from inpatient services to outpatient services.*
        - As the Hospital expects to experience a continuing shift of patients from an inpatient setting to an outpatient setting, the Hospital anticipates recognizing the benefit of a premium staffing model of providing care in the outpatient/ambulatory setting. To project this expense line item, the Hospital held the Salaries and Fringe Benefits per adjusted occupied bed constant throughout the projected period. The savings are recognized as the adjusted occupied bed statistic decreases between FY2014 and FY2016.

FINANCIAL ATTACHMENT 1B:

- *REVENUE:*
    - *Applicants expect to experience a one-time decrease in revenue in the first year of the JV as it completes the Change of Ownership process with CMS.*
        - See response to question 38a.
    - *Government reimbursement included the April 1, 2013 2% Sequestration cut.*
        - Sequestration is addressed in the response to question 38a.
    - *Payor mix will remain consistent with that projected in OHCA Financial Attachment 1(A).*
        - The receipt of the CON and creation of the JV will not affect the payer mix that the Hospital / JV experiences. As such, the payer mix presented in Financial Attachment 1A is representative of the payer mix that the JV will serve.
    - *Volumes stabilize and show modest growth in FY2015 and FY2016 as physician recruitment and enhanced ambulatory strategy take effect.*
        - Minimal volume growth is expected in FY2014 of the JV because the focus for initial year of the JV will be transitioning and integrating onto the Vanguard platform. In the following years, the JV will begin to recognize the benefit of deploying strategic capital investments and implementing an ambulatory strategy, whereby physician recruitment efforts, in conjunction with the development of strategic ambulatory assets, will drive growth and profitability.
    - *Non-operating revenue is decreased year over year to reflect the phase out of Meaningful Use incentive payments by FY2016.*
        - The non-operating revenue expense line item will be addressed in question 38b. Regarding Meaningful Use incentive payments, these payments are included within the "Other Operating Expense" line item, as Vanguard views these payments as an offset the Meaningful Use IT expenses. The incentive payments decrease throughout the projection period per CMS guidelines.
- *EXPENSE:*
    - *Purchased services are reduced to reflect insourcing of certain functions.*
        - Due diligence findings indicated that insourcing dietary, transport, and EVS functions would be in the JV's best financial interest. The JV will

have access to best practices in these areas from other Vanguard facilities, thereby increasing the quality of services provided. The savings associated with canceling these outsourced service agreements and the incremental costs of replacing these services are recognized over the first 2 years of the project and amount to approximately $1M.

- *Depreciation/Amortization and Interest expenses are reduced to reflect the retirement of debt as a result of the JV terms.*
  - "Depreciation/amortization" is addressed in the response to question 38c. The "Interest Expense" represents the interest paid by the JV to Vanguard for funds that the JV borrows from Vanguard. If there is an inadequate amount of cash on the balance sheet to fund operations and capital requirements, Vanguard lends the JV funds to ensure a minimum cash balance is maintained.
- *Average hourly rate for salaries are increased 2% year over year for non-union employees and per the union contract for unionized employees.*
  - For the purposes of projecting salary expenses, Financial Attachment 1B assumes non-union employees will experience a 2% annual merit based pay increase, which is in line with historical experience at the Hospital. The wages of union employees are increased as indicated in the union contracts, which are 2% increases in FY2013 and FY2015.
- *Supplies increase 2% year over year in step with volume increases.*
  - "Supplies and Drugs" is a function of both volume and pricing assumptions. Volume assumptions are addressed above. The projections assume an annual increase in supplies per volume statistic of 2% which accounts the rising costs of supplies on a per unit basis.
- *Inflation is fixed at 2%.*
  - Fixed expenses that are not correlated to volume increase annually at 2%, which is in line the CPI for Services less Energy for 12 months ending April 2013.
- *Overall benefit and insurance expenses are reduced as a result of savings associated with moving to Vanguard plans.*
  - These savings are reflected in the response to question 39.

FINANCIAL ATTACHMENT 1C:

Financial Attachment 1C reflects the Joint Venture impact on the Hospital. Revenue and Expense assumptions in the "without CON" columns are consistent with the assumptions used in Financial Attachment 1(A) above. Revenue and Expenses assumptions in the "with CON" columns are consistent with those used in Financial Attachment 1(B)above.

37. Regarding Other Operating Revenue on page 958 of the Application, please respond to the following:

a. Explain why amounts decrease by approximately $5.0 M beginning in FY 2013.

The FY2012 Other Operating Revenue contained several non-recurring items not accounted for in the FY2013 Other Operating Revenue. Specifically, these items include

meaningful use proceeds ($3.4M), non-grant related net assets released from donor imposed restriction ($875K), and a reduction in directorship services provided by Alliance Medical Group ($989K). During FY2012, the Hospital recognized the benefit of these sources of revenue but has not included these items in the budgeted and projected financials, thereby causing the decrease of approximately $5.0M to Other Operating Revenue in FY2013.

b. Explain why the Hospital apparently reported part of the audited financial statement of other operating revenue amount in the non-operating revenue input section of Financial Attachment 1A thus lowering the gain from operations amount.

The FY2011 and FY2012 non-operating revenue line items include unrealized gains. Non-operating revenue for FY2013-FY2016 does not include unrealized gains or losses.

38. Please answer the following regarding Financial Attachment 1B on page 959 of the Application:

a. Why the change of ownership process with CMS will cause the Applicants to experience a decrease in revenue in the first year of the project?

The JV will be subject to Vanguard accounting and reimbursement policies. As such, the projected financials are normalized for one-time, non-recurring items and Vanguard's contractual package is applied to the Hospital's financials. Adjustments to the FY2012 revenue reduce revenue by approximately $15M. These adjustments include but are not limited to rural floor proceeds, policies related to readmission and value based purchasing, the effect of sequestration, and the impact of the state budget.

b. Is the negative $4.8 million indicated for non-operating income a loss or just amounts the Hospital will not be receiving in the future?

The non-operating revenue represents expenses to be incurred by the JV. Specifically, non-operating revenue consists of the management fee and pension maintenance costs.

c. Why does depreciation decrease to $5.4 million for FY 2014 in Financial Attachment 1B as compared to $9.2 million in depreciation expense for FY 2014 on Financial Attachment 1A?

The FY2014 depreciation expense is calculated with the assumption that Buildings and Improvements have 20 year useful lives and that Furniture and Equipment have 7 year useful lives. The JVs fixed assets are depreciated using the straight line depreciation method.

d. Why does other operating revenue increase almost 50% beginning in FY 2014 from the FY 2013 amounts on Financial Attachment 1A?

As discussed in the response to question 37a, the Financial Attachment 1A does not include meaningful use payments for FY2013-FY2016, causing the line item to decrease

dramatically as reflected on Financial Attachment 1A. On Financial Attachment 1B, other operating revenue is adjusted to include the revenue associated with insourcing dietary services. The combination of these two factors accounts for the disparity between Financial Attachment 1A and 1B.

e. Why does lease expense increase over 60% beginning in FY 2014 from the FY 2013 amount on Financial Attachment 1A?

The disparity between lease expense on Financial Attachment 1A and Financial Attachment 1B is due to the classification of expense line items. The lease expense on Financial Attachment 1A only includes the Hospital's lease expense. The lease expense on Financial Attachment 1B includes the Hospital's lease expense as well as the lease expense of each of the Hospital's affiliates.

f. Why do professional contracted services decrease from $47 million on Financial Attachment 1A to $36 Million beginning in FY 2014 on Financial Attachment 1B?

The disparity between professional/contracted services on Financial Attachment 1A and Financial Attachment 1B is related to the assumption that dietary, transport, and environmental services will be insourced under the "with CON scenario". As such, the total savings to this expense line item is $8.2M. These savings are offset by the increased Salaries and Fringe Benefits expense line discussed in the following response.

g. Why do salaries and fringe benefits increase from almost $160 million on Financial Attachment 1A to $166 million in FY 2014 and over $172 million in FY2016 as indicted on Financial Attachment 1B?

Under the "with CON scenario", dietary, transport, and environmental services will be insourced, salaries of employees providing these services are incremental, thereby creating a disparity between Financial Attachment 1A and 1B. The magnitude of the incremental savings associated with Salaries and Fringe Benefits is $4.8M.

39. Throughout the CON Application and within the Financial Attachment 1B assumptions, the Applicants state that "[o]verall benefit and insurance expenses are reduced as a result of saving associated with moving to Vanguard plans." Please file the following tables demonstrating projected cost savings (reductions in expenses) for the Hospital for FY 2014-2016 if the CON is approved. These categories are consistent with the current OHCA HRS Report 175.

Table 1: Waterbury Hospital Cost Savings

Cost Savings	FY 2014	FY 2015	FY 2016
Salaries & Wages	($739,432)	($1,283,486)	($1,165,400)
Fringe Benefits	2,464,388	2,301,172	2,336,598
Contractual Labor Fees	-	-	-
Medical Supplies and Pharmaceutical	(2,483,439)	(3,690,668)	(3,690,668)
Depreciation and Amortization	-	-	-
Bad Debts	-	-	-
Interest Expense	1,517,668	1,432,219	911,135
Malpractice Expense	4,300,000	4,300,000	4,300,000
Utilities	-	-	-
Business Expense & Other Operating Expense	4,113,010	8,226,019	8,226,019
Total Cost Savings	$9,172,196	$11,285,257	$10,917,685

40. For Financial Attachments 1(A) through 1(C) on pages 958 to 960 provide all missing profit margins and debt principle payments or explain why they cannot be provided.

Please see revised Financial Attachments 1A, 1B, 1C, and 1C-revised (**Exhibit 15**), which include all profit margins and principal payments.

41. Please provide the following:

a. A revised Financial Attachment 1C that will include a summary of revenue, expense and volume statistics, without the CON project, incremental to the CON project, and with the project* for the Hospital only that does not include consolidated numbers for both the Hospital and its affiliates.

Please see Financial Attachment 1C – Revised, **Exhibit 15**.

b. The assumptions utilized in developing the Financial Attachment.

The assumptions provided in response to question 35 of the Application are applicable to Financial Attachment 1C – Revised.

c. The sources upon which the revenues and volume projection assumptions are based.

The response to question 36 above provides the details upon which the assumptions were made.

d. Related profit margins and debt principal payments.
***Note that the actual results for the fiscal year reported in the first column must agree with the Hospital's consolidating audited financial statements. The projections must include the first three full fiscal years of the project, FTE projections and utilization statistics by service.**

Please see Financial Attachment 1C – Revised, **Exhibit 15**.

42. The Joint Venture Organizational Chart post-closing on page 943 did not include the affiliates: Greater Waterbury Health Services, Inc., VNA Health at Home, Inc., Alliance Medical Group, Inc., Heart Center of Greater Waterbury, Inc., Waterbury Gastroenterology Co-Management, LLC, and Cardiology Associates of Greater Waterbury, LLC. Resubmit a Joint Venture Organizational Chart post-closing that will include the missing affiliates.

Pursuant to your request, please refer to the revised post-closing organizational chart for the Joint Venture at **Exhibit 16**, which includes all of the equity interests held by GWHN that are being acquired by the Joint Venture. VHS Waterbury Home Health, LLC is being formed to acquire the assets of VNA Health at Home, Inc., which is a wholly-owned subsidiary of GWHN. VHS Waterbury Real Estate Company, LLC is being formed to hold all real estate acquired in the transaction.

EXHIBIT 1: C.G.S §20-9

Sec. 20-9. Who may practice medicine or surgery. (a) No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he has obtained such a license as provided in section 20-10, and then only in the kind or branch of practice stated in such license.

(b) The provisions of this chapter shall not apply to:

(1) Dentists while practicing dentistry only;

(2) Any person in the employ of the United States government while acting in the scope of his employment;

(3) Any person who furnishes medical or surgical assistance in cases of sudden emergency;

(4) Any person residing out of this state who is employed to come into this state to render temporary assistance to or consult with any physician or surgeon who has been licensed in conformity with the provisions of this chapter;

(5) Any physician or surgeon residing out of this state who holds a current license in good standing in another state and who is employed to come into this state to treat, operate or prescribe for any injury, deformity, ailment or disease from which the person who employed such physician, or the person on behalf of whom such physician is employed, is suffering at the time when such nonresident physician or surgeon is so employed, provided such physician or surgeon may practice in this state without a Connecticut license for a period not to exceed thirty consecutive days;

(6) Any person rendering service as (A) an advanced practice registered nurse if such service is rendered in collaboration with a licensed physician, or (B) an advanced practice registered nurse maintaining classification from the American Association of Nurse Anesthetists if such service is under the direction of a licensed physician;

(7) Any nurse-midwife practicing nurse-midwifery in accordance with the provisions of chapter 377;

(8) Any podiatrist licensed in accordance with the provisions of chapter 375;

(9) Any Christian Science practitioner who does not use or prescribe in his practice any drugs, poisons, medicines, chemicals, nostrums or surgery;

(10) Any person licensed to practice any of the healing arts named in section 20-1, who does not use or prescribe in his practice any drugs, medicines, poisons, chemicals, nostrums or surgery;

(11) Any graduate of any school or institution giving instruction in the healing arts who has been issued a permit in accordance with subsection (a) of section 20-11a and who is serving as an intern, resident or medical officer candidate in a hospital;

(12) Any student participating in a clinical clerkship program who has the qualifications specified in subsection (b) of section 20-11a;

(13) Any person, otherwise qualified to practice medicine in this state except that he is a graduate of a medical school located outside of the United States or the Dominion of Canada which school is recognized by the American Medical Association or the World Health Organization, to whom the Connecticut Medical Examining Board, subject to such regulations as the Commissioner of Public Health, with advice and assistance from the board, prescribes, has issued a permit to serve as an intern or resident in a hospital in this state for the purpose of extending his education;

(14) Any person rendering service as a physician assistant licensed pursuant to section 20-12b, a registered nurse, a licensed practical nurse or a paramedic, as defined in subdivision (15) of section 19a-175, acting within the scope of regulations adopted pursuant to section 19a-179, if such service is rendered under the supervision, control and responsibility of a licensed physician;

(15) Any student enrolled in an accredited physician assistant program or paramedic program approved in accordance with regulations adopted pursuant to section 19a-179, who is performing such work as is incidental to his course of study;

(16) Any person who, on June 1, 1993, has worked continuously in this state since 1979 performing diagnostic radiology services and who, as of October 31, 1997, continued to render such services under the supervision, control and responsibility of a licensed physician solely within the setting where such person was employed on June 1, 1993;

(17) Any person practicing athletic training, as defined in section 20-65f;

(18) When deemed by the Connecticut Medical Examining Board to be in the public's interest, based on such considerations as academic attainments, specialty board certification and years of experience, to a foreign physician or surgeon whose professional activities shall be confined within the confines of a recognized medical school;

(19) Any technician engaging in tattooing in accordance with the provisions of section 19a-92a and any regulations adopted thereunder;

(20) Any person practicing perfusion, as defined in section 20-162aa; or

(21) Any foreign physician or surgeon (A) participating in supervised clinical training under the direct supervision and control of a physician or surgeon licensed in accordance with the provisions of this chapter, and (B) whose professional activities are confined to a licensed hospital that has a residency program accredited by the Accreditation Council for Graduate Medical Education or that is a primary affiliated teaching hospital of a medical school accredited by the Liaison Committee on Medical Education. Such hospital shall verify that the foreign physician or surgeon holds a current valid license in another country.

(c) This section shall not authorize anyone to practice optometry, as defined in chapter 380, or to practice dentistry, as defined in chapter 379, or dental hygiene, as defined in chapter 379a.

(d) The provisions of subsection (a) of this section shall apply to any individual whose practice of medicine includes any ongoing, regular or contractual arrangement whereby, regardless of residency in this or any other state, he provides, through electronic communications or interstate commerce, diagnostic or treatment services, including primary diagnosis of pathology specimens, slides or images, to any person located in this state. In the case of electronic transmissions of radiographic images, licensure shall be required for an out-of-state physician who provides, through an ongoing, regular or contractual arrangement, official written reports of diagnostic evaluations of such images to physicians or patients in this state. The provisions of subsection (a) of this section shall not apply to a nonresident physician who, while located outside this state, consults (A) on an irregular basis with a physician licensed by section 20-10 who is located in this state or (B) with a medical school within this state for educational or medical training purposes. Notwithstanding the provisions of this subsection, the provisions of subsection (a) of this section shall not apply to any individual who regularly provides the types of services described in this subsection pursuant to any agreement or arrangement with a short-term acute care general hospital, licensed by the Department of Public Health, provided such agreement or arrangement was entered into prior to February 1, 1996, and is in effect as of October 1, 1996.

(e) On and after October 1, 1999, any person licensed as an osteopathic physician or osteopath pursuant to chapter 371 shall be deemed licensed as a physician and surgeon pursuant to this chapter.

(1949 Rev., S. 4363; 1949, 1951, S. 2191d; 1959, P.A. 393, S. 1; 1971, P.A. 717; 1972, P.A. 80, S. 1; P.A. 75-39, S. 1; P.A. 77-519, S. 4, 6; 77-614, S. 349, 610; P.A. 84-546, S. 157, 173; P.A. 86-20; 86-403, S. 130, 132; P.A. 88-362, S. 1; P.A. 89-389, S. 4, 22; P.A. 90-211, S. 2, 23; P.A. 93-296, S. 7, 10; 93-381, S. 9, 39; P.A. 94-105, S. 2, 4; P.A. 95-98; 95-257, S. 12, 21, 58; P.A. 96-148; P.A. 97-311, S. 17; P.A. 98-43, S. 3; P.A. 98-166, S. 5, 9; June Sp. Sess. P.A. 98-1, S. 18, 121; P.A. 99-102, S. 2; 99-168, S. 5; P.A. 00-47, S. 2; 00-226, S. 11, 20; P.A. 03-252, S. 8; P.A. 05-280, S. 76, 77; P.A. 10-117, S. 61.)

History: 1959 act added exceptions from provisions of chapter re interns and hospital residents; 1971 act excepted trained assistants, registered or licensed practical nurses under supervision and control of licensed physician from provisions of chapter and added qualifying provision re optometry and dentistry; 1972 act rephrased exception re graduates of "foreign" medical schools to specify schools "located outside of the United States or the Dominion of Canada" and added exception re foreign physicians; P.A. 75-39 qualified exception re schools attended outside of U.S. or Canada by specifying applicability to schools "recognized by the American Medical Association or the World Health Organization"; P.A. 77-519 deleted proviso whereby exception for foreign physicians is inapplicable if physician declares intention of becoming U.S. citizen and deleted reference to failure to meet residence and citizenship requirements in exception for those attending recognized school outside of U.S. or Canada; P.A. 77-614 transferred regulation power from board to commissioner of health services, granting board an advisory role, effective January 1, 1979; P.A. 84-546 made technical changes to section substituting references to licensure for references to certification; P.A. 86-20 removed a three-year limitation on the exception for a foreign physician practicing in a medical school and added language requiring the Connecticut medical examining board to determine if an exception for a foreign physician is in the public interest; P.A. 86-403 changed effective date of P.A. 86-20 from October 1, 1986, to April 21, 1986; P.A. 88-362 limited the exception for students to persons participating in clinical clerkships and limited the graduate exception to persons who have been issued a permit; P.A. 89-389 added references to advanced practice registered nurses and to nurse-midwives; P.A. 90-211 added exemptions for "licensed" physician assistants and athletic trainers; P.A. 93-296 added provision exempting persons performing diagnostic radiology services from chapter provisions, effective June 29, 1993; P.A. 93-381 replaced commissioner of health services with commissioner of public health and addiction services, effective July 1, 1993; P.A. 94-105 designated provisions re prohibition on practicing without a license as Subsec. (a), exceptions to such prohibition as Subsec. (b) and provisions re authorization to practice optometry, dentistry or dental hygiene as Subsec. (c) and amended Subsec. (b) to insert Subdiv. indicators and add Subdiv. (19) re exception for technicians engaged in tattooing, effective May 23, 1994; P.A.

95-98 amended Subsec. (b) to specifically exclude paramedics from provisions of chapter; P.A. 95-257 replaced Commissioner and Department of Public Health and Addiction Services with Commissioner and Department of Public Health, effective July 1, 1995; P.A. 96-148 added Subsec. (d) concerning telemedicine; P.A. 97-311 amended reference to paramedics to reflect licensure under Sec. 20-206*ll*; P.A. 98-43 paragraphed the numbered Subdivs. in Subsec. (b), changed "1978" to "1979" and "continues" to "as of October 31, 1997, continued" in Subdiv. (16); P.A. 98-166 amended Subsec. (b)(11) to add medical officer candidates, effective June 4, 1998; June Sp. Sess. P.A. 98-1 made a technical change re a statutory reference in Subsec. (c), effective June 24, 1998; P.A. 99-102 added new Subsec. (e) re osteopathic physicians; P.A. 99-168 amended Subsec. (b)(6) by replacing "under the direction of" with "in collaboration with" and adding Subpara. (B) re advanced practice registered nurses under the direction of a physician if maintaining certain classification; P.A. 00-47 amended Subsec. (b)(14) by changing "licensed paramedic" to "paramedic, as defined in Sec. 19a-175(15), acting within the scope of regulations adopted pursuant to section 19a-179"; P.A. 00-226 amended Subsec. (b)(17) by changing "performing" to "practicing", deleting reference to Sec. 19a-16a and adding reference to Sec. 20-65f, effective the later of October 1, 2000, or the date notice is published by the Commissioner of Public Health in the Connecticut Law Journal indicating that the licensing of athletic trainers and physical therapist assistants is being implemented by the commissioner, i.e. April 11, 2006; P.A. 03-252 amended Subsec. (b)(5) to require out-of-state physician to be licensed in good standing and to allow such physician to practice without Connecticut license for period not to exceed 30 consecutive days; P.A. 05-280 added Subsec. (b)(20) re exception for persons practicing perfusion; P.A. 10-117 added Subsec. (b)(21) re exception for foreign physician or surgeon with current valid license in another country who is participating in supervised clinical training in a licensed hospital, effective June 8, 2010.

See Sec. 17b-407 re duty of physician or surgeon to report suspected abuse, neglect, exploitation or abandonment of the elderly.

See Sec. 19a-88 re annual renewal of licenses.

See Sec. 53-341 re penalty.

Cited. 130 C. 89; 207 C. 346.

Cited. 13 CS 463.

EXHIBIT 2: STATE OF CONNECTICUT ATTORNEY GENERAL OPINION DATED DECEMBER 3, 1954

STATE OF CONNECTICUT

PUBLIC DOCUMENT NO. 40

TWENTY-EIGHTH BIENNIAL REPORT

OF THE

ATTORNEY - GENERAL

FOR THE

Two Years Ended January 5, 1955

[1]GEORGE C. CONWAY
Attorney-General

[2]WILLIAM L. BEERS
Attorney-General

WILLIAM L. BEERS
Deputy Attorney-General

[3]MANSFIELD D. SPRAGUE
Deputy Attorney-General

THOMAS J. CONROY
JOSEPH A. HOFFENBERG
JACK RUBIN
RAYMOND J. CANNON
LOUIS WEINSTEIN
Assistant Attorneys-General

HARRY SILVERSTONE
Unemployment Compensation

DANIEL E. RYAN
Labor Relations

ERNEST H. HALSTEDT
Welfare Department

WALTER T. FAULKNER
Tax Department

[4]PETER B. SULLIVAN
Governor's Office
Departmental Assistant Attorneys-General

PAULINE MACFALL
Personal Secretary to Attorney General

the Town, in accordance with Section 510c of the 1953 Supplement to the General Statutes and are, therefore, entitled to be declared elected to the office of, and be sworn in as, Justice of the Peace.

Very truly yours,
WILLIAM L. BEERS,
Attorney General
By: JOSEPH A. HOFFENBERG,
Assistant Attorney General

HOSPITALS—MEDICINE

Non-profit charitable hospitals are not violating the provisions of the statutes concerning the legal practice of medicine or surgery when they employ full-time paid specialists who are licensed physicians to conduct necessary tests and perform services in the treatment of patients at the hospital.

The practice of medicine and surgery is restricted to individuals and does not include corporations. The corporations excluded from practice do not encompass non-profit charitable hospitals.

December 3, 1954

CONNECTICUT MEDICAL EXAMINING BOARD
160 ST. RONAN STREET
NEW HAVEN 11, CONNECTICUT

Attention: Creighton Barker, M. D., Secretary

Dear Dr. Barker:

This is in reply to your letter wherein you make the following inquiry:

"In those instances where hospital management employ physicians on full time salaries to render professional services, such as radiology, anesthesiology and pathology, and charge patients fees for the services of these employed physicians, the fees accruing to the benefit of the hospital, is it to be considered that these hospitals are engaged in the practice of medicine in a way that is in conflict with Connecticut law?"

As we understand your question, it is directed to the conduct of several of the general charitable hospitals in this state in employing licensed physicians at stated salaries and who devote their full time at the hospital. These physicians are experts in various fields of medicine; they use equipment and quarters furnished by the hospital and located in the hospital building for the purpose of conducting necessary tests, taking of x-rays and administering anesthesia for the benefit of patients in the hospital, those sent there by attending physicians, and emergency cases. The services are therefore limited to those persons who are actual or potential hospital patients and, generally as an aid to the attending physician or to the hospital staff of internes and resident physicians. For the services of these full-time paid physicians and the use of the testing preparations, material and equipment, a separate charge is made to the patient on the hospital bill without separate itemization which, when paid, is kept by the hospital as part of its general income.

The question is whether these hospitals are violating the statute (Sec. 1660c, 1953 Sup.) concerning the right to practice medicine or surgery, the material portion of which reads as follows:

"No person shall, for compensation, gain or reward, received or expected, diagnose, treat, operate for or prescribe for any injury, deformity, ailment or disease, actual or imaginary, of another person, nor practice surgery, until he shall have obtained such a certificate of registration as is in section 1661c provided, . . ."

Though not expressly stated in the statute, the implication is clear that the practice of medicine and surgery is restricted to individuals and does not include corporations (see 22 Op. Atty. Gen. 443; McMurdo vs. Getter, 298 Mass. 363, 10 N.E. 2d 139). However, the corporations excluded from practice, at least in this state, do not encompass non-profit charitable hospitals. The restriction is directed against the so-called commercial corporations which are run for profit. The obvious purpose of the licensing law is to protect the public from quacks and exploitation. These elements are not present in the service, care and treatment which a patient receives in a nonprofit, charitable hospital. (Group Health Assn. vs. Moor, 24 Fed. Sup. 445.)

The General Assembly has recognized the difference between a hospital and other corporations. Sec. 1545c, 1953 Sup., provides for the licensing of all hospitals, the material portion of which reads as follows:

"No person, firm or corporation shall operate a hospital for the care of the sick unless such person, firm or corporation shall have obtained a license therefor from the state department of health . . . For the purpose of this section, a hospital is defined as an institution for the lodging, care and treatment of persons suffering from disease or abnormal physical conditions."

Since a hospital, by the foregoing definition, is a place for the "treatment of persons suffering from disease or abnormal physical conditions," it is clear that the legislature has created an exemption to the prohibitions contained in Sec. 1660c in favor of duly licensed hospitals. The only way a hospital corporation could "treat" patients is through its personnel who are licensed physicians. It is significant that a hospital is organized for the purpose of treating patients. In hiring licensed physicians to treat patients it is rendering the service for which it is primarily organized. It has long been the accepted practice that internes and resident physicians treat patients in hospitals. Part of the hospital charge to the patient is for the services of such licensed personnel. No question has ever been raised that the hospital is practicing medicine illegally because it keeps the entire charge made for these services. No claim is being made that the various kinds of physicians involved in this controversy are not fully licensed and competent. The claim is that these individuals who unquestionably could act if they were not salaried employees of a hospital, are forbidden to act solely because they are on salary and the fee for their services is paid to the hospital rather than directly from patient to physician. We fail to see any distinction between this situation and the one involving the services of a resident physician who is on salary from the hospital, for whose services the hospital makes a charge in its general bill. (See Right of Corporation to Practice Medicine, 48 Y.L.J. 346).

In considering the right of a hospital to treat patients under similar statutory conditions as exist in this state it has been said:

"Thus a hospital duly incorporated under the membership corporations law unquestionably holds itself out as being able to diagnose, treat, operate, and prescribe for human disease, pain, injury, deformity, or physical condition; and such corporations do in fact offer and undertake publicly and frequently through the agency of advertisements to diagnose, treat, operate, and prescribe for such diseases. An institution of this character, possessing legislative authority to practice medicine by means of its staff of registered physicians and surgeons, comes under the direct sanction of the law in so doing, and by

the plainest implication, under well-settled rules of statutory construction relating to enactments dealing with the same general subject-matter, are excepted from the operation of the act of 1907 under which the defendant was convicted."

People v. Woodbury Dermatological Institute, 192 N.Y. 454, 85 N.E. 697.

See also Los Angeles County v. Ford, 121 Cal. App. 2d, 407, 263 Pac. 2d, 638; and Johnson v. Stumbo, 277 Ky. 301, 126 S.W. 2d, 165.

Our position is strengthened by the provision in the Dental Practice Act, Sec. 4444, to the effect that no corporation shall own or operate a dental office, but that "the provisions of this section shall not apply to hospitals." It would be anomalous to say that the legislature intended to exempt hospitals from the prohibition of corporate practice of dentistry and not of medicine. Furthermore, the legislature has recently allowed the formation of corporations to conduct medical clinics under certain safeguards (Sec. 1946c-1948c).

We are aware of the fact that there are Attorney General rulings in other states which hold contrary views than above expressed. A study of these opinions leads us to the conclusion that they are either based on different statutes than exist in this state or on a different factual situation. In any event, we are not bound by rulings affecting other states.

It is therefore our opinion that nonprofit, charitable hospitals are not violating the provisions of the statutes concerning the illegal practice of medicine or surgery when they employ full-time paid specialists, who are licensed physicians, to conduct necessary tests and perform services in the treatment of patients at the hospital.

Very truly yours,

WILLIAM L. BEERS,
Attorney General

By: LOUIS WEINSTEIN,
Assistant Attorney General

TEACHERS—RETIREMENT—BENEFICIARIES

In view of the fundamental rule that there should be no ambiguity or uncertainty in naming a beneficiary, members of the teachers retirement system should be advised to change the designation which appears to violate this rule while the member is still alive and able to do so.

December 7, 1954

STATE TEACHERS' RETIREMENT BOARD
STATE OFFICE BUILDING
HARTFORD, CONNECTICUT

Attention: Dorothy M. M. Shanley Lewis, Secretary

Dear Mrs. Lewis:

We have your letter of November 16, 1954, wherein you call our attention to three opinions from this office construing the beneficiary provisions of Sec. 1602, and request our advice as to the validity of eight different designations of beneficiary which do not comply with the instructions as to designation of beneficiaries attached to the beneficiary blank filed by the teacher in each case.

EXHIBIT 3: C.G.S. §33-182a et.seq., C.G.S. §34-119 et. seq.

Sec. 33-182a. Definitions. As used in this chapter:

(1) "Professional service" means any type of service to the public that requires that members of a profession rendering such service obtain a license or other legal authorization as a condition precedent to the rendition thereof, limited to the professional services rendered by dentists, natureopaths, chiropractors, physicians and surgeons, physician assistants, doctors of dentistry, physical therapists, occupational therapists, podiatrists, optometrists, nurses, nurse-midwives, veterinarians, pharmacists, architects, professional engineers, or jointly by architects and professional engineers, landscape architects, real estate brokers, insurance producers, certified public accountants and public accountants, land surveyors, psychologists, attorneys-at-law, licensed marital and family therapists, licensed professional counselors and licensed clinical social workers.

(2) "Professional corporation" means (A) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional service and which has as its shareholders only individuals who themselves are licensed or otherwise legally authorized to render the same professional service as the corporation, (B) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional services rendered by members of two or more of the following professions: Psychology, marital and family therapy, social work, nursing, professional counseling and psychiatry and that has as its shareholders only individuals who themselves are licensed or otherwise legally authorized to render one of the professional services for which the corporation was specifically incorporated, (C) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional services by physicians specializing in ophthalmology and optometrists and that has as its shareholders only individuals who themselves are licensed or otherwise legally authorized to render one of the professional services for which the corporation was specifically incorporated, (D) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional services by (i) physicians, and (ii) physician assistants or advanced practice registered nurses, or both, and that has as its shareholders only individuals who themselves are licensed or otherwise legally authorized to render one of the professional services for which the corporation was specifically incorporated, or (E) a corporation which is organized under this chapter for the sole and specific purpose of rendering professional services by physicians and chiropractors and that has as its shareholders only individuals who themselves are licensed or otherwise legally authorized to render one of the professional services for which the corporation was specifically incorporated.

(3) “Shareholder” means the holder of any shares of the capital stock of a professional corporation. The shareholders of a professional corporation may be designated as “members” in its certificate of incorporation, bylaws and other corporate documents and may be referred to, for all purposes, as “members”, whether or not so designated; and the term “shareholder” or “shareholders”, when used in the general statutes in reference to the shareholders of a professional corporation, shall include such “members”.

(1969, P.A. 332, S. 1; 775; 1971, P.A. 88; 182; P.A. 73-314; 73-470, S. 2; P.A. 77-140; P.A. 78-204, S. 1; P.A. 79-372; P.A. 81-472, S. 156, 159; P.A. 91-324, S. 5; P.A. 95-46; 95-173; P.A. 96-180, S. 106, 166; 96-254, S. 3, 10; P.A. 97-153, S. 1; P.A. 99-25, S. 1; 99-102, S. 42; P.A. 01-157, S. 1; P.A. 03-158, S. 1; P.A. 05-216, S. 1.)

History: 1971 acts included services of physical therapists, psychologists and podiatrists in definition of “professional service”; P.A. 73-314 included optometrists’ services in definition of “professional service”; P.A. 73-470 included services performed jointly by architects and professional engineers in definition of “professional service”; P.A. 77-140 included chiropractors’ services in definition of “professional service”; P.A. 78-204 added Subsec. (c) defining “shareholder”; P.A. 79-372 included services of osteopaths, occupational therapists, nurses and pharmacists in definition of “professional service”; P.A. 81-472 made technical changes; P.A. 91-324 amended the definition of “professional corporation” to delete the requirement that the shareholders be individuals licensed or authorized “within this state” to render the same professional service as the corporation; P.A. 95-46 included services of nurse-midwives in definition of “professional service”; P.A. 95-173 included services of certified marital and family therapists and certified independent social workers in definition of “professional service”; P.A. 96-180 amended definition of “professional service” to change “certified marital and family therapists” to “licensed marital and family therapists” and to change “certified independent social workers” to “licensed clinical social workers”, effective June 3, 1996; P.A. 96-254, like P.A. 96-180, redefined “professional service” to change “certified marital and family therapists” to “licensed marital and family therapists” and to change “certified independent social workers” to “licensed clinical social workers” and also amended definition of “professional corporation” by adding Subpara. (B) to include a corporation organized for the purpose of rendering professional services rendered by members of two or more of the professions of psychology, marital and family therapy, social work, nursing and psychiatry which has as its shareholders only individuals licensed or authorized to render one of such professional services, effective July 1, 1996; P.A. 97-153 redefined “professional corporation” in Subdiv. (2) to include corporations organized to provide professional services by ophthalmologists and optometrists; P.A. 99-25 redefined “professional service” to include licensed professional counselors and redefined “professional

corporation" to include professional counseling; P.A. 99-102 amended Subdiv. (1) by deleting obsolete reference to osteopathy and made a technical change; P.A. 01-157 redefined "professional service" to include real estate brokers and insurance producers; P.A. 03-158 added reference to physician assistants in Subdiv. (1), added Subpara. (D) re professional services by physicians, physician assistants and advanced practice registered nurses in Subdiv. (2) and made technical changes; P.A. 05-216 redefined "professional corporation" in Subdiv. (2) to insert new Subpara. (E) re corporations organized for purpose of rendering professional services by physicians and chiropractors.

Sec. 34-119. Restrictions on purposes and powers of limited liability companies. (a) A limited liability company may be formed under sections 34-100 to 34-242, inclusive, for the transaction of any business or the promotion of any purpose which may be lawfully carried on by a limited liability company except that of a state bank and trust company, savings bank, industrial bank or building and loan association.

(b) Except as otherwise provided in this subsection, a limited liability company may be formed to render professional services provided: (1) Each member of the limited liability company must be licensed or otherwise authorized by law in this state or any other jurisdiction to render such professional services; (2) the limited liability company will render only one specific type of professional services and services ancillary to them and may not engage in any business other than the rendering of professional services for which it was formed to render and services ancillary to them; and (3) the limited liability company may render its professional services in this state only through its members, managers, employees and agents who are licensed or otherwise legally authorized to render such professional services within this state. A limited liability company that will render professional services by licensed or certified alcohol and drug counselors may only be formed pursuant to subdivision (2) of subsection (c) of this section.

(c) A limited liability company may be formed to render professional services rendered by members of two or more of the following professions: (1) Psychology, marital and family therapy, social work, nursing and psychiatry; (2) medicine and surgery, occupational therapy, social work and alcohol and drug counseling; and (3) medicine and surgery and chiropractic; provided (A) each member of the limited liability company must be licensed or otherwise authorized by law in this state or any other jurisdiction to render any of the types of professional services specified in subdivision (1), (2) or (3) of this subsection, (B) the limited liability company will render only the types of professional services specified in subdivision (1), (2) or (3) of this subsection and services ancillary to them and may not engage in any business other than the rendering of professional services for which it was formed to render and services ancillary to them, and (C) the limited liability company may render its professional services in this state only through its members, managers, employees and agents who are licensed or otherwise legally authorized to render any of the types of professional services specified in subdivision (1), (2) or (3) of this subsection within this state.

(d) No limited liability company formed under sections 34-100 to 34-242, inclusive, shall have power to transact in this state the business of a telegraph company, gas, electric, electric distribution or water company, or cemetery corporation, or of any

company, except a telephone company, requiring the right to take and condemn lands or to occupy the public highways of this state.

(e) No limited liability company may be formed under sections 34-100 to 34-242, inclusive, for the purpose of transacting the business of an insurance company or a surety or indemnity company, unless (1) it is an affiliate of an insurance company chartered by, incorporated, organized or constituted within or under the laws of this state; and (2) at the time of the filing of its articles of organization, there is also filed a certificate issued by the Insurance Commissioner pursuant to section 33-646 authorizing the formation of the limited liability company. No limited liability company formed under sections 34-100 to 34-242, inclusive, shall have power to transact in this state the business of any insurance company or a surety or indemnity company until it has procured a license from the Insurance Commissioner in accordance with the provisions of section 38a-41.

(f) Nothing in sections 34-100 to 34-242, inclusive, shall be construed to authorize a limited liability company formed under said sections to transact any business except in compliance with any laws of this state regulating or otherwise applying to the same. The provisions of sections 34-100 to 34-242, inclusive, shall govern all limited liability companies, except that where by law special provisions are made in the case of a designated class or classes of limited liability companies governing the limited liability company procedure thereof in any respect, limiting or extending the powers thereof, conditioning action upon the approval of any agency of the state or otherwise prescribing the conduct of such limited liability companies, such procedure, power, action or conduct shall be governed by such special provisions whether or not such limited liability companies are formed under said sections.

(g) Nothing in this section shall prohibit the formation of a limited liability company under sections 34-100 to 34-242, inclusive, for the transaction of any business or for the promotion of any purpose in any other state if not prohibited by the laws thereof.

(P.A. 93-267, S. 8; P.A. 94-217, S. 3, 40; P.A. 96-254, S. 6, 10; 96-271, S. 185, 254; P.A. 98-28, S. 111, 117; P.A. 04-175, S. 2; P.A. 05-216, S. 3.)

History: P.A. 94-217 amended Subsec. (e) to insert language inadvertently omitted re governing law, effective October 1, 1994, and applicable to limited liability companies formed on or after October 1, 1993; P.A. 96-254 made a technical change in Subsec. (b) and inserted new Subsec. (c) authorizing the formation of a limited liability company to render professional services rendered by members of two or more of the professions of psychology, marital and family therapy, social work, nursing and psychiatry and setting forth the conditions for such formation, relettering the

remaining Subsecs. accordingly, effective July 1, 1996; P.A. 96-271 amended Subsec. (d) to replace reference to Sec. 33-286a with Sec. 33-646, effective January 1, 1997; P.A. 98-28 amended Subsec. (d) by adding electric distribution companies, effective July 1, 1998; P.A. 04-175 amended Subsecs. (b) and (c) by adding provisions re formation of limited liability companies to render professional services by licensed or certified alcohol and drug counselors and making conforming changes; P.A. 05-216 amended Subsec. (c) to add and reference Subdiv. (3) re services rendered by members of the medicine, surgery and chiropractic professions.

EXHIBIT 4: C.G.S. §33-182aa

Sec. 33-182aa. Definitions. As used in this chapter:

(1) "Certificate of incorporation" means a certificate of incorporation, as defined in section 33-1002, or any predecessor statute thereto;

(2) "Hospital" means a nonstock corporation organized under chapter 602, or any predecessor statute thereto, or by special act and licensed as a hospital pursuant to chapter 368v;

(3) "Health system" means a nonstock corporation organized under chapter 602, or any predecessor statute thereto, consisting of a parent corporation of one or more hospitals licensed pursuant to chapter 368v, and affiliated through governance, membership or some other means;

(4) "Medical school" means a school of allopathic medicine leading to the M.D. degree, accredited by the Liaison Committee on Medical Education, and affiliated through governance with or part of a university that is either incorporated in this state or established pursuant to any provision of the general statutes and accredited by the New England Association of Schools and Colleges Commission on Institutions of Higher Education; and

(5) "Provider" means a physician licensed under chapter 370, a chiropractor licensed under chapter 372, an optometrist licensed under chapter 380 or a podiatrist licensed under chapter 375.

(P.A. 09-212, S. 1; P.A. 10-117, S. 53; P.A. 11-151, S. 1.)

History: P.A. 09-212 effective July 1, 2009; P.A. 10-117 redefined "provider" in Subdiv. (4) to include licensed optometrist; P.A. 11-151 added new Subdiv. (4) defining "medical school" and redesignated existing Subdiv. (4) as Subdiv. (5).

EXHIBIT 5: BOARD OF TRUSTEE BYLAWS

BOARD OF TRUSTEES BYLAWS

THE WATERBURY HOSPITAL

Adopted _____, 2013

BOARD OF TRUSTEES BYLAWS

ARTICLE I - DEFINITIONS

The following terms, when capitalized, shall have the meanings set forth in these Bylaws; when not capitalized they shall have the meanings generally accorded to them by a dictionary:

1. **"Allied Health Professional Staff"** or **"AHP Staff"** means the allied health professional staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

2. **"Board of Directors"** means the board of directors of the Company who are elected by its members.

3. **"Board of Trustees"** means the local board of trustees of The Waterbury Hospital serving as the governing body to the extent designated by the Board of Directors.

4. **"Bylaws"** means these Board of Trustees Bylaws.

5. **"Chief Executive Officer"** or **"CEO"** means the administrator of the Hospital who is selected by the officers of the Company to be responsible for the day-to-day management of the Hospital.

6. **"Clinical Privileges"** or **"Privileges"** means the permission granted to a Practitioner by the Board of Trustees to render specific diagnostic, therapeutic, medical, dental, podiatric, surgical, or other professional services.

7. **"Company"** means VHS Waterbury Health System, LLC, organized in the State of Delaware, which owns and operates the Hospital.

8. **"Hospital"** means The Waterbury Hospital.

9. **"Medical Executive Committee"** means the medical executive committee of the Medical Staff.

10. **"Medical Staff"** or **"Staff"** means the medical staff of the Hospital, all of whom have been appointed pursuant to the Medical Staff Bylaws.

11. **"Medical Staff Bylaws"** means the bylaws adopted by the Board of Trustees governing appointment to, organization of, duties of, and operation of the Medical and AHP Staffs.

12. **"Practitioner"** means a licensed health care professional other than nurses, nursing assistants, technicians, and similar support personnel who are employees of (or employees leased to) the Hospital, and includes individuals eligible for appointment to either the Medical or AHP Staff.

13. **"Trustee"** means a member of the Board of Trustees.

The terms “he” and “him” are used in these Bylaws to designate both male and female for purposes of brevity.

ARTICLE II - GENERAL PROVISIONS

2.1 HOSPITAL MANAGEMENT

The Hospital is owned by the Company. The Company retains all authority and control over the business, policies, operations, and assets of the Hospital. The Company is managed by a Board of Directors that is elected by the members of the Company.

The Board of Trustees serves as the governing body of the Hospital to the extent that the Board of Directors has delegated authority to it. The rights and duties delegated to the Board of Trustees are described in these Bylaws. The Board of Trustees shall not have any authority over businesses of the Company other than the Hospital unless expressly set forth in these Bylaws and in the governance documents of such other businesses.

The Board of Directors has delegated to its officers, in accordance with the Company’s bylaws, the authority to select the CEO of the Hospital based upon his education and experience. The officers, in turn, have appointed the CEO to manage the day-to-day business affairs and administration of the Hospital. The CEO reports to the Board of Directors, while maintaining continuing communication with the Board of Trustees and Medical Staff.

The Board of Directors has appointed the Board of Trustees to assist and advise the CEO, the Board of Directors, and the Medical Staff. The primary function of the Board of Trustees is to assure that the Hospital and its Medical Staff provide quality medical care that meets the needs of the community. For this purpose, the Board of Directors has delegated to the Board of Trustees the authority to receive and evaluate periodic reports from the Medical Staff and its officers, to make decisions regarding Medical Staff appointment and Clinical Privileges, to oversee quality assessment and improvement, utilization review, risk management, and similar matters regarding the provision of quality patient care at the Hospital, and to establish polices regarding these matters.

The Board of Directors, through its officers and the CEO, retains authority for the Hospital’s business decisions, including long-range and short-range planning and budgeting, but may request the advice of the Board of Trustees on such matters. The Board of Directors expressly reserves the right to amend, modify, rescind, clarify or terminate at any time and without notice any delegation of authority given to the Board of Trustees and, if deemed necessary by the Board of Directors, to overrule decisions made by the Board of Trustees.

2.2 PURPOSES

The Hospital is an acute-care hospital providing health care services to the community. The primary purpose of the Hospital is to provide quality health care at the lowest possible cost consistent with the maintenance of high standards of care, the availability of resources, and the expectations of the Practitioners and the community served by the Hospital. In order to do so, the

Medical Staff, nursing staff, and the AHP Staff must cooperate with and be subject to the ultimate authority of the Board of Directors, and the cooperative efforts of the Medical Staff, the nursing staff, the AHP Staff, the Board of Trustees, the Board of Directors, and the CEO are necessary, subject, however, in all instances to the authority of the Board of Directors. These Bylaws have been adopted to facilitate these purposes.

2.3 CEO

The Board of Directors has delegated to the officers, who have in turn delegated to the CEO, broad authority and responsibility, including but not limited to the following:

(a) Carrying out the directives of the Company's officers and Board of Directors;

(b) Providing orientation for new Trustees and continuing education for all Trustees and reviewing their performance;

(c) Establishing and managing such non-Medical Staff departments of the Hospital as he deems necessary;

(d) Serving as the liaison among the Company's officers and Board of Directors, health care delivery organizations corporately and functionally related to the Hospital, the Board of Trustees, the Medical Staff, the AHP Staff and Hospital employees (or employees leased to the Hospital);

(e) Supporting the Hospital's quality assessment and improvement program;

(f) Negotiating, entering into, administering, modifying, and terminating such contracts (including contracts with Practitioners for the rendering of services at or to the Hospital) for the Hospital as he may deem necessary; and

(g) Performing or delegating the performance of all personnel, financial, strategic planning, and other management functions within the Hospital, except to the extent that such functions are explicitly and exclusively reserved to the Board of Trustees or to the Medical Staff pursuant to these Bylaws.

2.4 MEDICAL STAFF

The Medical Staff shall be established by and accountable to the Board of Trustees and shall operate as a part of the Hospital. Only the Medical Staff Bylaws, rules, and regulations as are recommended by the Medical Staff and adopted and approved by the Board of Trustees shall be effective.

Notwithstanding the foregoing, the Board of Trustees retains the right to recommend amendments to the Medical Staff Bylaws as necessary for the operation of the Hospital and as necessary for compliance with applicable laws, the requirements of The Joint Commission and other accrediting bodies, and the requirements of the Company. The Board of Trustees further

retains the right to rescind any authority delegated to the Medical or AHP Staff by the Medical Staff Bylaws or otherwise.

The Medical Staff Bylaws shall include a mechanism by which the Medical Executive Committee makes recommendations to the Board of Trustees regarding:

(a) The structure of the Medical Staff,

(b) The mechanism used to review credentials and to delineate individual Clinical Privileges,

(c) Individual Medical Staff or AHP Staff appointment and Clinical Privileges,

(d) The organization of the Medical Staff's quality assessment and improvement activities and the mechanism to conduct, evaluate, and revise such activities,

(e) The organization of the Medical Staff's (i) patient safety and (ii) identification and reduction of medical errors programs;

(f) The mechanism by which Clinical Privileges to the Medical Staff may be denied, modified or terminated, including a fair hearing procedure, and

(g) Selection of the Medical Staff department chairperson.

2.5 STAFF APPOINTMENT AND PRIVILEGES

In order for any licensed practitioner to practice in the Hospital, such individual must first be appointed to either the Medical Staff or the AHP Staff and be granted specific Clinical Privileges. Only those appointees to the Medical Staff who have been granted admitting privileges shall admit patients to the Hospital. If a patient is under the care of a Practitioner with a limited license, his general medical condition shall be the responsibility of a Practitioner who is appropriately licensed. The Board of Trustees shall appoint only those Practitioners meeting the qualifications prescribed in the Medical Staff Bylaws and other written or unwritten Hospital standards. The Medical Staff Bylaws shall set forth (a) the procedures by which, and criteria pursuant to which, appointments are made and Clinical Privileges granted or denied; (b) the procedures by which, and criteria pursuant to which, appointments and Clinical Privileges may be modified or terminated; (c) the duties and responsibilities of appointees to the Medical and AHP Staffs; and (d) the procedures and systems of governance of the Medical Staff.

2.6 AUXILIARIES

The Trustees may authorize the formation of auxiliary and associate organizations to assist in the fulfillment of the purposes of the Hospital. Each organization shall define its purpose and function, establish its bylaws, rules, and regulations, and make amendments to them, subject to Board of Trustees approval and consistent with these Bylaws. The CEO or designee shall approve individual volunteers providing services to or through any such organization.

ARTICLE III - TRUSTEES

3.1 QUALIFICATIONS

The Board of Directors shall establish the criteria for selection of Trustees, which shall include, but not be limited to:

(a) Willingness to give as much time as is reasonably requested;

(b) Availability to participate actively in Board of Trustees and committee activities, especially those activities where the Trustee has a special interest and expertise;

(c) Experience in organizational and community activities;

(d) Proficiency in the art of managing people and property; and

(e) Integrity, objectivity, and loyalty.

3.2 COMPOSITION

The Board of Trustees shall consist of at least five, but no more than 15, voting members. To the extent practicable, the Board of Trustees should include both appointees to the Medical Staff and a broad representation of lay persons from the community served by the Hospital. The CEO shall serve as a Trustee. Only in rare instances should the Medical Staff appointees to the Board of Trustees be officers of the Medical Staff or members of the Medical Executive Committee. Unless the Chief of Staff is selected to serve as a voting member of the Board of Trustees, the Chief of Staff shall be a nonvoting member of the Board of Trustees. If not a voting member, the Chief of Staff shall not be counted toward the number of Trustees for the purpose of the first sentence of this section.

3.3 SELECTION

Trustees, whether they will commence new terms or fill vacancies for the balance of a term, shall be appointed by the Board of Directors. The Board of Directors shall give strong consideration to the nominations made by a nominating committee composed of the existing chairperson of the Board of Trustees, the existing vice chairperson of the Board of Trustees, and the CEO, which committee shall be chaired by the CEO. All new Trustees shall participate in an orientation program, and all Trustees shall be provided with continuing education on matters pertinent to their duties.

3.4 TERM

Each Trustee shall serve for a term of three (3) years or until his successor is appointed, and the terms shall be staggered in order to provide continuity from year to year. Notwithstanding the foregoing, if staggered terms are needed, a Trustee may be appointed to serve a one, two or three

year term, as determined by the Board of Directors. A Trustee appointed to fill a vacancy shall serve the remainder of his predecessor's term.

3.5 REMOVAL

A Trustee may be removed at any time by the Board of Directors, with or without cause. A Trustee, other than the CEO, who has failed to attend two-thirds of the regular meetings of the Board of Trustees during the calendar year or two-thirds of the meetings of Board of Trustees committees of which he is a member, may also be removed by a two-thirds affirmative vote of the remaining Trustees. A Trustee may resign at any time by tendering his resignation in writing to the Board of Trustees. Resignation or removal as a Trustee shall also constitute resignation or removal as an officer of the Board of Trustees and as a member of any committee of the Board of Trustees.

3.6 CONFLICT OF INTEREST

Members of the Board of Trustees shall disclose to the CEO any and all potential conflicts of interest with the Hospital. Such disclosure shall include but not be limited to any control or ownership interest the Trustee may have in the Hospital, a vendor to the Hospital, or in any health care delivery organization that is competitive with or corporately and functionally related to the Hospital. If there is any doubt as to whether a conflict of interest exists, the CEO shall make the determination. Conflict situations may be present, for example, if an individual Trustee is a supplier of products or services to the Hospital or if the Trustee is a physician whose privileges are under review by the Hospital.

Each Trustee will sign a statement by which he agrees to be bound by the Hospital's policy on conflicts of interest. A Trustee shall absent himself from the discussion and abstain from voting on any issue in which such Trustee has an interest other than as a fiduciary of the Hospital. Nothing contained in these Bylaws shall prevent the remaining Trustees from voting on such matter, even if the absence of the Trustee having the conflict of interest causes there not to be a quorum.

The fact that a Trustee is also an appointee to the Medical Staff shall not by itself disqualify the Trustee from discussing or voting upon an issue presented to or by the Medical Staff; but the Trustee shall act in the best interest of the Hospital when acting as a Trustee and shall not act in the interest of the Medical Staff, any appointee to the Medical Staff, or himself.

3.7 COMPENSATION

Trustees shall receive no compensation for any services rendered in their capacities as Trustees or as officers or members of committees of the Board of Trustees.

3.8 DUTIES

The Board of Directors shall determine the duties and authority of the Board of Trustees from time to time. The current duties of the Board of Trustees are:

(a) Make final decisions, within a reasonable time as specified in the Medical Staff Bylaws, regarding Medical Staff appointments and reappointments, the granting or denial of Clinical Privileges, and the reduction, modification, suspension, or termination of Medical Staff appointments and Clinical Privileges pursuant to the provisions of the Medical Staff Bylaws, which provisions shall include a mechanism for the prompt resolution of differences between the Medical Executive Committee's recommendation and the Board of Trustee's proposed decision;

(b) Establish and revise standards for the quality of services to be made available at the Hospital and Hospital policies implementing such standards, which standards shall be uniformly applied to all patients, provided that all standards requiring capital expenditures shall be subject to Board of Directors' approval;

(c) Establish and revise standards for programs to (i) improve patient safety and (ii) identify and reduce medical errors at the Hospital, and establish and revise Hospital policies implementing such standards, which standards shall be uniformly applied to all patients, provided that all standards requiring capital expenditures shall be subject Board of Directors' approval;

(d) Review and advise the CEO regarding the Hospital's short-range and long-range plans and goals, including a three-year capital budget, in consultation with the Medical Staff, the nursing service, and others;

(e) Review and advise the CEO regarding the Hospital's plan for improving the organization's performance, describing an overall approach; assuring that the necessary processes and structures are in place; and that the planning and improvement process is collaborative;

(f) Encourage programs for continuing education for Medical and AHP Staff appointees and appropriate in-service education programs for Hospital employees (or employees leased to the Hospital);

(g) Maintain liaison with the appropriate corporate officer through the CEO by sending notice of all meetings with an agenda and subsequent minutes of actions taken, and being available for and consulting with the corporate officer;

(h) Confer with the appropriate corporate officer regarding the appointment and replacement of the CEO, Chief of the Medical Staff and Chief Nursing Officer;

(i) Require the Medical Staff to periodically review the Medical Staff Bylaws, rules and regulations, and policies governing the Medical and AHP Staffs;

(j) Approve the adoption, amendment, or repeal of Medical Staff Bylaws, rules and regulations, and policies governing the Medical and AHP Staffs;

(k) Review any communications or requests presented by the duly authorized representatives of the Medical Staff;

(l) Assure that the Medical Staff is represented by attendance and has the opportunity to comment at all Board of Trustee meetings, except such portions of the meeting where such attendance could waive a legal privilege, immunity, or confidentiality;

(m) Assure that all Medical and AHP Staff members practice within the scope of the Clinical Privileges delineated by the Board of Trustees;

(n) Require the development of a quality assurance program that includes a mechanism for review of the quality of patient care services provided by individuals who are not subject to the Clinical Privilege delineation process, reviewing and monitoring the quality assurance programs and the quality of patient care rendered at the Hospital on an ongoing basis, identifying and resolving problems, identifying opportunities to improve patient care, and assuring that the Medical Staff is provided with the administrative assistance necessary to conduct quality assessment and improvement functions and risk management functions related to patient care and safety (including the identification and reduction of medical errors) in accordance with applicable Hospital plans and policies;

(o) Require a process designed to assure that all individuals responsible for the assessment, treatment, or care of patients are competent in the following, as appropriate to the ages of the patients served: (i) the ability to obtain information and interpret information in terms of the patient's needs, (ii) a knowledge of human growth and development, and (iii) an understanding of the range of treatment needed by these patients;

(p) Require all Medical Staff and Hospital Departments to review policies and procedures at least once every three (3) years to assure that a collaboration between leaders has occurred in developing, reviewing and revising policies and procedures;

(q) Approve chairpersons for sections or departments of the Medical Staff as provided in the Medical Staff Bylaws;

(r) Subject to approval of the Board of Directors, adopt such Board of Trustee rules and regulations as may be necessary to further the purposes of these Bylaws, which rules and regulations shall become a part of these Bylaws;

(s) Periodically review and propose amendments to these bylaws;

(t) Evaluate the performance of the Board of Trustees and the CEO by completing questionnaires provided by the officers or Board of Directors of the Company; and

(u) Cooperate with the CEO to assure that the Hospital obtains and maintains accreditation by the applicable accrediting bodies, eligibility for participation in the Medicare, Medicaid, or other payment programs selected by the Hospital, and compliance with applicable municipal, county, state and federal laws.

3.9 INDEMNIFICATION

The Hospital shall indemnify any Indemnified Party (as defined) against actual and necessary expenses, costs, and liabilities (including settlements approved by the Company) incurred by him in connection with the defense of any pending or threatened action, suit, or proceeding to which he is made a party by reason of his acting or having acted in an official capacity on behalf of the Hospital. As used in these Bylaws, the term "Indemnified Party" shall mean a present or former Trustee or Medical or AHP Staff appointee or Hospital employee (or employee leased to the Hospital) acting in good faith on behalf of the Hospital through committee or other service, or any layperson who is or was a member of a body or committee formed and sanctioned by the Hospital, while acting within the scope of his duties on behalf of the Hospital. This indemnification shall not be exclusive of any other rights of indemnity to which the Indemnified Party may be entitled. Notwithstanding any other provision of these Bylaws to the contrary, no person shall be entitled to indemnity if the acts giving rise to the liability constituted misconduct, breach of fiduciary duty, self-dealing, and/or bad faith.

ARTICLE IV - OFFICERS

4.1 IDENTITY; SELECTION; TERM

The officers of the Board of Trustees shall be the chairperson, the vice chairperson, the secretary, and such other officers as the Board of Trustees shall deem advisable. The CEO shall be secretary of the Board of Trustees. The remaining officers shall be elected by the Board of Trustees from its members at its first regular meeting after being appointed. The officers shall hold office for a term of one year and until a successor is appointed.

4.2 REMOVAL

The Board of Trustees may remove an officer at any time with or without cause upon the affirmative vote of a majority of the Trustees excluding the officer. An officer may resign from office at any time by tendering his resignation in writing to the chairperson or vice chairperson of the Board of Trustees.

4.3 DUTIES

(a) Chairperson - The chairperson of the Board of Trustees shall preside at all meetings of the Board of Trustees. He shall appoint all committees and their chairpersons and shall be a member of all committees. He shall have such other duties and responsibilities as may be delegated by these Bylaws and by the Board of Directors from time to time.

(b) Vice Chairperson - In the absence of the chairperson of the Board of Trustees or in the event of that individual's inability or refusal to act, the vice chairperson shall perform the duties of the chairperson and in so doing shall have all the powers of the chairperson. The vice chairperson shall perform such other duties as may be assigned by the chairperson from time to time.

(c) Secretary - The secretary shall keep or cause to be kept the minutes of the meetings of the Board of Trustees, send out all notices of meetings, and perform such other duties as may be assigned by the chairperson of the Board of Trustees from time to time. The secretary shall forward copies of all minutes to the appropriate corporate officer.

ARTICLE V - COMMITTEES

5.1 ESTABLISHMENT

The chairperson of the Board of Trustees may appoint standing or special committees as he deems necessary and consistent with these Bylaws, and determine their membership, which may include members who are not Trustees. The chairperson shall include Trustees who are also Medical Staff appointees on any committee that deliberates upon issues affecting the discharge of Medical Staff responsibilities. In the event that Medical Staff representation on the Board of Trustees is inadequate to ensure communication between the Medical Staff and the Board of Trustees, the chairperson of the Board of Trustees shall appoint a standing joint conference committee composed of representatives from the Medical Staff and the Board of Trustees.

The chairperson shall include nurses as members of the Board of Trustees committees that deliberate issues affecting the discharge of the nursing staff's responsibilities

5.2 TERM

Each member of a committee shall serve on such committee until the next annual meeting of the Board of Trustees or until otherwise specified by the chairperson of the Board of Trustees.

5.3 MEETINGS

The provisions of Article VI of these Bylaws (governing meetings of the Board of Trustees) shall apply to all meetings of committees of the Board, unless the context clearly indicates otherwise, and references to "Board of Trustees" shall be deemed to include "committees of the Board of Trustees".

ARTICLE VI - MEETINGS

6.1 ANNUAL MEETINGS

The annual meeting of the Board of Trustees shall be held on the first _____ of _____ in each year at the Hospital or on such other day in each year acceptable to each of the Trustees. The purpose of the annual meeting shall be to elect officers and to transact such other business as may properly come before the meeting and shall not be limited to the matters set forth in the notice of the meeting.

6.2 REGULAR MEETINGS

Regular meetings of the Board of Trustees shall be held at least quarterly at the Hospital. Business to be transacted at any regular meeting of the Board of Trustees shall not be limited to the matters set forth in the notice of the meeting.

6.3 SPECIAL MEETINGS

Special meetings of the Board of Trustees may be called at any time by the chairperson of the Board of Trustees, the CEO, or any three or more Trustees. The business to be transacted at any special meeting of the Board of Trustees shall be limited to those items of business set forth in the notice of the meeting.

6.4 NOTICE AND PLACE

The Secretary of the Board of Trustees shall give each Trustee notice of each meeting of the Board of Trustees either personally, by telephone, or by mail to his residence or place of business as listed in the CEO's office. This notice shall be received not less than two days prior to the meeting. It shall set forth the time and place of the meeting and notice of the matters of business to be transacted. The meeting shall be held at the Hospital unless the CEO approves another location. Notice of any meeting of the Board of Trustees may be waived by the execution by all Trustees of a written waiver of such notice at any time, which writing shall be filed with or entered upon the records of the meeting, and attendance at any meeting without protesting the lack of notice prior to or at the commencement of the meeting shall be deemed to be a waiver by such Trustee of notice of the meeting. A majority of the Trustees present, whether or not a quorum exists, may adjourn any meeting of the Board of Trustees to another time and place. Notice of any such adjourned meeting shall be given to the Trustees who are not present at the time of adjournment and, unless the time and place of the adjourned meeting are announced at the time of adjournment, to all Trustees.

6.5 ATTENDANCE

Trustees shall attend as many Board of Trustees meetings as possible and shall attend the summation conference at the conclusion of each survey by the accrediting body. Each January the chairperson shall review the attendance records of all members for the prior year and shall

counsel each member whose unexcused absences exceed one-third of the regular meetings of the Board of Trustees.

6.6 QUORUM

A majority of the Trustees then in office shall constitute a quorum for the transaction of business. A Trustee shall be deemed to be present at a meeting if such Trustee participates in the meeting using a conference telephone, speaker telephone, or similar communications device by means of which all persons participating in the meeting can hear each other at the same time. After a quorum has been established at a meeting of the Board of Trustees, the subsequent withdrawal of Trustees from the meeting so as to reduce the number of Trustees present to fewer than the number required for a quorum shall not affect the validity of any action taken by the remaining Trustees at the meeting or any adjournment of the meeting.

6.7 VOTING

The act of a majority of the Trustees present and voting at a meeting at which a quorum is present shall be the act of the Board of Trustees.

6.8 ACTION WITHOUT A MEETING

Any action that may be taken at a meeting of the Board of Trustees may be taken without a meeting if consent in writing setting forth such action is signed by all of the Trustees and is filed in the minutes of the proceedings of the Board of Trustees.

6.9 MINUTES

A written record of all Board of Trustee proceedings, attendance, and actions shall be maintained by the Office of the CEO. A written record shall also be maintained of Trustee orientation and continuing education.

ARTICLE VII - AMENDMENTS TO BYLAWS

At least once annually the Board of Trustees shall review these Bylaws to determine whether they require amending. These Bylaws may be amended only by either of the following methods:

(a) By an affirmative vote of two-thirds of the members of the Board of Trustees, provided that a full presentation of such proposed amendments shall have been published in the notice calling the meeting, and provided the amendments are approved in writing by the Board of Directors;

Or

(b) In the event that the Board of Trustees fails to exercise its responsibility and authority, and after notice from the Board of Directors to such effect, including a reasonable period of time for response, by the Board of Directors.

ARTICLE VIII - ADOPTION AND EXECUTION

These Bylaws shall not be effective until they have been approved by the Board of Directors and by the Board of Trustees. The signatures set forth below signify that these Bylaws are the duly adopted Board of Trustees Bylaws of the Hospital.

APPROVED BY THE BOARD OF DIRECTORS ON _____, 2013.

_____
Secretary of the Company
(Acting at the direction of the Board of Directors)

APPROVED BY THE BOARD OF TRUSTEES ON _____, 2013.

_____
Secretary of the Board of Trustees
(Acting at the direction of the Board of Trustees)

TABLE OF CONTENTS

EXHIBIT 6: FAIRNESS EVALUATION EXPANSION LETTER

Principle Valuation, LLC
PEOPLE AND VALUES YOU CAN TRUST

May 30, 2013

Greater Waterbury Health Network, Inc.
64 Robbins Street
Waterbury, Connecticut 06708

Attention: Ms. Darlene Stromstad, FACHE

Re: Management Services Agreement – VHS Waterbury Management Company, LLC.

Ladies and Gentlemen:

We understand that in connection with your Transaction with Vanguard Health System that a Management Service Agreement will be entered into between the new operating company VHS Waterbury Health System, in which you will be a partial owner along with Vanguard Health System, and VHS Waterbury Management Company, LLC, a subsidiary of Vanguard Health System. Pursuant to requirements under the Connecticut General Statutes § 19a-486 et seq. ("Conversion Statute") a review of the Management Services Agreement is required to assess whether or not the Management Services Agreement is at Fair Market Value.

Fair Market Value for the purposes of this analysis is generally defined as rates that are commercially comparable to other rates found in the market place for similar contracts.

This letter serves as an expansion to our opinion provided to you on May 1, 2013 with regard to the Management Agreement.

In estimating our opinion we have reviewed specific management service agreements negotiated with hospital management companies at specific hospital facilities; we also interviewed Hospital Management executives at the publicly traded companies about the fees charged for management services; and reviewed financial statement data about charges for management service fees.

During our investigations we found that the management fee arrangements for joint venture transactions to be distinctly different than those arrangements found with independent healthcare management firms' such as Horizon, Quorum or Huron Consulting. These firms contract for specialty management services on a contractual basis to individual facilities generally for departmental healthcare services. These arrangements are often based upon a

fixed annual fee with incentive fees in some contracts. These contracts are for a fixed term with renewal options granted. The management firms in these transactions generally have no ownership stake in the business or assets they are managing. We found that these types of management service agreements to have little comparison to that of the subject property.

Our experience shows that often when a Hospital Ownership/Management group forms a joint venture arrangement with physicians or outside investors a Hospital Management Fee is charged to the joint venture. We have seen these fees vary by entity based upon a number of factors including; the size of the joint venture, the services offered at the corporate level to the joint venture, the profitable nature of the enterprise, the capital structure, etc.

In discussions with representatives that have entered into these type of arrangements; including executives and attorneys for Community Health Systems, Capella Healthcare, LHP Hospital Group, Triad Health Systems and Health Management Associates indicated that these management fee arrangements are primarily based upon on a percentage of net revenue collections that range from 2%-5% of net revenue collections. The executives indicated that if the fee was at the upper end of this range, the management fees were sometimes, but not always, subordinate to earnings or capital requirements.

A direct review of contracts with LHP Hospital Group, Community Health Systems, and Health Management Associates indicated net contractual terms of 2% - 5%. Also a review of these contracts listed varies similar terms and management responsibilities as detailed in the Draft Management Agreement provided to us for this review.

In the interest of maintaining client confidential information, we unfortunately cannot provide you with the detailed documents discussed above. But we can assure you that the conversations with these healthcare executives indicated a fairly tight range of parameters for this level of service in connection with the structure of joint venture management agreements.

Based upon these considerations; we believe that the proposed management agreement is at Fair Market Value.

Respectfully submitted,

Patrick J. Simers
Executive Vice President

EXHIBIT 7: SUPPLEMENTAL CAIN TRANSACTION ANALYSIS

WATERBURY HOSPITAL

Transaction Summary
Closing Cash Proceeds Funds Flow

- Below is an estimate of the net cash proceeds to GWHN at closing, before any NWC adjustment
- Some of the numbers may and will change between now and closing

Enterprise Value	$45,000,000
Less - Assumed Liabilities by Joint Venture [1]	13,397,902
Enterprise Value Less Assumed Liabilities	$31,602,098
Less - 20% GWHN Retained Equity Ownership	6,320,420
Cash Proceeds to GWHN Before Expenses & NWC Adjustment	$25,281,678
Less - GWHN Expenses:	
Estimated Advisor Fees	1,550,000
Estimated Medical Tail Insurance & Loss Portfolio Transfer Coverage	11,300,000
Contingencies	1,250,000
Net Cash Proceeds to GWHN Before NWC Adjustment [2]	$11,181,678

Note: Reflects September 30, 2012 GWHN trial balances excluding Cancer and Heart Centers
Actual consolidating balance sheet, closing balance sheet and adjustments may be substantially different
[1] Includes the Waterbury Hospital Cash Balance Retirement Plan, asbestos abatement and outstanding leases
[2] Normalized working capital benchmarked at $6.8 million per September 30, 2012 trial balances

WATERBURY HOSPITAL

Transaction Summary

GWHN Summary at Transaction Closing

- As part of the transaction, GWHN is retaining certain assets and liabilities
- Upon closing, GWHN will discharge a number of liabilities using unrestricted funds

	GWHN 9/30/2012	Assumed by Joint Venture	Retained by GWHN	Transaction's Effect on Retained GWHN Assets		GWHN Assets at Closing
				Inflows	Outflows	
Assets						
Unrestricted Cash	42,857,705	1,630,377	41,227,328	11,181,678	(29,139,210)[1]	**23,269,796**
Restricted Funds and Illiquid Assets	151,635,586	89,163,121	62,472,465	6,320,420	(191,056)[2]	68,601,829
Total Assets	194,493,291	90,793,498	103,699,793	17,502,098	(29,330,266)	91,871,625
Liabilities	92,424,461	46,646,468	45,777,993	0	(29,139,210)	16,638,783
Net Assets	102,068,830	44,147,030	57,921,800	17,502,098	(191,056)	**75,232,842**

Represents the closing funds flow's net effect on retained GWHN net assets after debt repayment upon closing

Note: Reflects September 30, 2012 GWHN trial balances excluding Cancer and Heart Centers
Actual consolidating balance sheet, closing balance sheet and adjustments may be substantially different, including the NWC adjustment
[1] GWHN will repay $29.1 million of debt related to the CHEFA Series D Bonds (with swap termination), AMG Notes Payable and Sodexo liability at closing
[2] GWHN will write down $191,056 worth of assets related to prepaid insurance and other expenses at closing

EXHIBIT 8: HALLORAN PROPOSAL AND TIMELINE

HOLLERAN
celebrating 20 years

Proposal Document for a
Community Health Needs Assessment

Waterbury, CT

Submitted by:
Holleran
September 11, 2012

TABLE OF CONTENTS

BACKGROUND

Waterbury Health Department, in collaboration with St. Mary's Hospital, Waterbury Hospital, the City of Waterbury, the StayWell Health Center, the Connecticut Community Foundation, the United Way, and other community partners, has requested that Holleran submit a proposal for the conduct of a Community Health Needs Assessment of Waterbury, CT and the surrounding towns.

Holleran, a national research and consulting firm headquartered in Lancaster, Pennsylvania, is celebrating 20 years of conducting stakeholder and community research and interpreting findings for clients.

Holleran was founded by owner Dr. Michele Holleran in 1992. President Lisa McCracken, who has been with Holleran for 12 years, leads a team of 75 staff including a Health & Human Services Team with more than 45 years of combined experience. The team includes hospital and public health industry professionals, research analysts, experienced project managers, and data collection specialists. With an in-house, bi-lingual Data Collection Center, all work is performed by Holleran in its Lancaster, Pennsylvania office.

A recognized leader in the health and human services and senior living fields, Holleran serves clients in 43 states and Canada. Our client partners include hospitals and health systems, public health entities, senior living providers, community partnerships, and other not-for-profit organizations. Holleran works with clients to conduct community and stakeholder research, provide organizational and leadership assessments, facilitate qualitative research, and integrate findings into community benefit activities and strategic planning. We specialize in conducting community health needs assessments (CHNA), interpreting data, and assisting clients plan to meet the unique needs of their communities.

Holleran works with a wide variety of community partners to conduct CHNAs. Our clients range from local health departments to state Departments of Health as well as single-site community hospitals and multi-hospital health systems. Lending our expertise and understanding

of individual and collective goals, Holleran encourages collaboration between public health agencies, hospitals, foundations, and community organizations.

Helping to lead the fields we serve, Holleran is a member of the Association for Community Health Improvement (ACHI), the National Association of County and City Health Officials (NACCHO), and LeadingAge. An expert in MAPP, Holleran has been a member of NACCHO's MAPP Workgroup since 2008, working to mobilize community partnerships around the conduct of CHNAs and health improvement planning. Additionally, Holleran is a technical advisor to the NACCHO Community Health Assessment/Community Health Improvement Planning (CHA/CHIP) project, funded by the Robert Wood Johnson Foundation.

Locally, Holleran staff is involved in the Pennsylvania State Health Improvement Plan through voluntary participation with the local committee, Lancaster Health Improvement Partnership (LHIP), serving as both the LHIP chair and Southeastern Pennsylvania delegate to the statewide SHIP from 2009 to 2011.

Holleran is highly familiar with both Public Health Accreditation Board (PHAB) standards and the CHNA requirement for not-for-profit hospitals as outlined in section 9007a of the Patient Protection and Affordable Care Act (PPACA). Holleran works with clients to outline research methodologies to meet compliance and accreditation standards, and regularly provides education about research methodologies and reporting requirements. Past education partners have included New Jersey Health & Senior Services, LeadingAge, VHA, the New England Society of Healthcare Strategy, the Ohio State Hospital Association Executives, the Hospital and Healthsystem Association of Pennsylvania, the Connecticut Hospital Association, and the Rhode Island Chapter of the Association of Community Hospital Executives.

Holleran's philosophy is that the value of a CHNA goes far beyond compliance. Beginning with valid research that portrays residents' health

status and barriers to optimal health, and culminating with a comprehensive plan for health improvement and measurement, a Holleran CHNA helps clients allocate resources effectively to meet the unique needs of the communities they serve.

Holleran's approach to conducting community health needs assessments is highly customized. Emphasis is placed on collaboration with clients to define process, customize interview instruments, and successfully integrate research into strategic planning, community benefit initiatives, and community health improvement activities.

The following pages outline Holleran's capabilities and pricing schedule for conducting a community health needs assessment of Waterbury, CT. Please consider this document as a starting point for future discussion. Thank you for the opportunity to submit this proposal.

Proposal respectfully submitted by:

Colleen Milligan, Health & Human Services Consultant
Holleran
3710 Hempland Rd., Suite 3
Mountville, PA 17554
cmilligan@holleranconsult.com
717-285-3394

Holleran is a proud member & supporter of:

OBJECTIVES

The objectives of the Community Health Needs Assessment are:

1. To gather statistically valid information of residents in Waterbury, CT and the surrounding communities.
2. To develop and finalize sampling strategies relevant to target populations.
3. To accurately represent all populations within the target area.
4. To develop accurate comparisons to the state and national baseline of health and quality of life measures to provide trending information for the future.
5. To interpret the meaning of the data collected so that needs are accurately depicted for area residents.
6. To integrate research findings into community benefit and strategic planning activities.
7. To conduct research in a fully confidential manner consistent with the Code of Standards and Ethics promulgated by the Council of American Survey Research Organizations (CASRO).

KICKOFF MEETING

Upon proposal acceptance, Holleran will conduct a kickoff meeting with key members of the Waterbury CHNA Steering Committee. The purpose of this meeting will be to clarify the research objectives, data collection requirements, appropriate sampling strategy, timetables, and report requirements of the project.

SECONDARY DATA ANALYSIS

Waterbury Health Department will oversee secondary data collection to depict Waterbury's demographics, health statistics, morbidity and mortality statistics, education and economic measures, and other socioeconomic measures. If State and National data is desired for benchmarking purposes, Waterbury Health Department will collect appropriate data.

Holleran will review the statistics for completeness and provide analysis of the data to include conclusions. If comparison data to state and national data are included, Holleran will include areas of strengths, opportunities, and differences compared to the benchmark.

STATISTICAL HOUSEHOLD SURVEY

As promoted by the Centers for Disease Control (CDC), Holleran offers a telephone survey methodology for the conduct of household surveys. Telephone surveys consistently yield higher response rates compared to other approaches, especially given the data collection experience of interviewers within Holleran's teleresearch center. An advantage of telephone interviews is the ability to address questions if the respondent is unclear as to what is being asked and to allow for the use of complicated skip patterns found within many household surveys. The ability for the

interviewer to clarify misunderstandings and answer questions also minimizes invalid response patterns.

Holleran will develop a statistically valid sampling strategy, paying particular attention to various sub-populations. Holleran recommends utilizing the CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey and Healthy People goals as a starting point for survey development. Holleran will work with the Waterbury CHNA Steering Committee to identify the questions for inclusion in the study. In an attempt to maximize participation and manage survey length, the instrument should not exceed 100 questions.

A telephone household survey will be conducted among randomly selected adult community members, with the goal of completing 1,100 interviews, which will yield a +/- 3% error rate respectively for the total universe at the 95% confidence level. It is important to note that, as data are broken down by sub-segments (i.e. zip code, county, race), the error rate increases.

Holleran operates its own internal teleresearch center and has the capacity to conduct interviews in both English and Spanish. Holleran has conducted numerous Hispanic/Latino-only studies and has extensive experience in this area.

It should be noted that while Holleran has had success with implementing a telephone data collection approach, at times, distributing written surveys or conducting face-to-face interviews in combination with telephone surveys may be ideal. This hybrid approach can be discussed further with the Waterbury CHNA Steering Committee, if requested.

Advanced Communication Plan

Based upon experience, Holleran strongly recommends that the client have a communication plan to the community regarding the purpose of the study. Informing community members in advance that their household may be randomly called to complete a survey will greatly affect the response rate. Holleran will provide the Waterbury CHNA Steering

Committee with a Communication Tool Kit to use in garnering community support of the survey. Suggested vehicles include:

- Print and electronic articles in news and organization publications
- Announcements on web and social media sites
- Public service announcements via local radio and/or television
- Flyers posted in local healthcare facilities such as clinics, hospitals, and physicians' offices

Deliverables

Upon completion of the data collection, Holleran will edit each survey for quality control and analyze the results using a variety of standard statistical tests. The deliverables will be:

1. A graphical summary report of the overall findings;
2. Comparisons between State, National, and HealthyPeople data, as applicable;
3. Five (5) hours of post-report analyses, cross tabulations, or additional breakdowns as requested.

Holleran will deliver an electronic version of the results from the household study. Also included within the scope of this discussion document is an on-site presentation. Typically, the final results are presented to a Steering Committee, executive management or a Board of Directors. Holleran is available to provide additional presentations to the community, as well as facilitate planning sessions, as requested.

FOCUS GROUPS

Holleran will facilitate five Focus Groups, focusing on issues of importance derived from the primary and secondary research. The purpose of the focus group research is to understand the "whys" behind health risk behaviors or research trends.

Focus groups will be conducted in four Waterbury neighborhoods and may be related to a specific health issue (e.g. women's health, diabetes, teen pregnancy) or to particular demographic groups (e.g. seniors, males, Latinos, etc.). A fifth focus group will be conducted with physicians.

The Waterbury CHNA Steering Committee will conduct recruitment for the groups, to ensure a representative sample of neighborhood residents and physician engagement. Holleran will develop the discussion guides (one for the neighborhood groups; one for physician group) and provide facilitation for the groups. Holleran recommends recruiting 12-15 individuals per group, assuming 10-12 will attend. Each group lasts approximately 90 minutes and a cash incentive (generally $50) is recommended in exchange for their time. Based on previous experience, physician recruitment will require addition effort through communication and location procurement. Often, a dinner meeting or coordinating meeting time with grand rounds or other regular meeting ensures success.

Holleran will prepare one aggregate narrative report of the findings depicting similarities and differences between neighborhoods as presented by Focus Group participants. A separate report will be provided for the Physician group. Participant quotes will be included in the report, although names will be withheld to protect confidentiality of participants.

KEY INFORMANT INTERVIEWS

Key informant interviews will be conducted via an online survey. It is recommended that the Waterbury CHNA Steering Committee implement a communication plan to notify potential respondents in advance and ask for their cooperation.

Potential respondents will be asked to complete an online survey. Holleran will oversee the programming of the survey and all data collection, ensuring confidentiality of the process. Attendees will be sent a link to the survey to complete. While there is not the same opportunity for in-depth

probing like the telephone interviews, there is the ability to include both closed-ended and open-ended items on the survey.

Holleran will provide a summary report of the findings, detailing numbers and ratings associated with the quantitative components of the report and will also summarize key themes from qualitative feedback provided.

FINAL CHNA REPORT

A full report of CHNA, including process, methods, participants, and results is compiled into an overall summary. The report is comprehensive in nature and pulls out the key themes across each research component. Data is synthesized to outline areas of strength and opportunity from the study and draw conclusions.

PRIORITIZATION AND ASSET MAPPING

This phase of the process is the first step between planning and action, and aligns with the IRS and PHAB requirements to prioritize needs, as well as asset-based community health improvement planning.

Holleran recommends that the Waterbury CHNA Steering Committee engage representatives from community organizations, specifically, public health experts, hospital and health care providers, and leaders that represent medically underserved, low income, minority populations, and/or populations with chronic disease needs. The Waterbury CHNA Steering Committee and its designees are led through a prioritization of community health needs, asset mapping of community resources, gaps analysis, and identification of special populations within the community. Holleran recommends a half day session, followed by a second half-day session (immediately following the original session or at a later date) with the Waterbury CHNA Steering Committee to review the findings and develop goal statements, strategies, and measurements to aid in community benefit and strategic planning activities.

IMPLEMENTATION PLAN

Holleran will work with Waterbury Hospital and St. Mary's Health System independently to create an Implementation Plan based on the goal statements, strategies, and measurements from the Prioritization and Asset Mapping Session. The strategy will reflect the requirements as outlined by the IRS in Section 9007 of ACA and the PHAB Standard 5.2.2L. Holleran will work in partnership with each hospital to outline its specific programs and resources to meet the identified community needs.

COMMUNITY HEALTH IMPROVEMENT PLAN

To aid in community-wide health improvement planning, Holleran will assist with the writing of a Community Health Improvement Plan. The content for this plan is driven by the prioritization and planning discussions from the Prioritization and Asset Mapping Session. Holleran will work to provide draft documents for review and adoption by the Waterbury CHNA Steering Committee. It should be noted that Holleran will supply the content in a professional, easy-to-read document depicting graphs from the research reports. Some client partners choose to engage a design firm to add additional graphical design components.

FINAL PRESENTATION

A full report of CHNA and the Implementation Strategy are delivered to hospital leadership, the board of directors, and/or the community at large, as requested by the client.

18-MONTH CHECK-IN

In an attempt to check-in on progress, Holleran will schedule a conference call (or onsite visit if requested) approximately a year and a half into the implementation phase. This is offered free of charge and is intended to prompt dialogue about potential roadblocks, thoughts on moving forward, evaluation mechanisms, etc.

PROPOSED FEES

A fee schedule for the proposed components are listed below.

Secondary Data Profile analysis ..... [redacted]

Statistical Household Telephone Survey:
1,100 surveys (+/-3% error rate/universe) ..... [redacted]
Includes data collection and one comprehensive report

Focus Groups
(four neighborhood groups, same topic guide/report)..... [redacted]
(one physician group, separate topic guide/report)..... [redacted]

Key Informant Interviews Base cost (online)..... [redacted]

Final CHNA Summary Report..... [redacted]

Prioritization & Goal Setting (One session) ..... [redacted]
Implementation Strategy (Two strategies; [redacted] per hospital) ..... [redacted]
Community Health Improvement Plan..... [redacted]

Final Onsite Presentation..... [redacted]

18-Month Check-In ..... [redacted]

Total ..... [redacted]

**Reflects [redacted] discount per Focus Group conducted on the same trip/same facilitator).*

OUT-OF-POCKET EXPENSES

Out-of-pocket expenses, such as household survey list procurement, travel, meals, incentives, meeting rooms, duplication, postage, and telephone expenses are not included and will be billed separately as incurred.

Out-of-pocket expenses are estimated as follows:

Anticipated Expense	**Estimated Amount**
Focus Group Incentives 60 participants	[redacted]
Household Survey Call List Procurement	[redacted]
Household Survey Telephone Expense	[redacted]
Travel (kickoff, focus groups, prioritization, final presentation)	[redacted]
Printing/Mailing	[redacted]
Total Estimated Expenses	[redacted]

Please Note:

1. Five (5) hours of household survey post-report analyses (after report is delivered) are included in the above price. Additional hours are charged at a rate of [redacted] per hour.
2. Proposed project fees are valid 90 days from submission date.
3. Proposed project fees are based on payment terms of net 30 days.

Greater Waterbury Community Health Improvement Partnership
Community Health Needs Assessment Overview
January 2, 2013

Background & Partners: On January 26, 2012, the Waterbury Department of Public Health, Saint Mary's and Waterbury Hospitals, StayWell Health Center, Northwestern CT Area Health Education Center, the Connecticut Community Foundation, Brass City Harvest, and the United Way of Greater Waterbury came together to form the *Greater Waterbury Health Improvement Partnership*, which serves as a steering committee for the Greater Waterbury Community Health Needs Assessment (CHNA). The Greater Waterbury Community Health Improvement Partnership has engaged Holleran, a research and consulting group located in Lancaster, PA, to facilitate the CHNA.

Purpose: To meet the hospitals' IRS 990 Schedule H requirements and the Waterbury Health Department's accreditation requirements.

Goals of CHNA:

- Identify community health needs and priorities within the Greater Waterbury Area.
- Provide a platform for collaboration between organizations to address sources of poor health outcomes and inequity.
- Provide a baseline measure of key health indicators and monitor trends in health status for Waterbury residents.
- Inform health policy and strategies for developing and implementing a comprehensive community health improvement plan.

Total Cost: [redacted] to Holleran: **Funding Partners:** Connecticut Community Foundation ($25,000), Saint Mary's Hospital ($10,000), Waterbury Health Department ($20,000, Waterbury Hospital ($10,000), and United Way of Greater Waterbury ($7,850); Staywell Health Center $2,000. [Plus $2,000 for Photo Voice Project]

Key Components:	**Timeline:**
Secondary Data Profile – Data collection to depict Waterbury's demographics, health statistics, morbidity and mortality statistics, education and economic measures, and other socioeconomic measures.	December 2012 – January 2013
Household Survey/BRFSS – 1,100 random telephone surveys of area residents; Holleran will use the CDC's Behavioral Risk Factor Surveillance System (BRFSS) survey along with some customized questions.	December 2012 – May 2013
Key Informant Surveys – Online survey targeted for area providers and key community stakeholders to gauge their perspective on health needs in the community.	December 2012 – March 2013
Focus Groups – Six focus groups will be conducted and will focus on key issues derived from the primary and secondary research. Four of the focus groups will target community members from the WOW, Hillside, Brooklyn, and South End neighborhoods in Waterbury (as identified by the Mayor's office); two focus groups will target area physicians (one group for Saint Mary's Hospital and one group for Waterbury Hospital). The WH physicians' focus group is currently scheduled for Friday, February 22, at 8:00 a.m.; it will engage up to 15 WH physicians.	January 2013 – March 2013
Final CHNA Report – Provides comprehensive outline of the process, methods, participants, and results.	June 2013 – July 2013
Implementation Planning – As required by the IRS, Holleran will work with Waterbury Hospital and Saint Mary's Hospital independently to create an Implementation Plan based on the goals, strategies, and measurements that are identified through a prioritization and asset mapping session. This information will drive the creation of a Community Health Improvement Plan (CHIP).	June 2013 – August 2013
Final Presentation – A final report of the CHNA and implementation strategies are delivered to hospital leadership, Board of Directors, and the community-at-large. *The CHIP must receive hospital Board approval by September 30, 2013 in order to meet the IRS requirements*.	September 2013

EXHIBIT 9: DUE DILIGENCE RESPONSE 4.2

Baptist Health System (Five facilities under 1 Provider Number)	San Antonio	TX	8/15/2011	Primary Stroke Certified Joint Replacement certified-Hip and Knee	Accredited American College of Surgeons- Commission on Cancer (ACoS-COC) 2012 Gold Get With The Guidelines - Heart Failure 2011 Silver Plus Get With The Guidelines - Stroke
Valley Baptist Harlingen	Harlingen	TX	10/17/2011	Primary Stroke Certified Joint Replacement certified-Hip and Knee	2011 Gold Plus Get With The Guidelines - Stroke 2009 Gold Get With The Guidelines - Heart Failure
Valley Baptist Brownsville	Brownsville	TX	3/13/2012	Primary Stroke Certified	2011 Gold Plus Get With The Guidelines - Stroke 2010 Gold Get With The Guidelines - Heart Failure
VHS of Phoenix, Inc	Phoenix	AZ	3/8/2011	Primary Stroke Certified	
Maryvale Hospital	Phoenix	AZ	5/3/2011	Primary Stroke Certified	
Arrowhead Hospital	Glendale	AZ	6/20/2011	Primary Stroke Certified	
Paradise Valley Hospital	Phoenix	AZ	9/26/2011		
Hospital of West Phoenix, Inc.	Goodyear	AZ	4/27/2010	Primary Stroke Certified	
Rehabilitation Hospital of Michigan (RIM)	Detroit	MI	5/24/2011		

Detroit Receiving Hospital	Detroit	MI	4/19/2011	Primary Stroke Certified	UHMS Clinical Hyperbaric Facility - Level 1 *** 2011 Top Performers on Key Quality Measures™ 2012 Gold Get With The Guidelines - Stroke 2009 Hospital Magnet Award
Harper/Hutzel	Detroit	MI	9/12/2011	Primary Stroke Certified Morbid Obesity Certified	Pathology and Clinical Laboratory - Accredited by American Society for Histocompatibility and Immunogenetics (ASHI)
Sinai-Grace	Detroit	MI	8/6/2011	Primary Stroke Certified	2009 Silver I - The Medal of Honor for Organ Donation
Children's Hospital	Detroit	MI	6/27/2011		2010 ACS National Surgical Quality Improvement Program Pediatric 2008 Hospital Magnet Award 2007 The Medal of Honor for Organ Donation 2006 The Medal of Honor for Organ Donation
Huron Valley	Commerce Twsp.	MI	6/7/2011	Primary Stroke Certified Joint Replacement certified-Hip and Knee	Joint Comission 2011 Top Performers on Key Quality Measures™
Weiss Memorial Hospital	Chicago	Il	2/14/2011		Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC) Joint Commission 2011 Top Performers on Key Quality Measures™

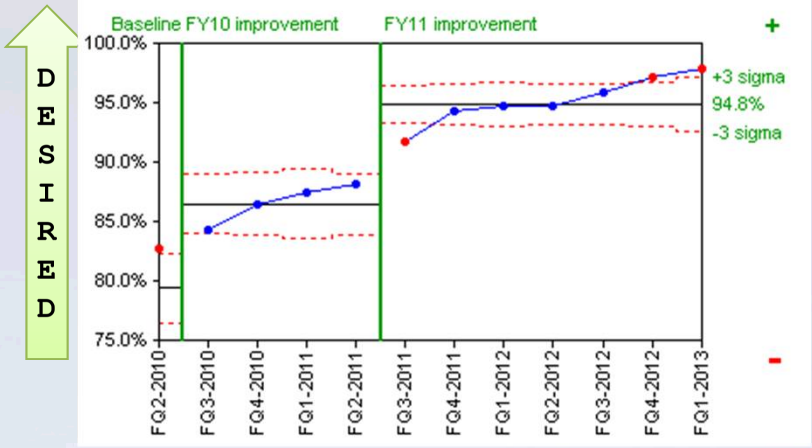
MacNeal	Berwyn	Il	4/12/2011 Hospital, Long Term Care, Home Health	Primary Stroke Certification	2012 Hospital Magnet Award 2011 Gold Plus Get With The Guidelines - Stroke Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC)
West Suburban Hospital	Oak Park	Il	*HFAP- Hospital Accredited Oct. 2010* *Will be accredited with TJC in 2013*	Primary Stroke Certification with TJC	
West Lake Hospital	Melrose Park	Il	*HFAP-Hospital Accredited Oct. 2010 Joint Commission Accredited forBehavioral Health (Methadone Detox program)*	Primary Stroke Certified with TJC	Westlake Hospital was honored with an "A" Hospital Safety ScoreSM by The Leapfrog Group
Metro West Hospital	Framingham	Mass	11/05/2012 Hospital, Home Health, Behavioral Health		2011 Gold Plus Get With The Guidelines - Stroke Accredited by American College of Surgeons-Commission on Cancer (ACoS-COC) 2010 ACS National Surgical Quality Improvement Program

				2010 ASMBS Bariatric Surgery Centers of Excellence®
St. Vincent Hospital	Worcester	Mass	9/11/2012	Accredited by American College of Surgeons-Commission on Cancer (ACoS- Joint Commission 2011 Top Performers on Key Quality Measures™ 2012 Gold Plus Get With The Guidelines - Stroke 2010 ACS National Surgical Quality Improvement Program 2006 The Medal of Honor for Organ Donation 2005 The Medal of Honor for Organ Donation

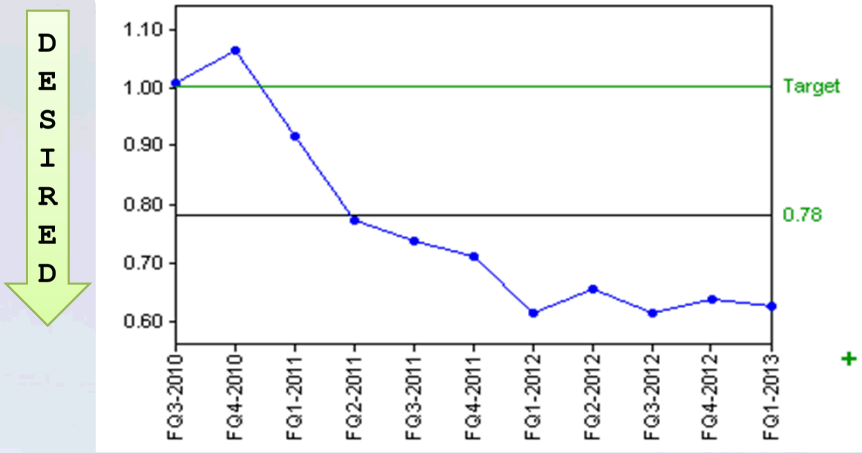
EXHIBIT 10: DUE DILIGENCE RESPONSES 9.1 AND 9.2

Quality Focused Leadership

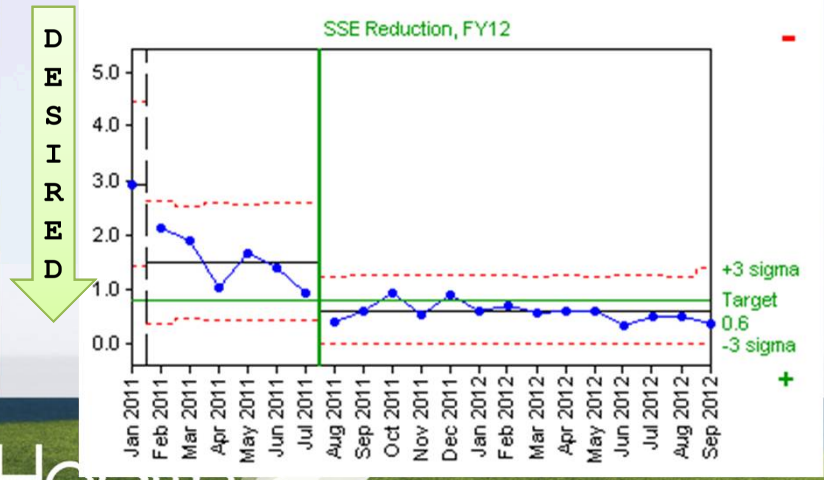
Core Measure All-or-None Bundle



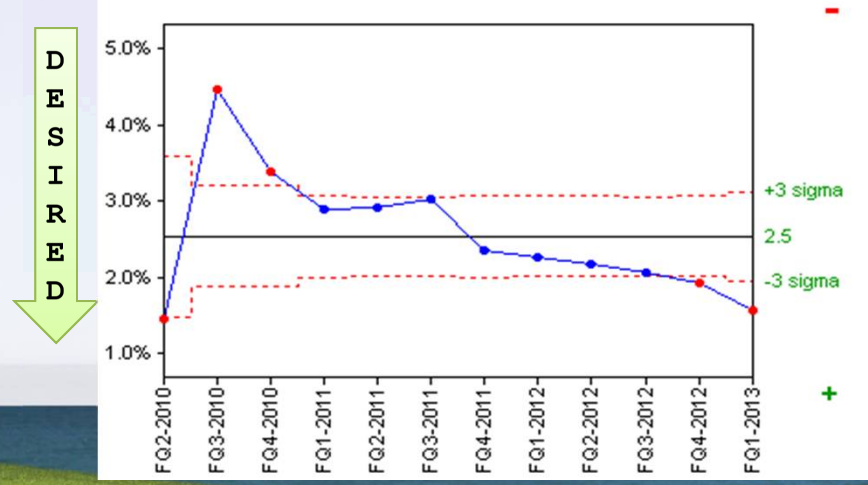
Severity Adjusted Hospital Mortality, Observed-to-Expected Ratio



Serious Safety Events (SSEs) per 10,000 Adjusted Patient Days



Hospital Acquired Pressure Ulcer Rate



Note: Valley Baptist not included in the above graphs.
DMC excluded from SSE graph because still in baseline period.

Health for Life

VANGUARD HEALTH SYSTEMS

001071

Hospital Inpatient Quality Reporting (IQR) Program Measures
for Vanguard Hospitals in response to request from Waterbury Hospital, Connecticut

Measure Code	Heart Attack (AMI) Inpatient Hospital Process of Care Measures	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
AMI-2	Heart Attack Patients Given Aspirin at Discharge	99%	99.00%	100.00%	100.00%	99.00%	100.00%	100.00%
AMI-8a	Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	94%			90.00%	100.00%	97.00%	97.00%
AMI-10	Heart Attack Patients Given a Prescription for a Statin at Discharge	98%	97.00%	100.00%	100.00%	100.00%	99.00%	99.00%

Measure Code	Heart Failure (HF) Inpatient Hospital Process of Care Measures	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
HF-1	Heart Failure Patients Given Discharge Instructions	93%	95.00%	98.00%	100.00%	96.00%	99.00%	98.00%
HF-2	Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function	99%	100.00%	100.00%	100.00%	100.00%	100.00%	100.00%
HF-3	Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	96%	99.00%	100.00%	100.00%	98.00%	100.00%	100.00%

Measure Code	Pneumonia (PN) Inpatient Hospital Process of Care Measures	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
PN-3b	Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics	97%	99.00%	100.00%	99.00%	100.00%	99.00%	99.00%
PN-6	Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)	95%	93.00%	100.00%	97.00%	100.00%	98.00%	95.00%

Measure Code	Surgical Care Improvement Project (SCIP) Inpatient Hospital Process of Care Measures	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
SCIP-Inf-1	Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection	98%	99.00%	98.00%	99.00%	98.00%	98.00%	96.00%
SCIP-Inf-2	Surgery patients who were given the right kind of antibiotic to help prevent infection	98%	97.00%	97.00%	100.00%	97.00%	99.00%	99.00%
SCIP-Inf-3	Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)	97%	97.00%	92.00%	99.00%	99.00%	96.00%	99.00%
SCIP-Inf-4	Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery	96%	92.00%	85.00%	94.00%	100.00%		97.00%
SCIP-Inf-9	Surgery patients whose urinary catheters were removed on the first or second day after surgery.	95%	92.00%	89.00%	100.00%	97.00%	97.00%	98.00%
SCIP-Inf-10	Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100%	100.00%	100.00%	100.00%	100.00%	99.00%	99.00%
SCIP-CARD-2	Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery	96%	96.00%	97.00%	99.00%	97.00%	99.00%	100.00%
SCIP-VTE-2	Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery	97%	97.00%	94.00%	100.00%	99.00%	98.00%	100.00%

Measure Code	Mortality Measures (Medicare patients)	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	15.5%	15.10%	15.30%	16.30%	12.20%	14.90%	12.80%
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	11.6%	11.20%	11.90%	10.00%	8.60%	10.70%	10.30%
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	12.0%	11.10%	11.80%	13.10%	9.80%	11.10%	11.70%

Measure Code	Readmission Measures (Medicare patients)	Hospital Compare National Average (Discharges 7/1/2008 - 6/30/2011)	West Suburban	Westlake	MacNeal	Weiss	METROWEST	ST VINCENT
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	19.70%	19.60%	20.20%	20.50%	22.80%	23.80%	17.90%
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	24.70%	15.70%	16.10%	16.80%	18.90%	19.70%	14.90%
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	18.50%	18.40%	17.10%	18.30%	21.30%	20.80%	18.70%

Hospital Inpatient Quality Reporting (IQR) Program Measures
for Vanguard Hospitals in response to request from Waterbury Hospital, Connecticut

Measure Code	Heart Attack (AMI) Inpatient Hospital Process of Care Measures	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
AMI-2	Heart Attack Patients Given Aspirin at Discharge	99.00%	100.00%	100.00%	99.00%	100.00%	100.00%	99.00%
AMI-8a	Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	93.00%		100.00%	89.00%	91.00%	93.00%	100.00%
AMI-10	Heart Attack Patients Given a Prescription for a Statin at Discharge	99.00%	100.00%	98.00%	98.00%	98.00%	99.00%	100.00%

Measure Code	Heart Failure (HF) Inpatient Hospital Process of Care Measures	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
HF-1	Heart Failure Patients Given Discharge Instructions	97.00%	100.00%	93.00%	98.00%	99.00%	92.00%	98.00%
HF-2	Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function	100.00%	99.00%	100.00%	100.00%	100.00%	100.00%	99.00%
HF-3	Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	100.00%	100.00%	98.00%	95.00%	100.00%	99.00%	88.00%

Measure Code	Pneumonia (PN) Inpatient Hospital Process of Care Measures	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
PN-3b	Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics	97.00%	97.00%	99.00%	96.00%	98.00%	99.00%	94.00%
PN-6	Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)	99.00%	97.00%	98.00%	98.00%	97.00%	98.00%	94.00%

Measure Code	Surgical Care Improvement Project (SCIP) Inpatient Hospital Process of Care Measures	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
SCIP-Inf-1	Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection	99.00%	96.00%	98.00%	99.00%	99.00%	99.00%	100.00%
SCIP-Inf-2	Surgery patients who were given the right kind of antibiotic to help prevent infection	99.00%	96.00%	98.00%	98.00%	99.00%	99.00%	97.00%
SCIP-Inf-3	Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)	99.00%	100.00%	95.00%	97.00%	99.00%	98.00%	97.00%
SCIP-Inf-4	Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery	90.00%			93.00%	95.00%	93.00%	96.00%
SCIP-Inf-9	Surgery patients whose urinary catheters were removed on the first or second day after surgery.	98.00%	89.00%	89.00%	95.00%	99.00%	96.00%	94.00%
SCIP-Inf-10	Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100.00%	100.00%	99.00%	100.00%	100.00%	99.00%	100.00%
SCIP-CARD-2	Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery	98.00%	100.00%	96.00%	95.00%	99.00%	98.00%	99.00%
SCIP-VTE-2	Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery	99.00%	98.00%	96.00%	97.00%	97.00%	98.00%	89.00%

Measure Code	Mortality Measures (Medicare patients)	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	15.90%		17.20%	17.30%	17.10%	14.90%	15.40%
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	11.00%	11.00%	13.90%	12.40%	11.60%	9.60%	11.70%
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	12.40%	11.90%	13.90%	15.30%	12.20%	9.90%	11.10%

Measure Code	Readmission Measures (Medicare patients)	ARROWHEAD	MARYVALE	PARADISE VALLEY	PHOENIX BAPTIST / AZ Heart	WEST VALLEY	San Antonio MARKET	Brownsville
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	18.40%		18.00%	20.30%	21.50%	18.20%	19.70%
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	14.60%		14.10%	16.30%	17.30%	16.20%	16.40%
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	19.20%	18.20%	19.10%	18.40%	18.00%	16.40%	17.10%

Hospital Inpatient Quality Reporting (IQR) Program Measures
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Measure Code	Heart Attack (AMI) Inpatient Hospital Process of Care Measures	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
AMI-2	Heart Attack Patients Given Aspirin at Discharge	99.00%	100.00%	99.00%	99.00%	98.00%
AMI-8a	Heart Attack Patients Given PCI Within 90 Minutes Of Arrival	75.00%		100.00%	98.00%	90.00%
AMI-10	Heart Attack Patients Given a Prescription for a Statin at Discharge	93.00%	100.00%	99.00%	99.00%	95.00%

Measure Code	Heart Failure (HF) Inpatient Hospital Process of Care Measures	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
HF-1	Heart Failure Patients Given Discharge Instructions	100.00%	99.00%	95.00%	92.00%	91.00%
HF-2	Heart Failure Patients Given an Evaluation of Left Ventricular Systolic (LVS) Function	100.00%	100.00%	100.00%	100.00%	100.00%
HF-3	Heart Failure Patients Given ACE Inhibitor or ARB for Left Ventricular Systolic Dysfunction (LVSD)	98.00%	100.00%	99.00%	98.00%	95.00%

Measure Code	Pneumonia (PN) Inpatient Hospital Process of Care Measures	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
PN-3b	Pneumonia Patients Whose Initial Emergency Room Blood Culture Was Performed Prior To The Administration Of The First Hospital Dose Of Antibiotics	97.00%	98.00%	92.00%	99.00%	97.00%
PN-6	Pneumonia Patients Given the Most Appropriate Initial Antibiotic(s)	92.00%	100.00%	99.00%	93.00%	96.00%

Measure Code	Surgical Care Improvement Project (SCIP) Inpatient Hospital Process of Care Measures	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
SCIP-Inf-1	Surgery patients who were given an antibiotic at the right time (within one hour before surgery) to help prevent infection	98.00%	100.00%	100.00%	99.00%	100.00%
SCIP-Inf-2	Surgery patients who were given the right kind of antibiotic to help prevent infection	96.00%	100.00%	99.00%	100.00%	100.00%
SCIP-Inf-3	Surgery patients whose preventive antibiotics were stopped at the right time (within 24 hours after surgery)	96.00%	98.00%	97.00%	98.00%	98.00%
SCIP-Inf-4	Heart surgery patients whose blood sugar (blood glucose) is kept under good control in the days right after surgery	90.00%		93.00%		95.00%
SCIP-Inf-9	Surgery patients whose urinary catheters were removed on the first or second day after surgery.	97.00%	99.00%	94.00%	93.00%	96.00%
SCIP-Inf-10	Patients having surgery who were actively warmed in the operating room or whose body temperature was near normal by the end of surgery.	100.00%	100.00%	100.00%	100.00%	100.00%
SCIP-CARD-2	Surgery patients who were taking heart drugs called beta blockers before coming to the hospital, who were kept on the beta blockers during the period just before and after their surgery	98.00%	100.00%	100.00%	97.00%	100.00%
SCIP-VTE-2	Patients who got treatment at the right time (within 24 hours before or after their surgery) to help prevent blood clots after certain types of surgery	95.00%	97.00%	98.00%	98.00%	98.00%

Measure Code	Mortality Measures (Medicare patients)	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
MORT-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Mortality Rate	16.10%	13.70%	12.70%	13.50%	15.10%
MORT-30-HF	Heart Failure (HF) 30-Day Mortality Rate	12.30%	10.20%	7.20%	8.90%	9.40%
MORT-30-PN	Pneumonia (PN) 30-Day Mortality Rate	8.90%	10.00%	9.80%	9.10%	10.90%

Measure Code	Readmission Measures (Medicare patients)	Harlingen	Detroit Receiving	Harper/Hutzel	Huron Valley-Sinai	Sinai-Grace
READM-30-AMI	Acute Myocardial Infarction (AMI) 30-Day Readmission Rate	21.10%	20.90%	20.90%	18.60%	21.90%
READM-30-HF	Heart Failure (HF) 30-Day Readmission Rate	17.90%	17.20%	18.10%	15.50%	19.10%
READM-30-PN	Pneumonia (PN) 30-Day Readmission Rate	18.70%	18.00%	17.90%	19.10%	22.80%

EXHIBIT 11: DUE DILIGENCE RESPONSES 10.1, 10.3 AND 10.5

When we partner with a hospital or health system we consider it an honor and a privilege to be selected. We take great pride in becoming good corporate citizens in the communities in which we operate. We are proud of the work that our hospital partners do in our communities, because we believe that caring for the community means that we must extend beyond the walls of our hospitals. We consistently fulfill our responsibilities to these communities, not only by providing high-quality medical care, but also by committing resources year after year to fund a variety of programs and services that benefit the most vulnerable community members through education, prevention and support. Listed below are just a few of the ways we are making a difference in the communities we serve. We fully anticipate providing similar outreach, not only in the Waterbury community, but also throughout the state of Connecticut.

Massachusetts

In August of 2010, the Massachusetts Senate unanimously passed a bill mandating that training programs be established to educate about the consequences of head injuries and concussions in student athletes. In response to this need The Worcester Sharks Youth Hockey League mandated that all players be ImPACT tested. (ImPACT testing is the first, most-widely used, and most scientifically-validated computerized concussion evaluation system available. It includes a baseline test administered prior to a concussion, and a post-test that measures and assesses the severity of symptoms after a concussion.) As part of its partnership with the Worcester Sharks, Saint Vincent Hospital has provided 85 ImPact tests for the young people affiliated with the Sharks Youth Hockey League and their nutrition and exercise program known as FinzFit Kids.

Detroit, Michigan

The Detroit Medical Center community promise is one of caring, community and commitment. In addition to providing more than 5,279 health screenings and hosting 22 Health and Wellness Lectures last year alone, DMC also meets the needs of the diverse community it serves in a number of ways.

This past year, Vanguard and DMC transferred ownership of a nearby building to the Detroit Community Health Connection (DCHC), a federally qualified health clinic that provides affordable or free health care to a cross-section of patients, including the underserved. The building is estimated to be worth just over $1M.

Other ways that DMC is meeting the needs of the community is through its commitment to at-risk youth. The Pathway to Excellence Program is a partnership with Detroit Parent Network and a local fraternity. It is a mentorship and leadership development program designed to empower young men with the skills and knowledge needed to foster academic success, establish a support network, support the goal of graduation and improve personal achievement by influencing leadership through representing unity and a commitment to collective betterment of the community.

At Vanguard, we believe that we must be committed to the communities we serve. In addition to the taxes that we pay which support our communities, as can be seen above, we provide ongoing support through our employees' time and our monetary contributions to various community programs. We take great pride in our track record and always encourage prospective partners to speak with leaders in our communities about our commitments.

10.3 – Charity Care

Vanguard's Hospitals shall provide charity care (free care) or financial assistance to uninsured patients for their emergency, non-elective care who qualify for classification as Financially Indigent or Medically Indigent in accordance with the Charity Care Financial Assistance Process set forth below. Vanguard's Hospitals shall adopt a written policy in conformity with the policy and procedure set forth herein. Charity Care (100% discounts) shall be available for uninsured patients with incomes below 200% of the Federal Poverty Level (the "Financially Indigent"). 40% to 80% discounts shall be available for uninsured patients either (1) with income below 500% FPL or (2) with balances due for hospital services in excess of 50% of their annual income (the "Medically Indigent").

D. CLINICAL NUTRITION SERVICES

POLICY #

Section:	CLINICAL NUTRITION SERVICES	**Policy #D001** **Date Issued: 5/95** **Date Revised: 1/00**
Subject:	COMMITTEE CONCERNED WITH NUTRITION CARE	

POLICIES:

The _____committee is designated as the facility approved committee concerned with nutritional care. This multidisciplinary committee is designed to standardize and communicate nutrition care approaches and processes throughout the organization, and members include physicians, nurses, pharmacists, and clinical dietitians.

PROCEDURES:

The Clinical Nutrition Manager or designee utilizes the committee for:

- Annual review/approval of the Diet Manual
- Approval of the Guide to Clinical Nutrition Services
- Approval of clinical nutrition (and patient services) policies & procedures
- Development and approval of any nutrition component of standard multidisciplinary practice guidelines, critical pathways, or protocols of care
- Approval of nutrition practice guidelines
- Review and approval of the enteral and parenteral nutrition formularies
- Integration of Performance Improvement activities related to Nutrition Care.

Section: CLINICAL NUTRITION SERVICES	**Policy #D002** **Date Issued: 5/95** **Date Revised: 1/00**
Subject: FORMULARY DEVELOPMENT	

POLICY:

A formulary specifying enteral and parenteral products shall be developed and reviewed routinely to standardize patient nutritional care and control costs and inventory.

PROCEDURES:

- Determine categories of products for appropriate medical nutrition therapy.
- Obtain information regarding Morrison and facility contract prices.
- Evaluate products on the basis of cost, patient acceptability, when appropriate and therapeutic requirements.
- Present proposed formulary to committee concerned with nutrition care for approval.
- Develop and distribute formulary information to facility staff (i.e., formulary card, in-service education).

Section: CLINICAL NUTRITION SERVICES	**Policy #D003** **Date Issued: 5/95** **Date Revised: 3/11**
Subject: REVIEW AND APPROVAL OF DIET MANUAL	

POLICY:

The Morrison *Manual of Clinical Nutrition Management* is adapted to the facility and specifies the standards for ordering and serving regular and modified diets.

The diet manual is reviewed annually, revised as necessary, and as updates occur by a qualified dietitian are approved by the medical staff.

PROCEDURES:

Clinical Nutrition Manager/Designee

- ADAPTATION -- Adapt the diet manual to the facility as necessary to ensure that:
  - The diet manual includes all diets that may be ordered in the facility.
  - The diet manual serves as a guide to ordering diets and states correct ordering terminology.
  - A statement on nutritional adequacy accompanies each diet except for test diets and addresses whether or not the diet meets the Dietary Reference Intakes.
- APPROVAL
  - Obtain necessary signatures on the diet manual approval form and place in front of the diet manual
    OR
  - For diet manuals posted on the hospital intranet site, document approval in the _____ Committee minutes and keep on file in the medical administration office and Food & Nutrition Services.
- DISTRIBUTION
  - Manual must be accessible to each patient care unit.
  - Maintain a copy of the distribution form on file.

Section: CLINICAL NUTRITION SERVICES	**Policy #D004** **Date Issued: 5/95**
Subject: GUIDE TO CLINICAL NUTRITION SERVICES	**Date Revised: 10/07**

POLICIES:

The *Guide to Clinical Nutrition Services* describes the scope of patient services ranging from basic services to medical nutrition therapies.

PROCEDURES:

Clinical Nutrition Manager

- Adapt Guide to Clinical Nutrition Services to the facility.
- In-service and/or distribute to the medical staff, nursing and other health care professionals.

P&P CROSS REFERENCE: D – Initial Assessment
Further Assessment and MNT Intervention
Nutrition Practice Guidelines

GUIDE TO CLINICAL NUTRITION SERVICES

a description of the Scope of Patient Services

BASIC services are provided to all hospitalized patients, as appropriate
MEDICAL NUTRITION THERAPY (MNT), individualized treatment based on assessed needs, is provided by the RD/LD

	SERVICE/DESCRIPTION	PATIENTS RECEIVING SERVICE	PERFORMED BY	TIME FRAME FOR DELIVERY
B A S I C	**MEAL SERVICE/NOURISHMENTS** As ordered	All patients on oral intake	Designee	Next meal after diet order received or as requested
	MENU MANAGEMENT Menu distribution, assistance and collection	All patients on selective menus	Designee	Within 24 hours of admission
	INITIAL ASSESSMENT (Nutrition Screening)	All patients as per screening policy	Nursing/ Designee	Within 24 hours of admission
	FURTHER PRIORITIZATION	All patients	Designee RD/LD	Ongoing during hospitalization
	MONITORING of patients who are NPO or on clear liquid diets	All patients who are NPO or on a clear liquid diet	Designee RD/LD	Investigate NPO/CL by the 5th day
	INTAKE SUPPORT Appropriate foods, nourishment/ supplements to improve intake within confines of diet order	Per physician/nursing request or RD/LD recommendation	Designee RD/LD	Within 24 hours of need identification
M N T	**FURTHER ASSESSMENT AND INTERVENTION** Evaluation of pertinent subjective and objective data, formation of patient goals and implementation of plan of care	1. Per assessed needs 2. Per physician/RN consult 3. Per standard protocol	RD/LD	Per the Prioritization Table, Policy D006A – maximum 48 hours for acute care. Subacute Care: ___ (time) maximum Behavioral Health Care: ___(time) maximum
	REASSESSMENT AND FOLLOW-UP Assessment of patient progress; adjustment of plan of care; monitoring of expected outcomes	Reassessment is ongoing for all patients throughout hospitalization Follow up: as determined by RD/LD or with physician/RN consult	RD/LD	Reassessment: ongoing Follow up: Frequency determined by RD/LD
	INTAKE ANALYSIS (Calorie Count) Assessment of food intake (specified number of days)	1. As determined by RD/LD 2. Per physician consult	Designee RD/LD	Intake Analysis is initiated within 24 hours of assessed needs or consult. RD calculates intake RD within 48 hours of initiation of intake analysis
	NUTRITION COUNSELING • Individual- education plan to meet nutrition intervention goals for disease management * • Group- classroom presentation with question and answer period • Follow-up- assessment of patient progress and further education*	*Inpatient* 1. Per assessed needs 2. Per physician/RN consult *Outpatient* 1. Per hospital discharge plan 2. Per physician consult	RD/LD	*Inpatient* Within ___ hours of assessed needs or consult *Outpatient* By scheduled appointment or series of classes for outpatient

*For inpatients, survival skills; for outpatient, self-management training

(Policy #D004)

Section: CLINICAL NUTRITION SERVICES	**Policy #D005** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: MEDICAL NUTRITION THERAPIES – HOW TO ORDER	

POLICIES:

Medical Nutrition Therapies are ordered according to standard procedures.

Verbal and telephone orders for medical nutrition therapies are accepted and implemented when dictated to an approved designee (nurse/dietitian*), and are countersigned by the physician according to hospital policy. The content of verbal orders must be clearly communicated. Nationally accepted read-back verification practice is to be implemented for every verbal order (71 FR 68680). Verbal orders should be recorded directly onto an order sheet in the patient's medical record or entered into the computerized order entry system, if the hospital employs one. As required by §482.24(b), all verbal orders must be promptly documented in the patient's medical record and signed by the individual receiving the order.

PROCEDURES:

Physician

- Orders services using standard terminology outlined in the *Guide to Clinical Nutrition Services*.
- Orders Medical Nutrition Therapies, Nutrition Counseling

Nursing

- On receipt of a verbal/telephone order for medical nutrition therapies, records the order in the order section of the medical record or in the computerized order entry system, reads it back to the person placing the order and receives confirmation that it was accurately written.
- Transmits the order to the diet office or dietitian.
- Seeks/verifies the physician's signature according to facility verbal order procedures.

Dietitian

- Provides services ordered.
- If less than the required notice for nutrition counseling is given, provides educational literature as appropriate.

*Credentials of those authorized to accept verbal order are documented in by-laws.

P&P CROSS REFERENCE:
Facility Policies & Procedures: Physician's Orders
Patient and Family Education

Section: CLINICAL NUTRITION SERVICES	**Policy #D006** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: INITIAL ASSESSMENT AND PRIORITIZATION	

POLICY:

An initial assessment program is implemented to identify patients who may require medical nutrition therapy (ies)

PROCEDURES:

Initial Assessment

Nursing

- Gathers information from patients within 24 hours of admission based on pre-determined nutrition criteria and documents the initial assessment in the medical record or computerized order entry system. It is recommended that pre-determined nutrition criteria be validated. Criteria may include, but is not limited to:
  - Adults: unplanned weight loss; decreased appetite (See FYI page that follows) *
  - Pediatrics: BMI-for-age-and-gender less than the 5th percentile (ages 2 to 20 years); Weight-for-length less than the 5th percentile (birth to 36 months); decreased appetite; inability to feed/eat *
  - Obstetrics: Underweight (<90% of desirable pregravida weight for height); Inadequate weight gain during 2nd and 3rd trimesters (< 1 pound/month , if obese, < 2 pounds/month for others); decreased appetite; multiple fetuses *

Based on results of initial assessment, consults dietitian

Dietitian

- Acts on information/consults resulting from Nursing Admission Assessment within timeframes specified in D006A

Further Prioritization

Technician/ Dietitian

- Evaluates information from the following sources as it becomes available.
  - Nursing: Pressure ulcer reports; patient assigned to hospital protocols that include nutrition intervention (according to schedule specified in protocol)
  - Information Services: Diet orders and changes; TF orders; admission diagnosis
  - Pharmacy: New orders for TPN/PPN
  - Consults from physicians, nurses and other healthcare professionals
  - Multidisciplinary team conferences
  - Food & Nutrition Services: Meal rounds; number of days patient has been NPO/CL (See D009: NPO/CL Monitoring)
  - Laboratory: for example - glucose, albumin, pre-albumin
  - Technician/Dietitian: patients requiring nutrition education / survival skills training prior to discharge (See D011: Patient and Family Education)
- Further assesses patients identified through initial assessment. See D006A: Further Assessment and Nutrition Intervention.

* Include a copy of the pre-determined nutrition criteria

Director, Food and Nutrition Services _____

Nursing _____

FYI

Policy #D006

VALIDATED SCREENING TOOLS FOR MALNUTRITION

It is essential that pre-determined nutrition criteria that is used as part of the nutrition screening has been validated to identify patients that are malnourished or at nutrition risk. In other words, if the criteria is designed to identify malnutrition, then the criteria must identify those who are malnourished (the true positives) while minimizing the number identified as malnourished, but who are actually well nourished (the false positives). Determining nutrition risk should be quick, inexpensive, non-invasive and acceptable to the population being evaluated. It is also important that the nutrition screening tool be validated for the patient population and the setting for which it is used.

The ADA's Evidence Analysis Library includes the screening tools listed below, which are specific to the acute care setting. Use of screening tools may be subject to fees, licensing requirements, copyright requirements or other terms and conditions. Prior to implementation, the organization should investigate and obtain all required consents with respect to use of a particular screening tool.

- MUST (Malnutrition Universal Screening Tool): This tool was validated by following the same group of adult patients across a variety of care settings, using multiple healthcare professionals. The 5 step process includes the calculation of BMI. It was developed by the British Association for Parenteral and Enteral Nutrition. (*http://www.bapen.org.uk/must_tool.html* accessed 11/3/07)
- NRS 2002 (Nutrition Risk Screen): This tool combines the results of a patient interview regarding weight and intake with disease severity. It was validated with hospitalized adults, and published by a committee of the European Society of Parenteral and Enteral Nutrition. (*http://www.sbnpe.com.br/artigos/015.pdf* accessed 11/3/07)
- MNA (Mini Nutrition Assessment): This tool has been validated with adults age 65 and older and includes those who are hospitalized or living in the community. The tool includes a 6 item screen, and if necessary, a 12 item assessment. MNA was developed by and is copyrighted by Nestle. (*http://www.mna-elderly.com/navigation_frames/clinicalpractice/navigation-clinicalpractice-frame-mnaforms.htm* accessed 11/3/07)
- SNAQ (Short Nutritional Assessment Questionnaire): This tool was validated by the Dutch Dietetic Association, following the study of medical and surgical patients at a university hospital. It includes 3 questions which are scored and an automatic intervention plan for enriched meals and snacks of an additional 600 calories and 12 grams protein. (*http://www.nature.com/ejcn/journal/v59/n10/fig_tab/1602222t1.html* accessed 11/3/07)
- MST (Malnutrition Screening Tool): This tool was validated in an acute care hospital in Australia, with adult medical and surgical patients. The screen includes questions on unplanned weight loss and poor appetite. Results using the MST compare with that of the same patient evaluated using SGA; the MST can be administered by a person without clinical skills and even by the patient himself. (*http://www.rosslearningcenter.com/library/MST_RD_CE.pdf* accessed 11/3/07)
- SGA (Subjective Global Assessment): The determination of malnutrition is based on a standardized medical history and physical exam and a decision by a skilled clinician at the conclusion of the review. The system requires calculations and takes more than five minutes to complete. SGA was originally validated during a study of patients undergoing major gastrointestinal surgery at two teaching hospitals in Toronto. (*http://www.hospitalmedicine.org/geriresource/toolbox/pdfs/subjective_global_assessmen.pdf* accessed 11/3/07)

The use of a tool appropriate to your setting and population will improve the identification of patients who are malnourished, enabling the implementation of early intervention.

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Section: CLINICAL NUTRITION SERVICES	Policy #: D006A Date Issued: 11/97 Date Revised: 3/11
Subject: NUTRITION ASSESSMENT, INTERVENTION, MONITORING AND EVALUATION	

POLICY:

Patients identified during the initial assessment or prioritization will be further assessed and receive nutrition intervention when applicable.

PROCEDURES:

Dietitian

- Further assessment may include any or all of the following (NCP Step 1. Nutrition Assessment*):
  - Food / Nutrition History
  - Biochemical Data, Medical Tests, and Procedures
  - Anthropometric Measurements
  - Physical Exam Findings
  - Client History
- Based on the findings, the dietitian identifies a Nutrition Diagnosis and gains patient agreement on the appropriate Nutrition Intervention.
  - When recommendations are made which require a physician order, the dietitian follows-up within _____ (time) on the physician's response. If the physician does not respond to the recommendation through ordering the requested service/product or through other entry in the medical record, the dietitian may:
    - Contact the physician to discuss the recommendation and documents the results of the discussion, OR
    - Enters the information on the approved Medical Records form (see SAMPLE that follows), requesting a response. If still no response, the dietitian contacts the physician to discuss the recommendation and documents the results of the discussion.
- Nutrition Monitoring and Evaluation: The dietitian monitors and evaluates the patient's response to care; the frequency of this is based on the type of intervention implemented. Monitoring and evaluation may include reassessment, meal rounds, or medical rounds and may or may not result in new recommendations. The results of monitoring and evaluation are documented in the patient's medical record.
- When nutrition goals are met or are no longer applicable a dietitian may "sign off" on a patient. The dietitian will document in the medical record that future follow up will be provided by consult or when additional information by way of reassessment, meal rounds, or medical rounds suggests further assessment/intervention is warranted.
- Hand Off Communication** When the care of a patient transfers from one dietitian to another, there is a "hand-off" of information about the patient. While the information may be written or verbal, there must always be the opportunity to ask and respond to questions, in a timely fashion. Information communicated during the "hand-off" includes the patient's current condition, nutrition interventions implemented and the patient's response to the interventions.

*****American Dietetic Association. *International Dietetics & Nutrition Terminology (IDNT) Reference Manual (3rd ed)*; 2010.
******Reference :Joint Commission's National Patient Safety Goal #2: Improve the effectiveness of communication among caregivers.

P&P CROSS REFERENCE: D –Guidelines for Nutrition Care

Section: CLINICAL NUTRITION SERVICES	**Policy #: D006A** **Date Issued: 11/97** **Date Revised: 3/11**
Subject: NUTRITION ASSESSMENT, INTERVENTION, MONITORING AND EVALUATION	

PRIORITIZATION FOR FURTHER ASSESSMENT AND EVALUATION

Insert prioritization table here (refer to FYI page for further instruction).

.

SAMPLE PATIENT PRIORITIZATION TABLE

Within 24 hours	Within 48 hours
• TPN/New Order for Tube Feeding • NPO/CL= 5 days	• Physician Referral • RN Referral (may include but is not limited to results generated from the initial nutrition screen completed by nursing within 24 hours of patient admission • Tube feeding (in use prior to admission) • Education referral • Pressure ulcers (Stage II or greater) • Heart Failure protocol- (ensure that protocol guidelines are aligned with this response time • Calculate Physician ordered calorie count • BMI < 19

REASSESSMENT AND FOLLOW-UP* GUIDELINES

2X in 5 day length of stay (LOS)	1X/Week
New or unstable PN	Stable PN
New or unstable TF	Stable TF
Severe malnutrition	Follow-up based on patient's care goals

** Follow-up may include reassessment, meal rounds, medical rounds, or brief documentation on intake or status. May or may not include new interventionss.*

Section: CLINICAL NUTRITION SERVICES	**Policy #: D006A** **Date Issued: 11/97** **Date Revised: 3/11**
Subject: NUTRITION ASSESSMENT, INTERVENTION, MONITORING AND EVALUATION	

FYI

Policy #D006A

Prioritization Table

The prioritization table **MUST** be customized by the onsite clinical team. Consider high risk and high volume populations served by your facility as well as the facility's length of stay when customizing this table. It is encouraged that you prioritize patients according to nutrition diagnosis opposed to medical diagnosis. However, limited access to patient information may require that prioritization include medical diagnosis. Please contact corporate and region level clinical support teams if assistance is require in customizing your priroritization table.

The following content are two samples of forms that could be used to alert physicians of the need to respond to nutrition care recommendations. If such a form is used, it should be approved to be a part of the permanent medical record.

Section: CLINICAL NUTRITION SERVICES	**Policy #: D006A** **Date Issued: 11/97** **Date Revised: 3/11**
Subject: NUTRITION ASSESSMENT, INTERVENTION, MONITORING AND EVALUATION	

FYI
Policy #D006A

SAMPLE APPROACHES FOR NOTIFYING PHYSICIAN OF DIETITIAN RECOMMENDATIONS

When the dietitian makes recommendations that require action by the physician, a system must be in place to track the status of the recommendations. The dietitian may choose to do this through an informal system, such as with notations on a personal work sheet. In other cases, a formal process may be in place to insert a sheet/notice into the medical record, alerting the physician that the recommendation in the Nutrition Notes. In either case, if the recommendation is not answered (either ordered or declined) in a designated time frame, the dietitian must follow-up with the physician to discuss the need for the requested service. This interaction is documented in the medical record.

The following content are two samples of forms that could be used to alert physicians of the need to respond to nutrition care recommendations. If such a form is used, it should be approved to be a part of the permanent medical record.

* * * * *

MEMO TO THE PHYSICIAN
FROM FOOD & NUTRITION SERVICES

PATIENT NAME:_____ DATE:_____

DR._____

RECOMMENDATION:
_____
_____
_____
_____

***** REFER TO TODAY'S NUTRITION NOTE FOR DETAILS*****

DIETITIAN:_____ PAGER:_____

* * * * * * * * * * * * * * * * *

Nutrition Recommendation Order Form

Room Number / Patient Name:_____
DOB_____
_
Original Diet
Order:_____
Nutrition
Recommendation:_____
Dietitian Signature:_____Time:_____ Date:_____

Please check appropriate box below and sign, date and time.

☐ Recommendation Noted. Thank You.

☐ Adjust Nutrition as Recommended.

Physician's signature:_____Time:_____Date:_____

V.O. / T.O. Read Back Initials:_____

Section: CLINICAL NUTRITION SERVICES	**Policy #D007** **Date Issued: 5/95** **Date Revised: 3/11**
Subject: NUTRITION PRACTICE GUIDELINES	

POLICIES:

Guidelines for Nutrition Care are implemented to:

- Provide patients with the highest quality of nutrition care that is recommended by the dietetics profession,
- Enhance the efforts of the dietitian, nurse, pharmacist, and physician to integrate all functions provided by the various disciplines,
- And simultaneously trackoutcome data that can be compared to other Morrison accounts to establish benchmarks and used to demonstate positive patient outcomes based on nutrition intervention

PROCEDURES:

Clinical Nutrition Manager

- Reviews the Morrison *Guidelines for Nutrition Care* with the clinical nutrition staff and adapts to the facility.
- Presents the *Guidelines for Nutrition Care* to the committee concerned with nutritional care for review and approval.
- In-services the clinical staff on the guidelines.
- Implements *Guidelines for Nutrition Care* and tracks, compiles and reports outcome data through the performance improvement process.

Section: CLINICAL NUTRITION SERVICES	**Policy #D008** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: INTERDISCIPLINARY PATIENT CARE PLAN	

POLICIES:

Problems related to nutrition care of the patient will be communicated to other disciplines via the Interdisciplinary Patient Care Plan.

PROCEDURES:

- Document nutrition problems noted during the assessment on the Interdisciplinary Patient Care Plan or designated form.
- Review / update the Interdisciplinary Patient Care Plan with each nutrition care follow-up.
- If no apparent nutrition problems are found, initial the Care Plan next to the standard problem(s) and note the date and "N/A" in the "Date Resolved" column.

P&P CROSS REFERENCE:

Section D – Enteral Nutrition
Parenteral Nutrition
Patient and Family Education
Discharge Planning for Nutrition Services
Food and Drug Interaction Education
Guideliness For Nutrition Care

_____

Nursing

_____

Food and Nutrition Services

_____

Social Services

FYI

Policy #D008

INTERDISCIPLINARY PATIENT CARE POLICIES AND PROCEDURES

The Interdisciplinary Patient Care Policy should serve as a guideline for areas that approach care from an interdisciplinary focus. Other conditions/diagnoses that are well served through a multidisciplinary approach to patient care are:

- Diabetes Education
- Cardiac Rehab
- Pulmonary Rehab
- Diagnoses that are on Critical Pathways
- Case Management Teams
- Patient Focus Care Units/Teams
- Patient Rounds
- Trauma
- Neurology
- Dialysis Unit
- Geriatric Unit
- Ostomy Care
- Wound Care

Include an interdisciplinary P&P for any area that takes this approach to patient care.

FYI

Policy #D008

INCLUDE FACILITY INTERDISCIPLINARY POLICIES HERE

Section: CLINICAL NUTRITION SERVICES	**Policy #D009** **Date Issued: 5/95**
Subject: NPO/CL MONITORING	**Date Revised: 10/07**

POLICIES:

To assure all patients receive appropriate nutritional care, patients receiving minimal or no nutrition (i.e., NPO) will be monitored.

PROCEDURES:

Nursing

- Notifies FNSD that a patient is NPO or on a clear liquid (CL) diet.

Clerk

- Maintains data on NPO or CL status of patients. Options include the NPO/CL Monitoring Form, the patient cardex, or a computer-generated report.

Technician/Dietitian

- Tracks days that patients have been on NPO/CL diets.

Dietitian

- By the 5th day, documents risk status in the medical record for patients on NPO/CL diets, including recommendations for diet advancement, nutrition support options, or discussions with physician.
- Continues to monitor NPO/CL status and documents every 2 days in the medical record until diet order changes.

Reference
ASPEN Board of Directors and the Clinical Guidelines Task Force. Guidelines for the use of parenteral and enteral nutrition in adult and pediatric patients. *J Parenter Enteral Nutr.* 2002;26 (suppl)(1):19SA.

NPO/CL MONITORING FORM

MONTH: _____

Room: Name:	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

CODES TO ENTER
NPO
CL = Clear liquids
ND = No Diet Order

Section: CLINICAL NUTRITION SERVICES	Policy #D010 Date Issued: 5/95 Date Revised: 07/09
Subject: INTAKE SUPPORT	

POLICIES:

Intake Support is defined as the provision of appropriate foods or nourishments to improve intake. A physician order is not needed to provide intake support as long as the foods/nourishments selected are within the confines of the diet order. A physician order is required for the provision of pharmaceutical nutrition supplements.

Definition of Intake Support Options
Food/Beverage support – Food/Beverages that are provided to the patient either as part of the meal or between meals that are within the confines of the diet order (Reference: Manual of Clinical Nutrition). Examples may include but are not limited to sandwiches, milkshakes, juice, crackers, ice cream, etc.
Nourishment Support – Nourishments that are provided to the patient either as part of the meal or between meals that are within the confines of the diet order (Reference: Manual of Clinical Nutrition Management). Examples may include but are not limited to items such as Carnation Instant Breakfast, Mighty Shakes, Magic Cup, etc.

PROCEDURES:

Dietitian

- Determines the food/beverage or nourishment options available.
- Determines whether pharmaceutical nutrition supplements should be recommended to support overall intake. *This level of intake support requires a physician order*
- Upon reviewing the screening data, assign technician/designee to provide Intake Support. Provide direction as to:
  - appropriate type of intake support, that is, whether items are served at meals or between meals
  - foods on tray
  - nourishments

Recommendations for pharmaceutical nutrition supplements - *This level of intake support requires a physician order.*

- Frequency of monitoring for intake.

Nursing

- Identifies patients who may benefit from intake support and informs diet office or dietitian.

Technician/Designee

- Provides foods/nourishments acceptable to the patient
- Provides pharmaceutical nutrition supplements per physician order
- Adjusts intake support as intake changes.

Nursing or FNSD

- Delivers foods/nourishments/supplements to patient
- Regularly communicates patient's acceptance and intake to dietitian.

Section: CLINICAL NUTRITION SERVICES	**Policy #D011** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: PATIENT AND FAMILY EDUCATION	

POLICIES:

Basic information on the prescribed modified diet will be given to patients.

Nutrition counseling and/or education on modified diets will be provided when the need for education has been identified through prioritization, the assessment process, critical pathways, or upon physician order.

PROCEDURES:

BASIC INFORMATION

Diet Clerk

- Attaches Diet Awareness Card to menu when the diet order is initiated or changed.

Hospitality Assistant/Designee

- Gives Diet Awareness Card to patient and makes patient aware of information.

OR

Trayline Starter

- Removes Diet Awareness Card from menu and places on tray.

NUTRITION COUNSELING

Dietitian/Technician

- Attempts to have the patient's family or significant other present during the educational process, as appropriate.
- Includes the phone number of the dietitian's office on diet instruction materials.
- Documents patient/family's preferred method of instruction, comprehension of the instruction, expected compliance, materials used, and any follow-up plans in the medical record when nutrition counseling/education is given.
- If patient is discharged prior to receiving nutrition counseling:
  - Written materials are mailed to the patient,
  - Materials include the dietitian's contact number,
  - Schedules patient for nutrition counseling using outpatient program at facility. If outpatient program is not available, provides patient with a list of community resources to receive counseling,
  - Documents actions taken in the medical record. (Done by nursing if dietitian not available.)

_____

Nursing

_____

Food & Nutrition Services

FYI

Policy #D011

PATIENT AND FAMILY EDUCATION

The following list of concerns need to be evaluated/investigated for your facility and included in your P&P on Patient and Family Education:

- Community services for patients unable to purchase or prepare food
- Services available for patients who are not able to have educational needs met while at facility, i.e., outpatient services, clinic, home health.
- Diverse educational needs which may be met through community services such as services for the blind, hearing impaired, non-English speaking individuals and people with low literacy.
- Follow-up visits for patients who need additional counseling.

SAMPLE

Hospital Name

NUTRITION COUNSELING REPORT

☐ Initial ☐ F/U ☐ Diet Rx: _____

Diet Hx: _____

_____

Patient's preferred method of instruction: _____

Instructional materials given to patient: _____

After diet instruction, patient demonstrated ☐ Poor ☐ Fair ☐ Good understanding of the diet based on ability to:

☐ verbalize rationale of diet ☐ understanding

☐ state _____ out of _____ diet principles ☐ financial situation

☐ other _____

Comments: _____

_____

_____

Pt _____ PF# _____ Signature _____

RD/Dietetic Technician

Section: CLINICAL NUTRITION SERVICES	**Policy #D012** **Date Issued: 5/95**
Subject: NON-ENGLISH SPEAKING PATIENTS	**Date Revised: 10/07**

POLICY:

The Food and Nutrition Services Department uses available resources to communicate diet/nutrition information to patients who do not speak English. Refer to approved hospital translator list to maintain patient confidentiality.

PROCEDURES:

Dietitian

- Coordinate translator for patient needing nutrition care.
    - Medical Center designated translator
    - AT&T Language Service or other hospital approved service

NOTE: While the use of a family member might be convenient, this practice is highly discouraged. As noted in the Joint Commission publication *Hospitals, Language and Culture: A Snapshot of the Nation*; 4/07 (page 56): "Several studies have shown that the use of family members or other ad hoc interpreters are more likely to misinterpret information, omit or add information, or insert their own values or judgments into the conversation."

Section: CLINICAL NUTRITION SERVICES	**Policy #D013** **Date Issued: 5/95**
Subject: DISCHARGE PLANNING FOR NUTRITION SERVICES	**Date Revised: 3/06**

POLICIES:

The Food & Nutrition Services Department (FNSD) participates in the interdisciplinary discharge planning process designed to assist patients and their families, representatives, and/or other health care providers in developing and implementing an appropriate post facility plan of care. Procedures are developed and approved jointly by the FNSD and Discharge Planning.

PROCEDURES:

Dietitian, Physician, Interdisciplinary Team

- Identify patients in need of nutritional counseling.
- Identify patients in need of community-based services such as Meals of Wheels, Food Stamps and other assistance to meet nutritional needs. Request involvement of Social Services.

Physician

- Orders Nutrition Counseling prior to patient's discharge.

Dietitian

- Provide nutrition counseling, educational literature or transfer instructions (description of dietary restrictions).
- Document in the medical record the patient/family's comprehension of education, materials given, expected compliance to diet therapies, family members present, and any follow-up plans.
- Make recommendation as needed for appropriate (post-discharge) care in cases where:
    - Nutrition counseling could not be completed prior to discharge;
    - Further nutrition counseling is necessary for patient to implement prescribed dietary modifications following discharge.

Note: The patient or family/representative has the right to modify or reject any discharge plan. Such modification and/or rejection shall be noted in the medical record.

_____

Social Services

_____

Nursing

_____

Food and Nutrition Services

FYI
Policy #D013

DISCHARGE NUTRITION COUNSELING REQUEST

Physician should be notified if patient doesn't receive counseling. Sample letter to notify for future referral:

Forward to the office of_____
Physician

Patient_____ Date_____

Diet Order_____

- -

We were unable to provide Nutrition Counseling due to:

_____ RD unable to
(Note: The policy of _____ facility requires that Nutrition Counseling is ordered at least ( ) hours prior to discharge.)

_____ Patient refused education.

_____ Patient not available.

_____ Other _____

_____ The patient was given/mailed applicable literature.

Nutrition Counseling services are available _____
(place and time)

On an outpatient basis: If you would like Nutrition Counseling for this patient, please refer them to outpatient services. Appointments may be made at _____.
(phone number)

Comments: _____

_____

_____
Clinical Dietitian

_____
Food and Nutrition Services Department

Section: CLINICAL NUTRITION SERVICES	**Policy #D014** **Date Issued: 5/95** **Date Revised: 3/11**
Subject: FOOD-MEDICATION AND HERB-MEDICATION INTERACTION EDUCATION	

POLICIES:

Patients will receive written instructions and verbal counseling on potential food-medication-herbal interactions during hospitalization and food-medication-herbal interaction education before discharge on drugs designated by the facility to have potential food-medication-herbal interactions.

PROCEDURES:

Nutrition Care Committee/Pharmacy and Therapeutic Committee

- Identifies drugs used in the facility with potentially significant food-medication-herbal interactions that require patient education. Consults Morrison *Manual of Clinical Nutrition Management* during development of materials.
- Determines process for education of patients:
  - Designates interdisciplinary team member who educates patient.
  - Reviews and approves patient educational materials.
  - Reviews food, medication and herbal interaction program annually and revises the materials as needed.

Dietitian, Pharmacist or Nurse

- Counsels the patient and/or family on potential food-drug- herbal interactions and documents education in the medical record.
- For patients who are taking herbal supplements, notify the patient's physician of this practice. From this information, the physician may order a consult on medication-herbal interaction as appropriate.
- For patients who bring herbal supplements into the hospital, notify the patient's physician, nurse and pharmacist.
- For patients receiving anticoagulant therapy, education includes the importance of follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse medication reactions and interactions.

Dietitian or Technician

- Modifies patient meal pattern or diet as needed.
- Ensures that the patient menu follows recommendations for Vitamin K intake follows information outlined in the Morrison *Manual of Clinical Nutrition Management 2011*. These recommendations include serving no more than 1 serving of foods identified to contain high levels of vitamin K per day and no more than 3 servings of foods identified to contain moderate levels of vitamin K per day (Reference: National Health Institute: Warren Grant Magnuson Clinical Center)..
- Ensure that patients receiving anticoagulant therapy receive no more than 1 cup of cranberry juice per day. (Reference: Zhaoping LI, Seeram NP, Carpenter CL, Thames G, Minutti C, Bowerman S. Cranberry does not affect prothrombin time in male subjects on warfarin. *J Am Diet Assoc.* 2006; 106:2057-2061).

P&P CROSS REFERENCE: Facility Home Medication Policy

Director, Food and Nutrition Services _____

Nursing _____

Pharmacy _____

FYI

Policy #D014

FOOD- DRUG and HERB-MEDICATION INTERACTION EDUCATION

Herb-Medication Interaction Education

Include an herbal warning on Herb-Medication Education sheets of certain drugs that may have nutritional concerns. Sample statement:

> Special care should be taken if you are considering taking a natural/herbal product with this medication. Talk to your pharmacist, physician or dietitian before taking a natural/herbal product.

See Morrison *Manual of Clinical Nutrition Management*'s Food-Medication and Herb-Medication Interaction sections for common foods and herbal supplements that are known to affect certain medications. Incorporate this information into the organization's food-medication and herb-medication interaction education sheets as appropriate. Also refer to the Morrison *Great Living Starts Here* Herb and Drug Interaction patient education sheets.

2012 Joint Commission National Patient Safety Goal (NPSG)

Improving the Safety of Using Medications: Anticoagulation Therapy

Standard: NPSG.03.05.01: Reduce the likelihood of patient harm associated with the use of anticoagulant therapy.
Elements of Performance (EP) specific to F&N department

EP4: Use authoritative resources to manage potential food and drug interactions for patients receiving warfarin
EP7: Provide education regarding anticoagulant therapy to prescribers, staff, patients, and families. Patient/family education includes the following:
- The importance of follow-up monitoring
- Compliance
- Drug-food interactions
- The potential for adverse drug reactions and interactions

Suggested Actions

EP4: Use of authoritative resources to manage potential food and drug interactions for patients receiving warfarin.

- Ensure that your hospital has approved authoritative resources and practices on how to manage potential food and drug interactions. Refer to *Morrison's Manual of Clinical Nutrition* Food-Medication and Herb-Medication Interactions section for common foods known to affect warfarin.

EP7: Provide education regarding anticoagulation therapy to prescribers, staff, patients and family.

- Ensure that your hospital has a policy in place that designates a discipline to be responsible for providing ongoing education to prescribers, staff, patients and family. EP #7 does not specify a responsible discipline to provide education and therefore this assignment is to be determined by the organization. Refer to Morrison's *Great Living Starts Here materials* for patient education specific to Food and Medication Interaction and Anticoagulant Education sheet (for Food-Medication interaction).
- Provide ongoing education to patient food service personnel on the dietary considerations associated with the anticoagulant therapy (i.e. CHAT & Daily Meeting Guide).
- Evaluate and monitor compliance of this standard .
- Ensure that your hospital has a policy in place that designates a discipline to be responsible for follow-up monitoring, compliance issues, dietary restrictions, and potential for adverse drug reaction and interactions. Refer to Morrison's *Great Living Starts Here* materials for patient education specific to Herbal and Medication Interaction and Anticoagulants (Food-Medication interaction)
- Evaluate and monitor compliance if this responsibility is assigned to the RD.

Section: CLINICAL NUTRITION SERVICES	**Policy #D015** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: DOCUMENTATION IN THE MEDICAL RECORD	

POLICIES:

The following individuals are authorized to enter nutrition related information in the medical record:

- Registered Dietitian
- Dietitian, not registered (if allowed by facility by-laws and state licensure regulations)
- Dietetic Technician, Registered

Documentation procedures follow guidelines obtained from or approved by the Medical Records Department.

PROCEDURES:

Medical Record documentation is completed using these guidelines:

- Use black ballpoint pen only.
- Use facility approved abbreviations (includes “do not use” list issued by Joint Commission January 1, 2004).
- Place current date and time on each entry; enter the documentation as soon as services are rendered or patient observation performed.
- Late entries: in the body of the entry, state the date and time the entry should have been recorded.
- Head the entry according to facility/department protocol (i.e., "Medical Nutrition Therapy," "Nutrition Note").
- For space remaining at the end of an entry, insert a straight, unbroken line from the last word of the entry to the end of the line.
- Record total time of MNT service provided at end of entry, when charging for units of service provided.
- Corrections: Correct entries only when the information is incorrect.
    - Draw a single thin line through each word or line which is inaccurate; the incorrect material should remain legible.
    - Date and initial the correction.
    - Place a note in the margin stating why the previous entry had to be corrected.
    - In questionable situations (from a risk management standpoint) ask a colleague to witness the corrected entry.
- Signatures: Sign the entry with full name and credentials (R.D.).
    - Per policy, co-sign student entries after reading and checking for accuracy (Co- sign by R.D. only)
    - Dietitians hired prior to completing the registration exam will demonstrate competency through the chart audit process in order to continue with charting privileges. Until clinical competency is confirmed, all notes will be co-signed by a R.D. A non-registered dietitian’s notes will be signed with the dietitian’s full name followed by “Nutrition Services”. (Check state licensure laws to verify that it is acceptable to allow a non-registered dietitian to chart without a co-signature after competency has been documented. In some states, by law, notes must be co-signed until the dietitian has passed the registration exam.)
- Use SOAP, PGIE or diagnosis related charting format, or approved forms only.
- When the patient is scheduled to transfer to another facility, the dietitian documents specific information about the care, treatment and services provided to the patient (such as an unusual meal pattern). This information will be shared during the “hand off” communication concerning the patient as a means to support continuity of care. Per facility policy, the information is documented in the _____ section of the medical record.

FYI

Policy #D015

RISK MANAGEMENT GUIDELINES FOR MEDICAL RECORD DOCUMENTATION

The following guidelines for documentation in the medical records pertain to risk management.

- The medical record should never be the forum for belittling, criticizing, placing blame, or casting doubt on the professionalism of another member of the health care team. Professional in-fighting documented in a medical record almost guarantees litigation and escalates settlement/jury verdict values.
- Biased or personal feelings about the patient should never be entered in the medical record. The claimant's attorney can use such remarks to give an unfavorable opinion of the health care professional and infer the patient possibly did not receive the best care.
- Omissions are to be avoided at all cost. Even if adequate professional services were rendered to a patient, if the chart does not provide a record of those services, the claimant's attorney can allege they were not performed. In almost every instance when a jury has to decide who to believe, the witness or medical record, it will go in the medical record.

- Contacts between the dietitian and other professionals (nursing, physician, other) both in person and telephone, should be documented. Include:
  - The complete names and titles of the medical professionals involved.
  - Means of communication.
  - Time of the contact and who initiated.
  - Details of the discussion.
  - Response of each to the discussion.

- Obliterating an entry or portions thereof can help the claimant's attorney in the same way as omissions. Medical record entries should never be made illegible by any means.
- Documentation should never mention that an Incident Report was completed.
- Charting must be objective. Words such as unintentionally, inadvertently, somehow, unexplainably, unfortunately, are not good choices because they reflect a judgment and can call for additional explanation. Works such as "appeared", "seems to be", "approximately", are not definitive and can be used by the claimant/plaintiff attorney to cast doubt as to what actually observed. Frivolous, extraneous, or humorous remarks that have nothing to do with patient should be avoided. They infer inattention to duty and bespeak of unprofessionalism.

REFERENCE: Wade, R.D.: Risk Management HPL: Hospital Professional Liability Primer. Columbus, Ohio: Ohio Hospital Insurance Co., l983. Library of Congress Catalog Card Number: 83-63029.

NOTE: Risk management guidelines for medical record documentation have not changed since the early 1980s. The following are additional references:

Rowland, H and Rowland B. "Legal Guidelines for Documentation" in Hospital Risk Management Forms, Checklist and Guidelines. Aspen Publishers, Inc. Gaitherburg, MD. Vol. 1, 22:11-12, 1993.

Greve, P. "Nursing and Patient Care Staff" in Risk Management Handbook for Health Care Facilities. American Hospital Publishing, Inc. L.M. Harpster and M.S. Veach (ed), Chicago, IL. pp 75-90, 1990.

"Recordkeeping can make or break your hospital defense." Hospital Risk Management. Vol 15(4): 59-63, April, 1993.

A "Minimum List" of Dangerous Abbreviations, Acronyms and Symbols

Beginning January 1, 2004, the following items must be included on each accredited organization's "Do Not Use" list:

Abbreviation	***Potential Problem***	***Preferred Term***
U (for unit)	Mistaken for "0" (zero), the number "4" (four) or "cc"	Write "unit"
IU (International Unit)	Mistaken for IV (intravenous) or the number "10" (ten)	Write "International Unit"
Q.D.,QD, q.d., qd (daily) Q.O.D., QOD, q.o.d., qod (every other day)	Mistaken for each other. Period after the Q mistaken for "I" and the "O" mistaken for "I"	Write "daily" Write "every other day"
Trailing zero (X.0 mg), Lack of leading zero (.X mg)	Decimal point is missed	Write X mg Write 0.X mg
MS MSO_4 and $MgSO_4$	Can mean morphine sulfate or magnesium sulfate Confused for one another	Write "morphine sulfate" Write "magnesium sulfate"

The following items should also be considered when expanding the "Do Not Use" list

Abbreviation	*Potential Problem*	*Preferred Term*
> (greater than) < (less than)	Misinterpreted as the number "7" (seven) or the letter "L" Confused for one another	Write "greater than" Write "less than"
Abbreviations for drug names	Misinterpreted due to similar abbreviations for multiple drugs	Write drug names in full
Apothecary units	Unfamiliar to many practitioners Confused with metric units	Use metric units
@	Mistaken for the number "2" (two)	Write "at"
cc	Mistaken for U (units) when poorly written	Write "ml" or "milliliters"
µg	Mistaken for mg (milligrams) resulting in one thousand-fold overdose	Write "mcg" or "micrograms"

Section: CLINICAL NUTRITION SERVICES	Policy #D016 Date Issued: 5/95 Date Revised: 10/07
Subject: ENTERAL NUTRITION	

POLICIES:

- Registered Dietitians monitor the nutritional care of all patients receiving enteral nutrition.
- Enteral feedings are provided to patients by Food and Nutrition Services upon receipt of a physician order.
- The enteral nutrition formula formulary is reviewed at least annually.

PROCEDURES;

Physician

- Orders enteral tube feedings for patients who have a functional gastrointestinal tract but are unable to orally meet their nutritional needs.
- Specifies in the patient's medical record:
  - name of enteral tube feeding formula
  - rate of feeding
  - feeding route (e.g., nasogastric, gastrostomy, jejunostomy, etc.)
  - amount of flush
  - plan for advancement of feeding, including goal rate
- Alternately orders *tube feeding per protocol.*

Nursing

- Processes tube feeding orders in the same manner as diet orders. The order must include the type of feeding, and rate of feeding.

Dietitian

- Assesses nutritional needs of the patient; monitors tolerance and efficacy of feeding; and documents in the medical record according to the established practice guidelines, i.e., including an assessment of anthropometric, biochemical and clinical parameters (i.e., fluid status, laboratory values, etc.).
- When *tube feeding per protocol* is ordered:
  - Selects an appropriate formula, advancement procedure and goal rate in conjunction with nursing and physician.
  - Recommends appropriate fluid level
  - Monitors patient's tolerance of formula and advances it to appropriate rate and strength when appropriate.
- Assists with:
  - transitional feedings to an oral diet; or parenteral feedings if enteral feedings not tolerated.
  - selection/transition to alternative enteral formula
  - progression of enteral formula feeding.

Diet Clerk

- As required, calculates the number of ready-to-hang bags or number of cans of ready-to-use formula needed per day and records on the formula card.

Nursing

- Insert nursing P&P

Food & Nutrition Services Staff

- Prepares and delivers formula to nursing stations at _____ as specified in Policy B021: Guidelines for Enteral Feedings and Nutrition Supplements Storage, Preparation and Delivery.

DISCHARGES:

Discharge Planner

- Contacts Home Health Care Medical Equipment Supply company to deliver product.
- Contacts Home Health Nurse to instruct patient on tube feeding administration.
- Contacts dietitian for assistance, if needed.

_____

Nursing

_____

Food and Nutrition Services

_____

Discharge Planning

Adult Enteral Nutrition Order Form (EN)

1. _____ **DIETITIAN CONSULT** - please check for dietitian to manage EN.

2. **EN ROUTE**
   _____ Nasogastric_____ Gastrostomy_____Orogastric
   _____ Nasojejunal_____ Jejunostomy

3. **TF FORMULA**

	Indication	**kcal/ml**
_____ Jevity Plus	standard, contains fiber	1.2
_____ Glucerna Select	diabetes, contains fiber	1.0
_____ Pulmocare	respiratory failure	1.5
_____ Nepro	renal - high protein	1.8
_____ Suplena	renal - low protein	2.0
_____ Optimental	malabsorption	1.0
_____ Oxepa	inflammation – ARDS, SIRS	1.5

4. **EN ADVANCEMENT**: Begin EN full strength at _____ ml/hr x 4 hr or x _____hr, advance by 20 ml q 8 hr or q _____ hr as tolerated to goal rate of _____ ml/hr.

5. **RESIDUAL CHECKS**: Check residuals q _____ hr. If residuals are > 200 ml on two consecutive checks, hold EN. Restart EN when residuals are < 100 ml.

6. **TOLERANCE TO EN**: Hold EN if the patient has increasing abdominal distention, cramping, and/or emesis.

7. **WATER FLUSHES**: Flush tube with 30 ml H_2O q 8 hr to maintain patency and before and after each medication dose given via the EN tube. Additional flushes: _____ ml H_20 q _____ hr.

8. **MEDICATIONS**: If the patient is receiving phenytoin via the feeding tube, hold EN one hour prior to and two hours after each dose.

9. **TOTAL FLUIDS**: Titrate maintenance IV fluids down as EN rate is advanced to maintain fluids and EN flow rate at _____ ml/hr

10. L**ABORATORIES**:_____

11. **ADDITIONAL ORDERS**:_____

Physician
Signature_____Date:_____

FYI

Policy #D016

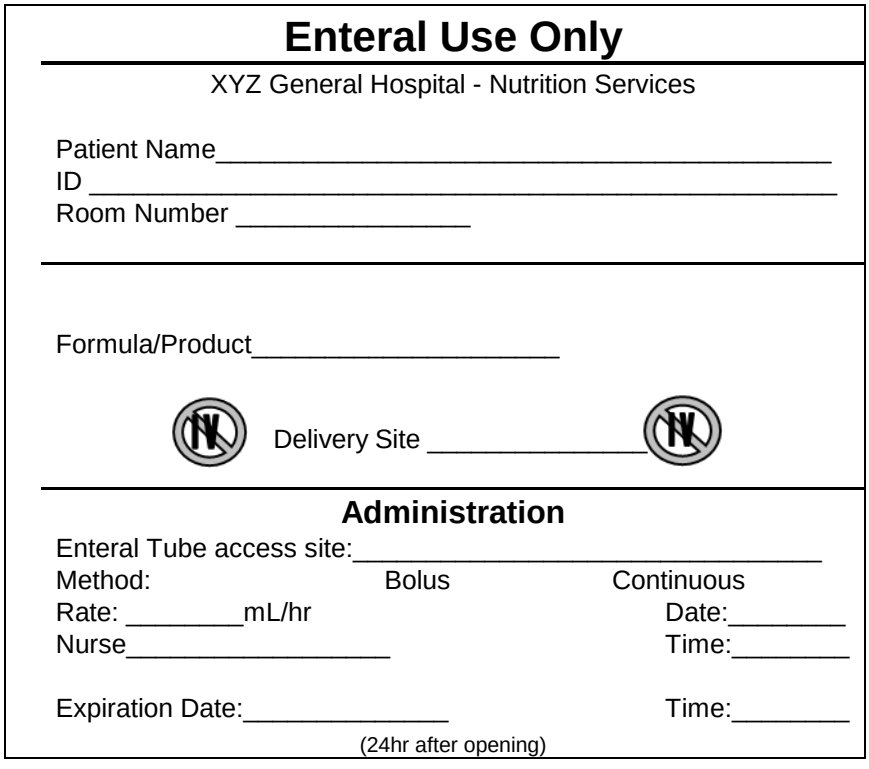
ASPEN ENTERAL NUTRITION LABEL GUIDELINES *

In 2009, ASPEN recommended the following guidelines for labeling Enteral Nutrition to ensure patient safety. Inclusion of the following information was recommended:

- Patient demographics
- Formula type
- Delivery site/access
- Administration method
- Name of person responsible for hanging the product
- Hang time
- Date information.

It is also highly recommended per the ASPEN guidelines, that the enteral nutrition label be compared to the enteral nutrition order for accuracy before administering any enteral feeding.

Below is an example of enteral nutrition label sticker.



Reference:

Bankhead R, Boullata J, Brantley S, Corkins M, Guenter P, Krenitsky J, Lyman B, Metheny N, Mueller C, Robbins S, Wessel J and A.S.P.E.N. Board of Directors. Enteral Nutrition Practice Guidelines. (Special Report). J Parenter Enteral Nutr. January 26, 2009. Available at: http://pen.sagepub.com/content/early/2009/01/27/0148607108330314.full.pdf+html. Accessed Feb. 4, 2011.

Section: CLINICAL NUTRITION SERVICES	**Policy #D017** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: PARENTERAL NUTRITION	

POLICIES:

- Pharmacy provides all parenteral nutrition formulas.
- Registered dietitians monitor the nutritional care of all patients receiving parenteral nutrition in conjunction with pharmacy.

PROCEDURES:

Physician

- Orders TPN/PPN.

Nursing

- Enters parenteral feeding orders into the computer.

Pharmacy

- Prepares all parenteral formulas.
- Notifies FNSD which patients are receiving PN.

Dietitian

- Completes nutrition assessment.
  - Reassesses patient per policy.
- Collaborates with physician and pharmacist on contents of TPN/PPN solution.
- Attends weekly nutrition support rounds.
- Works closely with the Nutrition Support Service to monitor laboratory values, nutritional and medical status.
- Monitors transition to enteral or oral feedings.
  - Conducts Intake Analysis per dietitian's discretion or physician order.

Nursing

- Completes nursing assessment.
- Monitors daily parenteral nutrition solution administration and patient's response to therapy.
- Provides catheter care according to protocol.

_____

Pharmacy

_____

Food and Nutrition Services

_____

Nursing

USE BALL POINT PEN – PRESS FIRMLY

☐ **STAT/NOW**
(Check Box to Left)

PHYSICIAN'S ORDER

HOSPITAL PROVIDED PRE-PRINTED PHYSICIAN'S ORDERS

Parenteral Nutrition Order

DATE: TIME:

1. Order for TPN changes MUST BE RECEIVED by 1400 for the following bag.
2. If no change in the TPN content or rate is needed, TPN orders do not need to be rewritten.
3. Acute replacement of electrolytes and fluids should be via separate infusion, not emergency orders for TPN changes.
4. All new TPNs start at 2000. Pharmacy will prepare a 24-hour supply of TPN.
5. If TPN must be stopped, or if TPN access is lost, infuse Dextrose 10% at the same rate and call Physician
   ☐ Central TPN ☐ Peripheral TPN

Amino Acids: Range **1.2 – 2.5** gm/kg/day _____ gm/kg/day
Calories: Range **13 – 35** kcal/kg/day _____ Kcal/kg/day
Amino Acids based on ☐ Ideal Body Weight ☐ Actual Body Weight
Calories based on Actual Body Weight

Amino Acids	_____ Gm/L
Dextrose	_____ Gm/L
Lipids	_____ Gm/L

Actual Body Weight: _____kg **Height** _____ inches
Ideal Body Weight: _____kg **Goal Rate**: _____ ml/hour

Standard Peripheral Formula
Recommended Concentration

Amino Acids	30 Gm/L
Dextrose	50 Gm/L
Lipids	45 Gm/L

LAB:

1. CMP, Phos, Magnesium, Triglycerides
   Prealbumin, CBC with Diff (TPN I)
   prior to first bag and every Monday
2. BMP, Phos, Magnesium, (TPN II)
   Every 24 hr x 3 days _____ _____ _____
3. BMP, Phos, Magnesium, Triglycerides,
   CBC with Diff (TPN III)
   Every Thursday

Insulin:

☐ Insulin Sliding Scale while on TPN
FSBS ☐ every 6 hours ☐ every 12 hours ☐ daily
Place Insulin Sliding Scale Orders/Protocol in chart
☐ Insulin Sliding Scale per Pre-existing order
(See current order in chart)
☐ Insulin Continuous Drip
(See current order in chart)
☐ Daily Intake/Output
Weight: ☐ daily ☐ _____

	☐ Standard Additives	☐ Desired Additives
Sodium Chloride	33 mEq/L	mEq/L
Sodium Acetate		mEq/L
Potassium Chloride	40 mEq/L	mEq/L
Potassium Acetate		mEq/L
Sodium Phosphate	27 mEq/L	mEq/L
Potassium Phosphate		mEq/L
Magnesium Sulfate	8 mEq/L	mEq/L
Calcium Gluconate	5 mEq/L	mEq/L
Reg. Human Insulin	Units/L	Units/L
MVI-13	10 ml/day	10 ml/day
MTE 5 Concentrate	1 ml/day	1 ml/day
Sodium Iodide	75 mcg/day	75 mcg/day
Famotidine		mg/day
Thiamine		mg/day
Folic Acid		mg/day
Ascorbic Acid		mg/day
Zinc Sulfate		mg/day

Rate _____ ml/hr for a total _____ ml/day
Cyclic TPN _____

NST or Physician Signature:	**Date Signed:**	**Time Signed:**
Printed Name/Telephone #:		

TPN ADULT

Exp. 01/2010

DEPARTMENT/DIVISION	DATE
	7/13/07

PATIENT IDENTIFICATION

(Policy #D017)

001113

Section: CLINICAL NUTRITION SERVICES	**Policy #: D018**
Subject: INTAKE ANALYSIS	**Date Issued: 5/95** **Date Revised: 10/07**

POLICIES:

Intake analysis of calories and protein is initiated within 24 hours of receipt of physician order or is instituted by the dietitian as part of a needs assessment, protocol or critical pathway, or physician ordered consult. Other/additional nutrients may be ordered or specified by the dietitian.

The duration of the intake analysis is ____ day(s) unless specified otherwise. If the patient is NPO for part or all of the __ day period, the dietitian may extend or suspend the intake analysis; changes will be documented in the medical record.

PROCEDURES:

Physician

- Orders Intake Analysis

Nursing

- Communicates the physician's order to FNSD.

Dietitian or Designee

- Initiates the Intake Analysis.
- Confirms physician's order in the medical record.
- Explains significance of the Intake Analysis to the patient or family.
- Optional: Coordinates Intake Analysis with nursing:
  - Gives nurse an "Intake Analysis" sign to post on patient's door
  - Gives nursing copy of "Between Meal Food Intake Log" or "Intake Analysis Form."
  - Instructs patient/family to record food brought from home.

FNSD Clerk

- Maintains information on patients requiring intake analysis, such as in the cardex, on a separate list, on a computer-generated report, etc. (Notes meal to be started per Dietitian instructions).
- For a _____ day period, marks menu and nourishment slips with "Intake Analysis" (or other system that designates that a patient is on intake analysis).

Nursing or FNDS

- Following the meal, evaluates intake and marks the intake of each food item as 0, l/4, l/2, 3/4, all. Clips the menu to the patient I & O clipboard OR:
- Holds menus in designated place or forwards menus to Food & Nutrition Services with the Diet Change Sheet.

Dietitian

- Calculates and reports intake in medical record.
- Documents analysis of results and appropriate plan of care in the medical record.

A list may be used in the Food and Nutrition Services Department and/or posted on Nursing Units, to keep track of Intake Analysis in progress.

_____

Nursing

_____

Food and Nutrition Services

INTAKE ANALYSIS IN PROGRESS

DATE	ROOM #	PATIENT'S NAME	START DATE	END DATE

BETWEEN MEAL INTAKE RECORD

ROOM:_____ NAME:

DATE:		**DATE:**		**DATE:**	
10:00 a.m.	RN Initials	10:00 a.m.	RN Initials	10:00 a.m.	RN Initials
Nourishments		Nourishments		Nourishments	
Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten
2:00 p.m.	RN Initials	2:00 p.m.	RN Initials	2:00 p.m.	RN Initials
Nourishments		Nourishments		Nourishments	
Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten
8:00 p.m.	RN Initials	8:00 p.m.	RN Initials	8:00 p.m.	RN Initials
Nourishments		Nourishments		Nourishments	
Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten	Item(s) Passed	Amount Eaten
Other Foods	RN Initials	Other Foods	RN Initials	Other Foods	RN Initials
	Amount Eaten		Amount Eaten		Amount Eaten

If there are any comments, please write on the back of this form. Thank you.

INTAKE ANALYSIS WORKSHEET

ROOM:_____ NAME:_____

DIET:_____ CALCULATED BY:_____

DAY #: _____ DATE:_____

FOOD ITEM (Specify)	PORTION SIZE	AMOUNT EATEN					CALORIES (Dietitian to Calculate)	PRO (g) (Dietitian to Calculate)
		ALL	3/4	1/2	1/4	NONE		
BREAKFAST								
	SUBTOTAL:*							
MID-MORNING NOURISHMENT:								
	SUBTOTAL:*							
NOON:								
	SUBTOTAL:*							
MID-AFTERNOON NOURISHMENT:								
	SUBTOTAL:							
EVENING:								
	SUBTOTAL:*							
BED-TIME NOURISHMENT:								
	SUBTOTAL:*							
OTHER NOURISHMENT:								
	SUBTOTAL:*							
		TOTAL:						

*** = OPTIONAL**

(Policy #D018)

FYI
Policy #D018

INTAKE ANALYSIS SIGN

An Intake Analysis sign is an optional tool which may be posted on the patient's door in order to alert various nursing shifts as to the Intake Analysis in progress.

INTAKE ANALYSIS -

PLEASE RECORD

AMOUNT OF MEALS

& SNACKS EATEN

Section: CLINICAL NUTRITION SERVICES	**Policy #D019**
Subject: COORDINATION OF ACTIVITIES OF FOOD AND NUTRITION SERVICES DEPARTMENT DIETITIANS WITH OTHER MEDICAL CENTER DIETITIANS	**Date Issued: 5/95** **Date Revised: 1/00**

POLICIES:

Systems of communication and referral have been established between the dietitians of the Food and Nutrition Services Department and other medical center dietitians.

PROCEDURES:

(Describe in-unit system of communication).

Nutrition Support Services Dietitian

Diabetes Center Dietitian

WIC Dietitian

Section: CLINICAL NUTRITION SERVICES	**Policy #D020** **Date Issued: 5/95** **Date Revised: 10/07**
Subject: CLINICAL NUTRITION COVERAGE	

POLICY:

The provision of clinical nutrition services will be consistently monitored and/or offered through a registered dietitian so that patients will receive clinical nutrition services as outlined by policies/procedures and practice guidelines.

PROCEDURES:

Clinical Dietitian

- In the event of vacation or extended illness, the clinical dietitian will notify the Director of Food and Nutrition Services as soon as possible to arrange for clinical nutrition coverage in her absence.

Director

- Include facility's coverage procedure. See FYI page for suggested options.
- Weekend coverage includes: (insert weekend coverage policy, suggestions on FYI page).

Clinical Dietitian Replacement

- Provides proof of credentials, record of continuing education and has been evaluated for competency. Receives orientation to routine policies and procedures and job expectations prior to providing dietitian coverage.

FYI

Policy #D020

CLINICAL NUTRITION COVERAGE

This policy is indicated for single dietitian facilities or facilities where dietitians do not work weekends. It is important that each facility has a plan for dietitian coverage at all times or whenever needed. The following options may be considered. Discuss this policy and procedure with your Regional Director, Operations.

Options:

- Develop partnership agreements with other RDs in your area and make arrangements with them to cover in the absence of the RD.

Other Considerations:

- In the absence of the RD, the diet tech will perform routine duties and upon return the RD will review his/her medical record documentation and co-sign all entries. The RD will assess all high risk patients such as patients receiving tube feedings and TPN.

Weekend Coverage for Single Dietitian Facilities:

- The fulltime RD is on call, by beeper, fax, or voicemail, for nutritional issues. On call services can address diet order questions, supplement/snack issues, enteral/parenteral consults and questions with information given over the phone and make nutrition support recommendations. The RD makes a professional judgment on the need to come into the hospital to provide direct patient care.
- The policy for Further Assessment should be set at "within 48 hours" as the standard response time. In order to meet this, the RD should be on call for patients admitted Friday night. For patients admitted later in the weekend, the RD can see on Monday morning. Use criteria above to identify patients who may need to be seen by RD prior to Monday.
- Outpatient nutritional services are available for the patient referral once discharged.

Weekend Coverage for Non-single Dietitian Facilities:

- A fulltime RD is available *on premise* for a minimum of 8 hours for nutritional issues each weekend. The RD is on call by beeper, fax or voicemail for nutritional issues if not on premise both Saturday and Sunday.

For patients identified at potential nutritional risk from the nurse's initial assessment (admission screen):
Notify the diet clerk of the nutritional concern. The diet clerk will provide automatic nutrition intervention, e.g., patients with poor appetite and weight loss will receive a nourishment with each meal; the patient who is part of the spoken menu process will be visited for preferences, special needs, supplement/snack requests and menu selections. The automatic nutrition intervention process will be in place for all meals until the RD completes the further assessment and determines the plan of care.

For patients discharged needing nutrition education:

- The RD provides nutrition education on Friday for those patients who are expected to be discharged over the weekend. Diet education material, follow-up phone numbers, etc. are provided and documented.
- Discharge nutrition education packets are given to the patient by nursing or the diet clerk. The packet includes a cover letter explaining the packet, nutrition care survival skills, a phone number to call the dietitian for questions, and the phone number for outpatient nutrition services. Once a packet is given, it is documented on the patient's Interdisciplinary Education Record. The RD will follow-up with a phone call to the patient within the week.

Performance Improvement Process
Keep a running log of the weekend admissions, initial assessment (screening) information, consults ordered, the number of times patients received nutrition intervention, and those patients who may have been underserved by not having the RD available on the weekend.

Section: CLINICAL NUTRITION SERVICES	**Policy #D021**
Subject: CLINICAL NUTRITION LOG AND MONTHLY STATUS REPORT	**Date Issued: 5/95** **Date Revised: 10/07**

POLICIES:

A monthly summary of clinical nutrition medical therapies will be provided for the Director of Food & Nutrition Services, administration of the facility, and Regional Team. This information will also be used to adjust clinical staffing as needed.

PROCEDURES:

Providers of Clinical Nutrition Services/Dietitians/Diet Technicians:

- Maintain logs of services rendered on Clinical Nutrition Daily Log.

Clinical Nutrition Manager

- Prepare Clinical Nutrition Status Report. Include at least:
  - Number of inpatient and outpatient consultations
  - Revenue generated, if applicable
  - Groups/classes
  - Community activities
  - Continuing education activities
  - Patient satisfaction scores/activities
  - Goals achieved
  - Goals planned for next month.

Director of Food & Nutrition Services

- Retain reports for 3 years.

Clinical Nutrition Daily Log (Sample)

Excel Form for Data Entry Available on Morrison Today

Productivity															
RD:															Time
Date:															
Hours must be put in military time (24:00)			Inappropriate Referral	Assessment	Intervention/Education	F/U	RN referral	MD consult	Screening	Total Time	Meetings				
Last Name	Medical Rec #	Reason									Pt Sat/Rounding				
										0	Inservices				
										0	Presentations				
										0	Projects				
										0	MD rounds				
										0	Performance Improvement				
										0	Supervisory/Training				
										0	Tray Audits				
										0	AM clerical				0:00
										0	PM clerical				0:00
										0	Clerical Total				0:00
										0	# Pt Satisfaction visited				0
										0	Total hours worked				0:00
										0	0	0	0	0	
										0		Subtract 1/2 hour lunch			0
										0					0
										0	0		0	0	0
										0			Actual minutes		0
										0					
										0			Meal count		
										0					
										0					
										0					
										0					
										0					
										0					
										0					
Daily Totals			0	0	0	0	0	0	0	0					
0	Number patients seen									0					

INSTRUCTIONS: Complete one log daily. On the last day of the week worked, complete weekly totals, staple logs together with page displaying totals on top.

FYI
Policy #D021

CLINICAL NUTRITION STATUS REPORT

The following sample form may be customized to meet your client's needs.

Explanation on how to use the form:

Total Number of Patients Who Received Medical Nutrition Therapy (MNT)

- Refer to the Guide to Clinical Nutrition Services for services to include under this category.
- If last year's information is not available, delete line. However, start keeping track of this information so you can show a comparison as soon as possible. By including last month's number of MNTs, you will inform the client of the consistency of your staff's productivity (or increase/ decrease).

Projects/Activities Related to Patient Care

- Consider including inservice of Catering Associates, *Hospitality, Plus...*, Nutrition Focus Group, *Nutrition Practice Guidelines*, etc.

CLINICAL NUTRITION STATUS REPORT (MONTHLY)
(This is a Sample)
Excel Form Available on Morrison Today

Total Number of In-Patients Who Received Medical Nutrition Therapy	This Year	Previous Year
Nutrition Assessments		
Nutrition Follow Ups		
Nutrition/Diet Education		
Nutrient Intake Analysis		
Total Number of Outpatients who received Medical Nutrition Therapy		
Initial Visits		
Follow Up Visits		
Clinic or Class setting		
Revenue Generated		
Outpatient Services/clinics		

SIGNATURE _____

Participation with Committees/Interdisciplinary Care meetings

Other Meetings

Performance Improvement Activities

Activities related to Quality Control

# of patients visited for meal rounds	
# of test trays completed by clinical staff	
# tray accuracies completed by clinical staff	
# of shadow reports completed by clinical staff	

Projects/Activities Related to Patient Satisfaction

Current Month Score	
Current Quarter Score	

Community Presentations/Projects

Facility Presentation/Projects

Dietetic Association Leadership Activities

Professional Seminars/Continuing Education Attended by Staff

Departmental In-Services Provided by the Clinical Team

Title	Conducted by	For

(Policy #D021)

Section: CLINICAL NUTRITION SERVICES	**Policy #D022** **Date Issued: 5/95**
Subject: CONSULTANT DIETITIAN	**Date Revised: 3/06**

POLICIES:

When the registered dietitian serves only in a consultant capacity, this individual regularly prepares written reports of the services provided.

There is a contract which outlines the services to be provided by the consultant dietitian.

PROCEDURES:

Director

- The Consultant Dietitian will sign an agreement to provide Clinical Nutrition Services. If the Morrison's approved contract is not acceptable, the desired changes will be submitted to the Legal Department in Atlanta.
- Completes personnel file to include the following documents
  - Primary source verification (PSV) from the Commission on Dietetic Registration and for the state (in licensure states).
  - Proof of clinical compentency (reference E009)
    - Peer reviewed chart audits (minimum of 5 charts)

NOTE: Sample contract under References/Resources Tab.

Consultant Dietitian

- Completes a Consultant Dietitian Report and submits it to the Director no more than _____ days following the visit.

- Supplies proof of professional liability insurance coverage of $1,000,000.00 per occurance

Director

- Regularly submits reports of Consultant activities to the Administrator and Regional Director, Operations

- Retains Consultant reports for 3 years.

CONSULTANT DIETITIAN'S REPORT

SUMMARY OF DAY'S VISIT	COMMENTS
CONFERENCES WITH: ___ Administrator ___ Director of Nursing Services ___ Physician ___ Other:	
AREAS REVIEWED/DISCUSSED WITH DIRECTOR OF FOOD AND NUTRITION SERVICES: ___ Food Storage ___ Food Prep./Recipe Use ___ Patient Tray Service ___ Safety Precautions ___ Employees Hygiene Practices ___ Sanitation Procedures ___ *Policies & Procedure Manual* ___ Menu Program/Revisions ___ In-Service Training Program ___ Other:	
ACTIVITIES ACCOMPLISHED: ___ Conducted Patient Visitation ___ Reviewed Medical Records/Charted ___ Counseled Patients/Families ___ Consulted with Head Nurses During Meal Service ___ Observed Meal Preparation ___ Checked Food Temp./Portion Control ___ Observed Meal Service of: _B _N _E ___ Observed Dishwashing Procedures ___ Reviewed Dietary Records (cardex, tray cards, etc.) ___ Reviewed Nourishment Lists ___ Checked Floor Refrigerators ___ Conducted In-Service Program ___ Other:	

RECOMMENDATION	RECOMMENDED ACTION PLAN

FUTURE GOALS

_____ _____ _____

Director of Food and Nutrition Services/Facility | Consultant Dietitian | Date

(Policy #D022)

Section:	CLINICAL NUTRITION SERVICES	**Policy #D023** **Date Issued: 5/95** **Date Revised: 1/03**
Subject:	OUTPATIENT SERVICES	

POLICY:

Outpatient services are scheduled, reported and billed according to facility procedure.

PROCEDURES:

Food and Nutrition Services Department Secretary

Scheduling:

- Receive calls from physician's office, patient, or dietitian, and schedule appointments.
- Time needed:
  - allow 60 minutes for new patients
  - allow 30 minutes for follow-up patients
- When selecting the date, consider the time needed to fill out food records (as directed by dietitian).
- Cancellations: attempt to reschedule.

Patient Data:

- When the physician's office schedules an appointment, obtain information to complete an Outpatient Nutrition Counseling - Data Form.
- When the patient schedules the appointment, follow up with a call to the physician's office to obtain the data.

Reminder Letter to Patient:

- If time permits, send a reminder letter to the patient as well as a Nutrition History Form (plus any food records as directed by the dietitian).
- Cover the following information in the reminder letter:
  - Date and time of appointment
  - Cancellation procedure
  - Where to come for appointment
  - Payment method and receipt for insurance reimbursement provided
  - As appropriate, need to fill out Nutrition History Form or Food Records
  - What to bring: orders from physician and any previous diets.

New Patient Admission

- Patient is informed of use and disclosure of his/her health information per organization's policy and procedures and signs appropriate form, indicating receipt of the information.

After RD has Completed Counseling:

- Schedule follow-up appointment as requested by dietitian. Collect payment per facility policy, i.e., bill insurance company/managed care organization or pay business office.

Ongoing:

- Call no-shows and attempt to reschedule
- Notify physician's office of no-show patients who have failed to reschedule within 2 weeks
- Keep department logs up to date for purposes of utilization analysis
- Implements outcome tracking process

Progress Report:

- Send Progress Report to referring physician.
- File copy in Food and Nutrition Services Department attached to Outpatient Nutrition Counseling Data Form.

OUTPATIENT NUTRITION COUNSELING - DATA FORM

NAME: **PHYSICIAN:**

HOME PHONE: **DIET:**

CLINIC PATIENT? yes / no
O.P. CHART #

PRIVATE PATIENT? yes/no
MEDICARE? yes/no
MANAGED CARE yes/no Company
INSURED yes/no Company

BIRTHDATE:

DIAGNOSIS:

RELEVANT LAB DATA: BS_____ CHOL_____ TG

OTHER:

EXERCISE RESTRICTIONS:

OTHER MEDICAL CONDITIONS:

COMMENTS:

APPOINTMENT DATE: **MAILING ADDRESS:**

TIME:

LETTER SENT:

FORMS SENT: NUTRITION HX / HEALTHY HEART FOOD REC/EATING HABITS DIARY

(Policy #D023)

FYI

Policy #D023

REMINDER LETTER TO PATIENT

Date: _____

Address:

_____

_____

_____

Dear _____:

Your appointment with the dietitian has been set for _____. If you are unable to keep this appointment, please call by_____. When you come for your appointment, go to _____ and inform the receptionist that you have an appointment with the dietitian. She will call us so that we can meet you and take you to our office.

Payment for services can be made by cash, check, MasterCard or Visa. A receipt will be provided which can be filed with your insurance company. (Reimbursement varies with insurance companies.)

Please bring any written orders from your physician and any old diets that you have been following. Enclosed are Nutrition History forms which we would appreciate your completion prior to your appointment. Please bring the completed forms with you. We look forward to working with you.

Sincerely,

Clinical Dietitian

Enclosures

NUTRITION QUESTIONNAIRE

Please answer the questions as completely as possible.

NAME:

ADDRESS:

PHONE NUMBER:_____WORK _____HOME

AGE:_____ HEIGHT:_____FT _____IN CURRENT WEIGHT_____LBS

OCCUPATION:

DO YOU CURRENTLY FOLLOW A SPECIAL DIET? _____YES _____NO

IF YES, WHAT KIND?

DO YOU HAVE ANY MEDICAL CONDITIONS? _____YES _____NO

IF YES, WHAT KIND?

DO YOU TAKE ANY MEDICATIONS? _____YES _____NO

IF YES, WHAT KIND?

DO YOU TAKE A VITAMIN/MINERAL SUPPLEMENT? _____YES _____NO

IF YES, WHAT KIND?

DO YOU HAVE ANY FOOD ALLERGIES? _____YES _____NO

IF YES, WHAT KIND?

HOW MANY ARE IN YOUR HOUSEHOLD?____ WHAT IS YOUR WEEKLY FOOD COST?

HOW MANY MEALS PER DAY DO YOU EAT?

HOW MANY SNACKS DO YOU EAT BETWEEN MEALS?_____ PER DAY.

WHO PREPARES THE MEALS?

HOW MANY MEALS DO YOU EAT AWAY FROM HOME?_____ PER WEEK.

HOW MANY ALCOHOL-CONTAINING BEVERAGES DO YOU HAVE?_____ PER WEEK.

IS SALT USED IN THE PREPARATION OF YOUR FOOD? _____YES _____NO

DO YOU ADD SALT TO YOUR FOOD AT THE TABLE? _____YES _____NO

HOW WOULD YOU DESCRIBE THE WAY YOUR FOODS ARE PREPARED MOST OFTEN?
_____ prepared with fat, i.e., butter, margarine, shortening, oils, sauces
_____ prepared without fat

WHAT TYPES OF PHYSICAL ACTIVITY (walking, cycling, etc.) DO YOU UNDERTAKE?

HOW OFTEN:_____ TIMES PER WEEK:_____ TIMES PER MONTH:

NUTRITION HISTORY

Please indicate how often you eat the following listed foods by checking the appropriate box.

FOOD ITEM	ALMOST DAILY	ALMOST WEEKLY	MONTHLY	SEASONALLY/ HOLIDAYS	NEVER
Milk (what kind)					
Yogurt					
Ice Cream					
Cheese					
Eggs					
Sausage/Bacon					
Luncheon Meats					
Hot Dogs					
Liver					
Gravy					
Bread					
Cereal					
Vegetables					
Fruit					
Fruit Juice					
Snack Chips					
Candy					
Desserts					
Soft Drinks (regular) (diet)					
Frozen Dinners					
Canned Soup					
Fried Food					
Meat - Beef/Pork					
Meat - Chicken/Turkey					
Fish/Shellfish					
Nuts					
Alcohol/Beer/Wine					

YOUR FOOD RECORD

Please record the food/drink you would choose for a typical day's meals and snacks. Include the sugar added to beverages, butter on bread and vegetables, the dressing on salads, etc.

TIME	PLACE	AMOUNT	FOOD/DRINK	HOW WAS IT PREPARED?
Example: 6:00 p.m.	home	1 large	potato	baked with 1 tbsp. margarine and 2 tbsp. sour cream

FOR OFFICE USE ONLY

CALORIES_____ FAT_____ SODIUM

(Policy #D023)

001133

Section:	CLINICAL NUTRITION SERVICES	**Policy #D024** **Date Issued: 10/07**
Subject:	CLINICAL PRIVILEGES	**Date Revised:**

POLICIES:

Clinical privileges may be extended to Registered Dietitians if they are approved in the hospital by-laws, and consistent with state and federal regulations, state licensure statutes, Joint Commission and other accrediting agency standards and the Scope of Dietetics Practice of the American Dietetic Association.

PROCEDURES:

Registered Dietitians practice within the Scope of Dietetics Practice framework.[1]

Clinical privileges which exceed the Scope of Dietetics Practice are approved by the hospital and documented in the by-laws. This list includes, but is not limited to:

- Independently writing therapeutic diet orders
- Performing processes that break the skin, such as a finger stick
- Providing services that are considered medical level of care
- Ordering nutrition related labs
- Instruction on the use of an insulin pump
- Taking blood pressure
- Recommending medications
- Acceptance of verbal orders*

Preparation for the request for approval and inclusion of a clinical privilege in the hospital's by-laws includes a review of all of the following to ensure that proposed activity is appropriate:

- Review of regulations that hospital must meet to operate (federal and state regulations)
- Review of standards that hospital must meet to maintain accreditation (Joint Commission or the Healthcare Facilities Accreditation Program of the American Osteopathic Association)
- Review of state licensure regulations for dietitians
- Review of the Scope of Dietetic Practice of the American Dietetics Association
- Use the Scope of Dietetics Practice Framework Decision Analysis Tool in conjunction with or separate from the Scope of Dietetics Practice Framework Decision Tree. [1]

Dietitians may seek to implement hospital-approved nutrition protocols which include advanced level practice, such as writing of diet orders, and is ordered by the physician on a patient-by-patient basis.

The hospital may determine that an activity, such as diet order writing, is medical level of care and require that the registered dietitian be credentialed, as a means to demonstrate their competence.[2]

When clinical privileges are granted and documented in the hospital's by-laws, an addendum is attached to the job description which lists the specific privileges granted, the date approved and reapproval dates. The content of the addendum must be reviewed and approved by the Division Director, Nutrition.

*NOTE: As described in the State Operations Manual, Appendix A – Survey Protocol, Regulations and Interpretive Guidelines for Hospital (Rev.1, 5-21-04), 482.23 (c) (2): "Verbal communication of orders should be limited to urgent situations where immediate written or electronic communication is not feasible."

[1]O'Sullivan-Maillet J, Skates J, Pritchett E. American Dietetic Association: Scope of Dietetics Practice Framework. *J Am Diet Assoc.* 2005;105:634-640.

[2]Hager M. Hospital therapeutic diet orders and the Centers for Medicare and Medicaid Services: Steering through regulations to provide quality nutrition care and avoid survey citations. *J Am Diet Assoc.* 2006;106:198-204.

FYI

Policy #D024

Ordering of Therapeutic Diets

In August 2005, the Centers for Medicare and Medicaid Services (CMS) issued a revision to the Interpretive Guidelines that address the writing of diet orders (482.28 (b) (1)). The result has been that advanced level practices that were previously accepted or assumed must be reviewed to ensure they are in compliance with all applicable regulations and standards. An example of this involves the writing of diet orders by registered dietitians.

In September 2005, representatives from CMS and ADA met to gain an understanding of the regulations on writing of orders for therapeutic diets and their application to registered dietitians. ADA issued a White Paper [1] in September 2006 outlining the discussions. Refer to this paper for a review of the options available to physicians who prefer a greater involvement by the registered dietitian in writing diet orders, when granted by the hospital by-laws and in compliance with hospital regulations and standards.

Opinions on the latitude that dietitians have in implementing the physician-prescribed diet order vary greatly, with the most restrictive being that the dietitian cannot implement a snack, downgrade the texture of a diet or start a nutritional supplement without a physician order. Contact your RCNM or DDN if you have further questions.

Advanced Level Practice

The American Dietetic Association has developed standards which describe competent performance.[2] Registered dietitians may also choose to specialize in specific types of care. Three Dietetic Practice Groups have developed guidance on the skills needed by Registered Dietitians to practice at the generalist, specialty or advanced level in diabetes care[3], behavioral health care[4] and oncology nutrition care[5].

[1] American Dietetic Association. White Paper: 482.28 Conditions of Participation: Food and Dietetic Services Interpretive Guidelines for Therapeutic Diet Orders. http://www.eatright.org/ada/files/Therapeutic_Diet_Order_White_Paper_083006.pdf. Accessed August 28, 2007.

[2] Kieselhorst K, Skates J, Pritchett E. American Dietetic Association: Standards of Practice in Nutrition Care and Updated Standards of Professional Performance. *J Am Diet Assoc.* 2005;105:641-645.

[3] Kulkarni K, Boucher JL, Daly A, Shwide-Slavin C, Silvers BT, O'Sullivan Maillet J, Pritchett E. American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty and Advanced) in Diabetes Care. *J Am Diet Assoc.* 2005;105:819-824.

[4] Emerson M, Kerr P, Del Carmen Soler M, Anderson Girard T, Hoffinger R, Pritchett E, Otto M. American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty and Advanced) in Behavioral Health Care. *J Am Diet Assoc.* 2006;106:608-613.

[5] Robien K, Levin R, Pritchett E, Otto M. American Dietetic Association: Standards of Practice and Standards of Professional Performance for Registered Dietitians (Generalist, Specialty and Advanced) in Oncology Nutrition Care. *J Am Diet Assoc.* 2006;106:946-951.

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Perioperative Services
Operating Room

Abortion Dilatation & Suction, Elective

I. Policy Statement

No physician or other immediately involved personnel shall be compelled to perform any act which violates his/her good judgment. Neither physician nor any other person associated with the hospital shall be required to perform any act that violates personally-held moral connections.

II. Purpose

To define the parameters under which abortions are performed at MetroWest Medical Center, Framingham Union Hospital.

III. Procedure

- They may be booked per convenience of physician and patient. Bookings must be made 24 hours prior to schedule date.
- Consultation: Abortions performed during the first 12 weeks of pregnancy do not require a consultation.
  Abortions performed after 12 weeks of pregnancy and up to 24 weeks will need a consultation by another physician on the staff of the hospital but not affiliated with the same corporation, partnership or association as the physician requesting consultation.
  No abortions shall be performed after 24 weeks of pregnancy except in an emergency that requires immediate action.

  Abortion procedures are to be performed in the O.R. only.
- Written consents shall be obtained by the physician performing the abortions using forms provided by the Commissioner of Public Health. The following signature shall be obtained as appropriate:
  a. Patient's signature at least 24 hours prior to the procedure, except in emergencies
  b. Husband's signature (optional)
  c. Unmarried Minor Females (under age 18)
     i. The physician must obtain her consent and the consent of her parents or guardian. If one of the woman's parents has died or is unavailable within a reasonable time and in a reasonable manner, consent of the remaining parent is sufficient. If both of the woman's parents have died or are otherwise unavailable within a reasonable time and in a reasonable manner, consent of the woman's guardian(s) is sufficient. If the woman's parents are divorced, consent of the parent having custody is sufficient.
     ii. If one or both parents or her guardian refuse to consent to the abortion, or if the woman elects not to seek the consent of one or both of her parents or guardian, a Judge of the Superior Court Department of the Trial Court may, upon petition or motion, and after a confidential hearing, authorize a physician to perform the abortion.
     iii. The Judge must determine that the woman is mature and capable of giving informed consent, or, if the Judge determines that she is not mature, that the operation is in her best interest. The woman may participate in the court proceedings on her own behalf, and the Court may appoint a guardian ad litem for her. She also has the right to court appointed counsel.

4. Check patient's type and screen.

:

Definitions:

Guardian ad Litem is a volunteer appointed by the court to protect the rights and advocate the best interests of a child involved in a court proceeding.

Abortion is the termination of a pregnancy by the removal or expulsion from the uterus of a fetus/embryo, resulting in or caused by its death

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Contact:	Educator Perioperative Services
Effective Date	**6/17/93**
Reviewed:	**8/8/94, 11/99, 6/06, 9/09; 8/12**
Revised:	**9/11/96, 8/98, 12/99, 7/03**
Approved by:	
Signatures:	Barbara Wilson, MSN, MBA, RN, CNOR (original signature on file) V. P. Perioperative Services

SUBJECT: CYTOTEC - (MISOPROSTOL), (PROSTAGLANDIN E 1) FOR TERMINATION OF PREGNANCY	REFERENCE #
DEPARTMENT: PERINATAL	PAGE: 1 of 2
APPROVED BY:	EFFECTIVE: 9/2003
	SUPERCEDES: 1/1997
	Reviewed: 7/06, 9/09

POLICY: **USE OF CYTOTEC (MISOPROSTOL), (PROSTAGLANDIN E 1) FOR TERMINATION OF PREGNANCY**

PURPOSE: To terminate pregnancy in the following instances:

- The evacuation of uterine contents in the management of missed abortion or intrauterine fetal death.
- The evacuation of uterine contents in the management of 2nd trimester terminations up to 22 weeks gestation.

SPECIAL CONSIDERATIONS:

- Any physician or nurse who feels he/she is unable to care for the family due to religious or moral reasons should contact the nurse manager/clinical coordinator.

PROTOCOL:

- An attending phyisican or resident (PGY II or greater) must be on the hospital premises at the time of initiation of Misoprostol therapy.
- Misoprostol dosages:
    - 200 micrograms q 12 hours for a total of 4 doses only for second trimester abortions.
    - 100 micrograms q 12 hours for a total of 4 doses only for third trimester abortions.
- Misoprostol tablet (moistened with water) is inserted into the posterior vaginal fornix by the attending physician or resident.

SUBJECT: CYTOTEC - (MISOPROSTOL), (PROSTAGLANDIN E 1) FOR TERMINATION OF PREGNANCY	REFERENCE #
DEPARTMENT: PERINATAL	PAGE: 2 OF: 2
APPROVED BY:	EFFECTIVE: 9/2003
REVIEWED: 9/09	SUPERCEDES: 1/1997

- After 32 weeks gestation, a previous uterine incision is a contraindication for use of Misoprostol.

- A saline lock or IV is started prior to the administration of Misoprostol.

- Blood tests should include CBC, type and screen, and fetal demise panel.

- Baseline VS are recorded prior to insertion of the medication. BP, P, & R are obtained q 30 minutes and temperature q 1 hour for 2 hours. The VS are done q 1 hour thereafter.

- The patient is carefully monitored for changes in VS, adverse side effects, and progress of labor.

- One dose of terbutaline 0.25 mg SC is kept at the bedside in case of hyperstimulation.

- Please refer to the following Standards of Care:

    - The Grieving Process – Fetal Death
    - The patient with Termination of Pregnancy

SUBJECT: PROCEDURES WHICH MAY BE PERFORMED IN LABOR AND DELIVERY SUITE	REFERENCE #
DEPARTMENT: PERINATAL	PAGE: 1 of 1
APPROVED BY:	EFFECTIVE: 9/2003
	SUPERCEDES: 2/1999
	Reviewed: 8/06, 9/09

POLICY: **PROCEDURES WHICH MAY BE PERFORMED IN THE LABOR AND DELIVERY SUITE**

PURPOSE: To identify those procedures other than vaginal and cesarean births which may be Performed in the delivery suite.

PROTOCOL:

- Only obstetrical procedures may be performed in the delivery suite.
- Tubal ligation at the time of cesarean section may be performed.
- Tubal ligation immediately following vaginal birth may also be performed in the suite designated for cesarean section.
- In an emergency an immediate postpartum hysterectomy (with hypogastric artery ligation if necessary) may be performed in the cesarean section room.
- Placement of circlage.
- Other patients with threatened or spontaneous abortion routinely will be admitted to the third floor. If a D&C is necessary, it will be performed in the O.R. unless it is an emergency or the O.R. is not available. In this case, at the discretion of the charge nurse in collaboration with the physician, these patients may be admitted and treated in the delivery suite including D&C if necessary.
- Terminations of pregnancy may be performed in the following instances:
    - The evacuation of uterine contents in the management of missed abortion or intrauterine fetal death.
    - The evacuation of uterine contents in the management of second trimester terminations up to 22 weeks.

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Do Not Resuscitate (DNR) Orders

I. Policy Statement

The commitment of the staff at MetroWest Medical Center to the health and well being of patients establishes an ethical and legal presumption in favor of attempting resuscitation to preserve the patient's life, unless the patient or patient surrogate decision maker states a desire not to be resuscitated when cardiac or respiratory arrest occurs. Patients have a right to refuse resuscitation.

II. Purpose

To describe the guidelines and procedures for initiating or discontinuing Do-Not-Resuscitate (DNR) orders.

III. Definitions

A. Resuscitate: A medical intervention intended to restore cardiac or respiratory functions in a patient whose respirations or heartbeat has stopped.

B. Resuscitation Measures: Measures undertaken in a resuscitative effort, including but not limited to the following: chest compression, endotracheal intubation, manual ventilation, mechanical ventilation, defibrillation, use of emergency cardiac drugs and the use of electric pacemakers.

C. Do Not Resuscitate Order: An attending physician's order, "DNR" means that none of the resuscitative measures are to be undertaken to resuscitate the patient when cardiac or respiratory arrest occurs.

D. Attending Physician: The attending physician is usually the patient's primary care physician or the physician covering his or her practice.

E. Substitutive Judgment: In those instances in which a patient is deemed incompetent or incapacitated, a designated person, the surrogate, will assist in the decision-making process, representing what he or she understands to be the patient's wishes.

IV. Categories of Patients

A. Patients arriving with a pre-existing DNR document

Patients en route to the hospital who have both a signed Massachusetts Department of Public Health Comfort Care/Do Not Resuscitate ("DNR") Order Verification form or a purple wristband will not be resuscitated by emergency medical technicians. Patients wearing a "Comfort Care" bracelet will have their care preference honored in the Emergency Department and in all ambulatory and inpatient areas of MetroWest Medical Center.

B. Patients in the hospital

1. Competent patient: A patient who is presumed competent and able to understand and make judgments about his or her medical care.

2. Incompetent patient: A patient who has been declared incompetent by a judge and has been appointed a guardian. Unemancipated minors under the age of 18 are considered incompetent.

3. Emancipated minor: A competent person under eighteen (18) years of age who is (M.G.L. 112.s.12F) married widowed, divorced, the parent of a child, a member of any of the armed forces, pregnant or believes herself to be pregnant, living separate and apart from his/her parent or legal guardian and managing his/her own financial affairs or has been adjudged "emancipated."

4. Incapacitated patient: A patient who has not been adjudged incompetent but who appears to lack the capacity (mental or physical) to understand or make judgments about a DNR decision. In these instances, a staff psychiatrist evaluates and documents the patient's capacity to understand and make judgments about his or her medical care.

V. Substitutive Judgment (Surrogate)

A. The patient's guardian first and the health care proxy second are recognized in Massachusetts law to be in a position to provide substitutive judgment. Copies of the court order of health care proxy form must be placed in the medical record.

B. In the absence of a surrogate with legal substitutive judgment status, the usual hierarchy (highest authority to lowest authority) of surrogate decision making authority is spouse, adult children, parents, adult siblings, or nearest relative. Exceptional situations may occur. If the patient is a minor, the authority rests with the custodial parent(s).

C. In the absence of any surrogate, family member, close friend, pre-existing DNR order of known patient wishes, consultation with the ethics committee is recommended.

VI. Procedure

A. Writing a DNR Order

1. The Attending physician fully informs the patient or the patient's surrogate about the patient's medical condition and the risks and benefits of the available treatment options.

2. The attending physician listens to the patient and the surrogate to fully understand the patient's wishes with respect to resuscitation.

B. Discontinuing a DNR Order

1. A DNR order may be discontinued by the attending physician in response to a request for discontinuation made by the patient or surrogate.

2. Before a perioperative period, defined as beginning with the anesthesia induction and ending with discharge from the operative or procedure area, a surgeon or anesthetist may ask the patient or surrogate to discontinue and afterward reinitiate the DNR order. This discontinuation must be approved in advance by the patient or surrogate.

VII. Documentation and Review

A. When a DNR order is decided, the attending physician writes, "Do Not Resuscitate" or "DNR" with the date and time on the order sheet in the medical record. When a DNR order is discontinued, the attending physician writes, "Discontinue DNR Order" or "Patient is Full Code."

B. At the time of writing or discontinuing the DNR order, the attending physician documents in the medical record the discussions that led to the DNR decision. This documentation includes a description of the information provided to the patient, the patient's understanding of that information, and the patient's wishes with respect to DNR.

C. In extraordinary circumstances, the attending physician may give the DNR order by telephone. In such cases, the attending physician signs the DNR order and records the process in the medical record within 24 hours.

D. The attending physician reviews the DNR order, consulting as appropriate with the patient and caregivers of the patient, on approximately a weekly basis or as frequently as the attending physician deems appropriate, and documents the time, date, and results of each such review in the medical record.

E. Unless discontinued in accordance with Section VI B, the DNR order remains in effect for the duration of the patient's hospital admission. The DNR order automatically expires upon discharge unless the patient or surrogate decides to continue it.

F. Code status must be clearly documented before the patient leaves the perioperative area.

VIII. Identification of the DNR Patient

A. Patients with a DNR order are identified by a purple wristband.

B. When the DNR order is written, the RN/LPN transcribing the order s applies a purple wristband, with the patient's information, and attaches the band to the patient's wrist in addition to the white identification band attached on admission.

C. The DNR order is also written and dated on the nursing Kardex and Clinical Documentation system.

D. If the DNR order is discontinued, the purple wristband is removed.

E. The RN/LPN documents in the nursing note when the purple DNR wristband is added or removed.

IX. Role of the Ethics Committee

Any individual who has ethical questions concerning a DNR order may refer his/her concern to the Ethics Committee.

X. Role of Hospital Administration

Hospital administrative staff, as represented by the nursing director, nursing supervisor, department chairman, chief medical officer, chief nursing officer, or the administrator on call, is contacted prior to writing or discontinuing a DNR order for an incompetent or incapacitated patient in the following circumstances:

A. The attending physician believes a DNR order is appropriate and the immediate family disagrees.

B. The immediate family believes that a DNR order is appropriate and the attending physician disagrees.

C. There is a disagreement among the members of the patient's immediate family regarding the appropriateness of a DNR order.

D. The patient had, while competent, requested resuscitation and is now incapacitated.

E. There is no surrogate or other family member available.

Contact:	Chief Medical Officer	
Reviewed:	9/2000, 7/2002, 8/2003	
Revised:	4/1995, 2/1997, 4/2005, 11/2006, 4/2011	
Approved by:	Ethics Committee	4/14/2011
	Policy Review Committee	4/20/2011

Signatures:

Chief Medical Officer

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

Medical Nutrition Therapy

POLICY:

All physicians will review and approve the Registered Dietitians (RD) recommendations on the Medical Nutrition Therapy Clarification Form.

PURPOSE:

To provide documented physician approval for any Medical Nutrition Therapy (MNT) recommendations.

IMPLEMENTATION:

DEFINITION:

Qualified Dietitian:

1. Maintaining registration through the Commission on Dietetic Registration, and
2. Maintaining licensure through the Massachusetts Department of Professional Regulation, and
3. Demonstrating Clinical Nutrition competency as verified by the Clinical Nutrition Manager initially and as part of quarterly chart audits and annual performance appraisals

GUIDELINES:

1. The Practitioner:
    a. Has direct control of patient care in all cases and at all times
    b. Signs the recommendations per the Medical Nutrition Therapy Order form.

2. The RD:
    a. Must be qualified as defined above
    b. Comprehensive nutrition assessment performed by the qualified dietitian
    c. Provide recommendations to the MD on the Medical Nutrition Therapy Order form.

RD will provide recommendations to:

1. Modify Diets
    a) Change diet texture and/or liquid consistency based on patient tolerance, request, suspected swallowing dysfunction, or as recommended by Speech Therapy (ST), i.e. Change from Regular to Mechanical Soft diet or Thin to Nectar-thick liquids

    b) Modify diets to a more restrictive diet when warranted for clinical condition or patient request,

    c) Liberalize the diet order if the patient is consuming < 50% of meals

    d) Determine or modify the sodium, phosphorus, protein and potassium restrictions on the Renal diet for patients on dialysis to avoid unnecessary restrictions

2. Fortify Diets
    a) Initiate, change, or stop nutrition supplements within the diet order based on the RD's nutrition assessment or patient request

b) Initiate, change, or stop modular supplements based on the RD's nutrition assessment for increased needs of specific nutrients

3. Supplement Diets with Vitamins and Minerals
   a) Order a multivitamin/mineral (MVI) in pill or liquid form when diet intake is inadequate to achieve 75-100% of the RDA, presence of pressure ulcers, or p.o. intake < 75% of meals (specify renal vitamin preparation for patients with chronic kidney disease)

   b) Order 500 mg Vitamin C twice per day if patient has Stage II or greater pressure ulcers or non-healing wounds (except for patients with chronic kidney disease)

   c) Order 10,000 International Units of Vitamin A per day for 10 days if patient has Stage III or IV pressure ulcers or non-healing wounds (except for patients with chronic kidney disease)

   d) Order 220 mg Zinc Sulfate x 10 days if patient has Stage III or IV pressure ulcers or non-healing wounds

4. Order Labs and Other Metabolic Tests
   a) For monitoring of safe provision of nutrition/diet regimens and adequate nutrition therapy, the RD may recommend:
      1.) For general nutrition assessment: Albumin/Pre-albumin, 25-hydroxyvitaminD, Zinc, Vitamin C
      2.) For Nutrition Support: Pre-albumin, Magnesium, Phosphorus, Ionized Calcium, LFT's, Nitrogen Balance, and Triglycerides

5. Order Other interventions
   a) Obtain Heights and / or weights to assist in completion of a nutrition assessment or reassessment

   b) Write order for identified food allergies

6. Initiate or Modify Enteral Nutrition
   a) Order and daily management

   b) Substitute a hospital approved formula that has a similar nutrient profile

   c) Change the formula to meet the metabolic and medical needs of the patient

   d) Change the goal rate or current infusion rate to meet calorie, protein and nutrient needs

   e) Adjust the amount of water given per tube feeding flushes to meet patient's fluid needs if patient is not on a fluid restriction

   f) Decrease the rate to estimated nutrition needs if the current rate promotes overfeeding or refeeding syndrome

   g) Adjust the infusion rate based on patient's tolerance or medical changes

   h) Write for acceptable gastric residual volume goals for patient tolerance

   i) Write the nocturnal or bolus TF regimen if the physician writes an order to "Change TF to Bolus / Nocturnal feedings per RD"

7. Initiate or Modify Parenteral Nutrition (PN) – TPN & PPN
   a) Using the hospital's approved TPN order form and protocol

   b) Adjust the PN rates to meet nutritional and hydration needs

c) Change the macronutrient (carbohydrate, protein, fat) composition to meet nutrient and metabolic needs, adjust micronutrients and additives to meet metabolic needs or acid/base balance, and adjust total volume

Contact:	Nutrition	
Reviewed:	March 1999, September 2000, July 2002	
Revised:	February 1997, November 2010	
Approved by:	Policy Committee	November 17, 2010
	Pharmacy & Therapeutics	February 9, 2011

Signatures:

Emily Lotterhand, MBA, RD, LDN
Director of Nutrition Systems

Christine Brzozowski
Chairperson of Policy Committee

Linda Mansfield
Director of Quality & Patient Safety

MetroWest Medical Center
Framingham Union Hospital • Leonard Morse Hospital

M.POORDER

PHYSICIAN ORDERS - Medication and Treatment

MEDICAL NUTRITION THERAPY ORDERS

Orders valid only if checked (✓)

A Physicians Signature is Mandatory Prior to Implementation of this Order

ALLERGIES: (If None, so indicate) ❑ **None**

Date:	**Time:**	**Pt. Weight:** _____ ; **Height:** _____

Therapeutic Diet

Therapeutic Diet Recommendations:

❑ Change diet from _____ to _____

Fortify Diets

Add the following nutrition supplement:

√ Oral Liquid Nutritional Supplement per Registered Dietician (RD)/ patient preference

❑ Ensure ___ times per day	❑ Ensure Clinical Strength ___ times per day
❑ Glucerna Shake ___ times per day	❑ Ensure Plus ___ times per day
❑ Mighty Shakes ___ times per day	❑ Mighty Shakes No Sugar Added ___ times per day
❑ Ensure Pudding ___ times per day	❑ Enlive ___ times per day
❑ Juven with breakfast and lunch	❑ Promod Liquid Protein ___ times per day
❑ Nepro ___ times per day	❑ Other _____

Medications: Vitamins and Minerals – For Pharmacy

❑ Multivitamin with minerals one tablet by mouth daily
❑ Renal Vitamin one tablet by mouth daily
❑ Vitamin C ___mg by mouth ___ times per day
❑ Zinc Sulfate 220mg by mouth daily ___ days
❑ Multivitamin one tablet by mouth daily

Enteral Nutrition

Add/Modify the following enteral tube feeding:

❑ Jevity 1.2 Cal	❑ Jevity 1.5 Cal	❑ Promote
❑ Nepro	❑ Osmolite 1.2 Cal	❑ Glucerna 1.2 Cal
❑ Promote w/fiber	❑ Osmolite 1.5 Cal	Other
	❑ Vital AF 1.2 Cal	_____

Additive:

❑ Promod: 30 ml ___ times per day
❑ Juven ___ times per day

Physician /NP/PA Signature **Printed name:** **Beeper #**

MetroWest Medical Center
Framingham Union Hospital · Leonard Morse Hospital

* M . P O O R D E R *

PHYSICIAN ORDERS - Medication and Treatment

MEDICAL NUTRITION THERAPY ORDERS

Orders valid only if checked (✓)

ALLERGIES: (If None, so indicate) ❑ **None**

Date:	**Time:**	**Pt. Weight:** _____ ; **Height:** _____
	Administer ❑ Start tube feeding at ___ ml/hour via _____ ❑ Advance by ___ml/hr every ___ hours ___ to goal of ___ml/hour ❑ Bolus with ___ ml (feeding/formula) every ___ hours	❑ Continuous infusion of ___ ml/hr from ___pm to ___ am ❑ Add water flushes of ___ ml every ___ hours ❑ Water flushes per MD ❑ Head of bed 30° to 45° at all times
Labs	**Labs and Other Metabolic Tests**: **Labs to be drawn** _____ ❑ Liver Function Panel (**LF**) ❑ Magnesium (**MG**) ❑ Ionized Calcium (**CAION**) ❑ Vitamin C (**VITC**) ❑ Ferritin (**FER**) ❑ Nitrogen Balance (24 hr urine for urea nit, collect from midnight to midnight) (**TUUN**)	❑ Pre-albumin (**PREALB**) ❑ Phosphorus (**PHOS**) ❑ Vitamin D, 25OH (**VITD**) ❑ Triglycerides (**TRIG**) ❑ Serum B12 (**B12**) ❑ Folate (**FOL**) ❑ Iron (**IRON**) ❑ Serum Zinc (**ZINC**)

Physician /NP/PA Signature **Printed name:** **Beeper #**

NO ORDERS WRITTEN IN THIS AREA WILL BE ACCEPTED

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

End of Life Care

I. **Policy Statement:**
MetroWest Medical Center ensures that patients and their families receive care at the end of life that promotes patient comfort, preserves patient dignity and provides evidence based care that meets their physical, spiritual and emotional needs.

II. **Purpose:**
To provide guidance to all healthcare providers caring for patients and their families at the end of life.

III. **Definitions:**
Comfort Care:
Interventions ordered by the attending physician or his/her designee for patients who will no longer benefit from therapeutic efforts to control or treat the medical conditions that imminently threatens the patient's life and whose life expectancy is a matter of days to hours. Comfort care meets the physical, psychosocial and spiritual needs of the patient and family at the end of life.

IV. **Procedure:**
General Guidelines:
A. Implement and honor wishes of the patients' advanced directive
B. Obtain a Do Not Resuscitate (DNR) order
C. Implement comfort care orders that do not exclude specific therapeutic efforts;
D. Enlist appropriate members of the healthcare team to address the physical, spiritual and emotional needs of the patient and their family
E. The following measures may be initiated taken to provide comfort to the patient

Pain
- Pain assessment includes the assessment for differential diagnoses including anxiety, urinary retention, constipation, nicotine or alcohol withdrawal, sleep deprivation, respiratory distress and drug related side effects
- Assume the pain stimulus is still present even if the patient is unresponsive
- Maintain analgesia; titrate analgesics to optimal comfort
- Avoid acute opioid withdrawal or pain crisis from abrupt discontinuation or reduction of opioid by > 50%/24 hr or administration of opioid antagonist
- Pain relief may be more important than alertness. Re-evaluate based on patient and family preferences
- Assess vital signs to ensure adequacy of pain relief. Do not reduce dose of opioid dose solely for decrease in blood pressure or respiratory rate. If the patient is comfortable, the frequency of vital signs may be reduced
- Modify routes of administration as appropriate (PO, IV, SQ, PR) applying equivalent dose conversions

Delirium/Agitation/Terminal Restlessness
- Assess for causes of delirium/agitation/terminal restlessness such as anxiety, urinary retention, constipation, nicotine or alcohol withdrawal, sleep deprivation, respiratory distress and drug related side effects
- Provide patient and family support
- For medication management refer to **End of Life Symptom Management Orders**

Anorexia/Cachexia
- Assess patient and families perception of anorexia and cachexia
- Inform patient and family of the following:
  - ► Absence of hunger and thirst may be normal in the dying patient
  - ► Nutritional support may not be metabolized in these patients
  - ► Nutritional support and hydration may cause discomfort, fluid overload, and hasten death
  - ► Symptoms such as dry mouth can be treated effectively with mouth care

Dyspnea and Terminal Secretions

- Assess symptom intensity
- Relieve symptoms with goal of optimizing comfort
  - ► Oxygen if patient reports relief; otherwise may not be indicated
  - ► Non-pharmacologic therapies such as massage, breathing techniques, re-positioning and music therapy
  - ► For medication management refer to **End of Life Symptom Management Orders**

Anxiety

- Assess cause of anxiety e.g. fear, dyspnea etc.
- Non pharmacologic measures such massage, breathing techniques
- For medication management refer to **End of Life Symptom Management Orders**

Nausea and Vomiting

- Refer to **End of Life Symptom Management Orders**

Constipation

- Refer to **End of Life Symptom Management Orders**

Hopelessness, Spiritual and Emotional Concerns

- Assess patient and family's spiritual and emotional concerns
- Invite the patient to participate in decision making as much as possible
- Consult with chaplain/social worker to guide patient and family through the end of life process
- Encourage family members to participate in patient's care as appropriate

V. References

Contact:	Nursing Administration	
Reviewed:	September 2006	
Revised:	June 2003, October 2006, February 2007, May 2012	
Approved by:	Policy Review Committee	5/16/12

Signatures:

Senior Director of Nursing

Chairperson of the Policy Review Committee

Vice President of Quality & Patient Safety

METROWEST MEDICAL CENTER Framingham Union Hospital • Leonard Morse Hospital **EMERGENCY DEPARTMENT POLICY AND PROCEDURE**	Effective Date: Reviewed: 8/03 7/06 7/09 7/12
Subject: **SEXUAL ASSAULT VICTIM CARE**	Revised: 10/93 3/97 2/00 9/00 3/02 6/05 7/08 7/09 8/10

POLICY:

A. The examination of sexual assault victims involves an interface between the medical and the legal professions. Detailed and carefully documented information is needed to aid the police investigation and to provide corroborating evidence in court, as well as for the health needs of the victim.

B. The victim should be encouraged to report the crime to the police. It is her/his choice and responsibility to do so. Reporting of the case is not the responsibility of the emergency staff members and should be avoided unless the patient wishes to do so.

C. Whether the victim decides to press charges or not, the anonymous, STATE MANDATED PROVIDER SEXUAL CRIME REPORT FORM 2A, located in the Sexual Assault Kit, is to be filled out completely out (see Attachment 1). The report is faxed to the EOPS at (617) 725-0260 and called or faxed to the local public safety authority where the incident occurred. The victim remains anonymous in the reporting. The filing should be done within 24 hours.

D. Recording of all findings must be placed on the sexual assault reporting forms located in sexual assault kit. The Massachusetts Sexual Assault Evidence Collection Kit should be used on all alleged sexual assaults in order to collect evidence in an accepted procedure.

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Definition: The legal definition of rape in Massachusetts is a sexual act performed without consent and with the use of threat or force.

E. All patients reporting sexual assault or attempted sexual assault should be urged to have a medical examination. Medical examination documentation and evidence collection should be done in accordance with the Massachusetts Sexual Assault Evidence Kit and instruction manual with the patient's consent. Patient must have capacity if patient has consumed any alcohol (below legal limit), to give consent for sexual assault evidence kit.

F. Survivors under the age of 18 meet the criteria for emancipated minor due to concerns of STD/pregnancy and may consent to treatment.

PURPOSE:

To identify the proper method and manner of caring for a patient who has been the alleged victim of sexual assault.

PROCEDURE:

A. The patient should be moved expeditiously to a private area and a rape counselor, nurse, friend or other source of support should remain with him/her if possible. One nurse should be assigned to the care of the patient and, wherever possible, remain with the patient until discharge. Best practice is for rape crisis center to be called when patient arrives so that services may be offered once they arrive.

SEXUAL ASSAULT VICTIM CARE

I. Sexual Assault Evidence Collection Kits are available in the Emergency Department. The instructions that accompany each kit should be followed in order to collect evidence necessary to prosecute sexual assault cases. After the specimens are collected, the collection box should be sealed and the report of the evidence on the front of the box filled out. The evidence should then be given to the police who must sign a "Chain of Possession (Evidence)" which is on the front of the kit. If patient is unsure of whether to report case, kit should be labeled with kit number and turned over to local police of town where incident occurred to be sent to the State Police Crime Lab.

II. If the victim is wearing clothing from the time of the assault, clothing should be collected, stored in bags provided in the sexual assault kit and labeled with the label provided in the kit. Seal the bag with label and/or kit number labels. Staff member should initial labels. Medical record number is NOT documented on bag. Bags should be given to the police with the kit. Document on the ED Medical Record the name of who received the evidence.

B. Information including Emergency Contraception After Sexual Assault Key Facts For Survivors should be introduced promptly early in visit by primary nurse. (See Attachments 5 to 8)

C. Pregnancy test. Should be offered before any emergency contraception is provided. Emergency contraception may be given even if test is refused.

D. Sexually Transmitted Disease (STD) testing within 5 days of sexual assault will likely be testing for exposure to STD before the assault. Patient is strongly encouraged to have follow-up STD testing with PCP or GYN MD/Clinic.

E. Comprehensive toxicology testing should be offered to those individuals who present with amnesia or confused state and suspicions that he/she was sexually assaulted. (See Attachments 2, 3 & 4)

I. Testing must occur within 72 hrs of suspected ingestions of sexual assault drugs.

II. Patient must consent to collection of urine and blood samples with the understanding that it may reveal any legal or illegal substances taken in the weeks prior to the assault. A separate consent form enclosed in Toxicology kit must be signed by patient. Sexual assault kit # must be placed on Toxicology kit box.

F. Treatment:

I. Treat all injuries.

II. Prophylactic treatment for the prevention of STD is offered to all patients.

III. Postcoital contraception, by law, must be offered to the patient and initiated in the ED on request of patient. Pills must be provided by ED. Prescription does not constitute compliance. Written information written by the Commissioner of Public Health about emergency contraception must be provided – see attached information sheet 5. SANE recommends levonorgestrel 1.5mg po once to be given up to 120 hours after assault.

IV. Victims of sexual assualt/rape will be evaluated and counseled concerning a critical exposure. The patient will be offered Post Exposure Prophylaxis (PEP) according to the guidelines for post exposure HIV prophylaxis for victims of sexual assault.

V Follow critical exposure policy for treatment and follow-up.

VI The patient should be given information for a follow up appointment with a gynecologist.

SEXUAL ASSAULT VICTIM CARE

VII Emotional support - the patient is to be evaluated according to her/his emotional state. A counselor from the Rape Crisis Center, psychiatric consultation, and/or social work consultation provided as needed.

VIII Arrangement for discharge from the Emergency Department should be made by RN and MD in collaboration with the patient. Involvement of the patient's family/significant other should be explored and considered. Discharge paperwork should be reviewed with dates and phone #s of follow-up resources given to the patient by RN assigned to the patient at time of discharge. Patient safety should be a high priority. Advocates can assist with safety planning and housing. Victim's compensation form should be given to the patient.

Reference: Massachusetts Sexual Assault Evidence Collection Kit

(ppsexasviccare)

PROVIDER SEXUAL CRIME REPORT

Per MGL C.112, S. 12A 1/2

NK

A. PATIENT/VICTIM INFORMATION *Name, address and other identifying information should not be written on this anonymous form.*

1. **Age:**_____ **2. Gender:** ☐ Female ☐ Male
3. **Race:** ☐ White (non-Hisp.) ☐ Hispanic ☐ Black (non-Hisp.) ☐ Asian/Pac. Isl. ☐ Other: _____
4. **Date of Assault (e.g., 01/01/2000):** _____ **5. Approx. Time of Assault:** _____ ☐ AM ☐ PM
6. **City/Town of Assault:** _____ **State:** _____ **Neighborhood:** _____
7. **Specific surroundings at time of Assault:**
   ☐ House/Apartment ☐ Outdoors ☐ Dormitory ☐ Hotel/Motel ☐ Other _____ ☐ Unsure
8. **Date of hospital exam (e.g., 01/01/2000):** _____ **9. Time of hospital exam:** _____ ☐ AM ☐ PM
10. **Hospital providing service:** _____
11. **Exam completed by a Sexual Assault Nurse Examiner (SANE)?**
    ☐ **Yes** ☐ **No**

AFFIX KIT NUMBER LABEL HERE.

B. ASSAILANT(S) INFORMATION *Did the patient/victim voluntarily report any of the following relationships with the assailant(s)?*

12. **Total number of assailants:** _____ **Unsure:** ☐
13. **Assailant(s) relationship to patient/victim and gender of assailant (m/f)** *(If >1 assailant, designate relationship of each).*

	# Male	# Female		# Male	# Female
☐ Parent/ Step-parent			☐ Boy/ girlfriend		
☐ Spouse/ live-in partner			☐ Ex-boy/ girlfriend		
☐ Ex-Spouse/ live-in partner			☐ Date		
☐ Parent's live-in partner			☐ Acquaintance		
☐ Other relative			☐ Friend		
☐ Stranger			☐ Unknown		
			☐ Other (specify): _____		

C. WEAPONS/ FORCE USED *(Check all that apply as per patient report and/or physical findings)*

14. ☐ Unknown ☐ Bites ☐ Gun ☐ Restraints
    ☐ Verbal threats ☐ Hitting ☐ Knife ☐ Chemical(s)
    ☐ Choking ☐ Burns ☐ Blunt Object ☐ Other weapons Describe: _____
    ☐ Other physical force Describe: _____

D. ACTS DESCRIBED BY THE PATIENT/VICTIM:

Was there penetration, however slight, of:

15. Vagina ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
16. Anus ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
17. Mouth ☐ No ☐ Unsure ☐ Attempt ☐ Yes *BY* ☐ Penis ☐ Finger ☐ Tongue ☐ Object/Other: _____
18. During the assault, were acts performed by the patient/victim upon the assailant(s)? ☐ YES ☐ NO ☐ UNSURE
    If yes, specify: _____
19. Did ejaculation occur? ☐ YES ☐ NO ☐ UNSURE
20. Did assailant(s) use a condom? ☐ YES ☐ NO ☐ UNSURE
21. Any injuries to patient/victim resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE
    If yes, specify: _____
22. Any injuries to assailant(s) resulting in bleeding? ☐ YES ☐ NO ☐ UNSURE
    If yes, specify: _____

E. CASE STATUS AT TIME OF THE EXAM

23a. Evidence Collection Kit completed?	☐ Yes	☐ No	
23b. Toxicology Kit completed?	☐ Yes	☐ No	
24. Reported to police?	☐ Yes	☐ No	*If yes, specify police dept.:* _____
25. DSS Involved?	☐ Yes	☐ No	*If yes, describe status:* _____
26. Restraining order in place before assault?	☐ Yes	☐ No	*If yes, date and court location:* _____
27. Restraining order filed after assault?	☐ Yes	☐ No	*If yes, date and court location:* _____

F. MANDATORY REPORTING (Check all that apply):

28. 19A Elder Abuse Report	☐ Yes	☐ No	**31.** 12A Weapon Report	☐ Yes	☐ No
29. 51A Child Abuse Report	☐ Yes	☐ No	**32.** 70E Emergency Contraception Administered	☐ Yes	☐ No
30. 19C Disabled Persons Report	☐ Yes	☐ No			

G. KIT TRACKING INFORMATION

33. Name of Police Department notified for pick up and transport of Evidence: _____

REMA:WEBPSCR.1 1/08

FAX this report to: **Massachusetts Executive Office of Public Safety-Research and Policy Analysis Unit**
FAX : 617-725-0260 AND: Local public safety authority

PROVIDER SEXUAL CRIME REPORT

Overview

The Provider Sexual Crime Report (PSCR) was created as a mechanism for determining the volume and characteristics of rape and sexual assault crimes occurring in Massachusetts. These crimes are often not reported to police and are, as a result, not recorded or tracked. Medical providers can be of great assistance to law enforcement by reporting their cases to the State Police and local police department via the Provider Sexual Crime Report, thus enabling these crimes to be counted and cases of serial offending to be identified. Massachusetts General Law requires the Provider Sexual Crime Report to be completed by medical providers for every victim of rape or sexual assault. Specifically, *Chapter 112, Section 12½* requires:

"Every physician attending, treating, or examining a victim of rape or sexual assault, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the criminal history systems board and to the police of the town where the rape or sexual assault occurred but shall not include the victim's name, address, or any other identifying information. The report shall describe the general area where the attack occurred. Whoever violates any provision of this section shall be punished by a fine of not less than fifty dollars nor more than one hundred dollars." M.G.L.C. 112§ 12½

Instructions and Definitions

- DO NOT write a patient's name, address, or any other identifying information on the PSCR. To ensure patient safety, the Report is anonymous.
- Question 20: Check "YES" only if all assailants used a condom. If one or more assailants did not use a condom, check "NO."
- Question 26 & 27: These questions pertain to restraining orders in place or filed for assailant(s) involved in this attack only.

Rape: "Whoever has sexual intercourse or unnatural sexual intercourse with a person, and compels such person to submit by force and against his will, or compels such person to submit by threat of bodily injury and if either such sexual intercourse or unnatural sexual intercourse results in or is committed with acts resulting in serious bodily injury, or is committed by a joint enterprise, or is committed during the commission or attempted commission of an offense..."
M.G.L.C. 265 § 22.

Unnatural sexual intercourse: "Any penetration of the mouth, vagina, or anus by any foreign object or extremity; or, any penetration not understood to be what is collectively referred to as "sexual intercourse." M.G.L.C. 265 § 22.

19A Elder Abuse Report: M.G.L. Chapter 19A, Section 15 requires certain professionals (including physicians, physician assistants, medical interns, and nurses) to report suspected occurrences of elder abuse, neglect and financial exploitation.

51A Child Abuse Report: M.G.L. Chapter 119, Section 51A requires certain professionals (including physicians, physician assistants, hospital personnel engaged in the examination, care or treatment of persons, medical interns, and nurses), who, in their professional capacity shall have reasonable cause to believe that a child under the age of eighteen years is suffering physical or emotional injury resulting from abuse inflicted upon him which causes harm or substantial risk of harm to the child's health or welfare including sexual abuse, or from neglect, including malnutrition, or who is determined to be physically dependent upon an addictive drug at birth, shall immediately report such condition.

19C Disabled Persons Report: M.G.L. Chapter 19C, Section 10 requires certain professionals (including physicians, medical interns, hospital personnel engaged in the examination, care or treatment of persons, nurses) to report a serious physical or emotional injury resulting from the abuse of a disabled person including nonconsensual sexual activity.

12A Weapon Report: M.G.L. Chapter 112, Section 12A requires every physician attending or treating a case of bullet wound, gunshot wound, powder burn or any other injury arising from or caused by the discharge of a gun, pistol, BB gun, or other air rifle or firearm, or examining or treating a person with a burn injury affecting five percent or more of the surface area of his body, or, whenever any such case is treated in a hospital, sanatorium or other institution, the manager, superintendent or other person in charge thereof, shall report such case at once to the colonel of the state police and to the police of the town where such physician, hospital sanatorium or institution is located or, in the case of burn injuries, notification shall be made at once to the state fire marshal and to the police of the town where the burn injury occurred.

70E Emergency Contraception Report: M.G.L. Chapter 111 Section 70E requires hospitals to report the dispensing of emergency contraception to a victim of rape.

Submission Requirements:

- Upon completion, please FAX the PSCR to:

Massachusetts Executive Office of Public Safety-Research and Policy Analysis Unit
FAX: 617-725-0260

- In addition, please mail a copy of the PSCR to the local public safety authority where the rape or sexual assault occurred.

Additional Information: Should you have any questions regarding the PSCR, please call the Massachusetts Research and Policy Analysis Unit at (617) 725-3301.

RE2MA: PSCRINS.2 1/08

Executive Office of Public Safety and DPH Sexual Assault Nurse Examiner (SANE) Program Comprehensive Toxicology Testing Protocol and Guidelines For Authorized Medical Personnel

Guidelines and criteria for testing have been established in collaboration with the Boston Area Rape Crisis Center, Jane Doe, Inc., the Suffolk County District Attorney's office, Lawrence General Hospital, the Massachusetts State Police Sexual Assault Unit, Beth Israel Deaconess Medical Center, MA Department of Public Health SANE Program and Sexual Assault Prevention and Survivor Services, Boston and State Police Crime Laboratories, Massachusetts State Laboratory Institute and Massachusetts College of Emergency Physicians.

Indications for Offering Testing:

1. Amnesia or confused state with suspicions that she/he was sexually assaulted
2. Amnesia or confused state after minimal consumption of alcohol, or with no known consumption of mind-altering substances
3. Suspected ingestion of sexual assault-facilitating drugs within 72 hours of emergency department visit

Contraindications for Offering Testing:

1. Patient presents to emergency department within after 72 hours of suspected ingestion
2. No signs or symptoms consistent with ingestion of sexual assault-facilitating drugs, i.e., no report of amnesia/loss of consciousness
3. If testing is contraindicated, but patient still requests testing, the patient should be encouraged to discuss concerns with a rape crisis counselor.

Source: MDPH Sexual Assault Nurse Examiner Program Protocols. Complete protocols available from the SANE Program: 617-624-5432.

Additional information regarding toxicology testing:

If toxicology testing is indicated, it can be performed only with informed patient consent. The authorized medical professional needs to thoroughly review the official, standard "Consent for Comprehensive Toxicology Testing" form contained in the Sexual Assault Evidence Collection Kit with the patient prior to obtaining patient signature and test sample. The Kit form (distributed by the Executive Office of Public Safety, 617-727-6300) is designed to collect the following information:

-Date and time of evidence collection
-Has the assault been reported to law enforcement?
-Is the patient a smoker?
-Is the patient taking any prescription medication?
-Is the patient taking any over the counter drugs?

The form also asks the patient to acknowledge and initial the following items, in order to ensure informed consent:

-consent and authorization for the provider to obtain urine and blood samples for the purpose of detecting the presence of substances that may have caused sedation and/or amnesia in the setting of a suspected sexual assault

-samples must be obtained within 72 hours of ingestion

-samples will be transferred to the State Police Crime Laboratory and information regarding the results of the testing may be released to the defense, prosecution, and other law enforcement officials

-the drug test will include a full toxicology panel which may detect any substances, medications or drugs, both legal and/or illegal that may have been taken in the weeks prior to the assault

-once the assault is reported to law enforcement, officials will have access to the test results even if patient changes his/her mind about voluntary participation in prosecution of assailant(s)

-blood and urine samples will be tested and will be discarded if the assault is not reported to law enforcement within 6 months of evidence collection

-if assault has been reported to the police, results will be available to law enforcement officials within approximately 6 weeks of testing; patient can contact victim-witness advocate from DA's office working on the case if patient wants to find out the test results

-for testing performed after April, 2003 only: if assault has not been reported to the police, results will be available to a confidential service approximately 6 weeks after testing; patient can contact the confidential test results phone number listed in hospital aftercare instructions and provide his/her kit number to find out test results

-the patient has discussed toxicology testing with the medical provider and had an opportunity to ask questions and discuss concerns

Statewide Sexual Assault Nurse Examiner Program (SANE) Designated Sites and Regional Coordinators
January 2004

Boston Regional SANE Coordinator: Patricia Duggan, 617-624-5448; patricia.duggan@state.ma.us
Designated Boston Area SANE sites: Massachusetts General Hospital, Boston Medical Center, Brigham and Women's Hospital, Beth Israel Deaconess Hospital, Newton Wellesley Hospital, Cambridge Hospital

Northeastern Regional SANE Coordinator: Linda Molchan, 978-683-4000 x2627; Lmolchan@comcast.net
Designated Northeastern Area SANE sites: Lawrence General Hospital

Southeastern Regional SANE Coordinators: Collen Dube, CnewtRN@aol.com , Lori Banning, 508-326-9973; imsaneru@hotmail.com
Designated Southeastern Area SANE sites: Brockton Hospital, Charlton Memorial Hospital, St. Luke's Hospital, Morton Medical Center, Tobey Hospital, Jordan Hospital

Central Regional SANE Coordinator: June Ellis, 508-334-8230; ellisj@ummhc.org, Joan West, 508-334-8686; Westj@ummhc.org
Designated Central Area SANE sites: Harrington Memorial Hospital, Worcester Medical Center, University of Massachusetts Memorial Hospital, University of Massachusetts University Hospital

Western Regional SANE Coordinator: Kathryn Jolin, 413-245-0469; sanewest@fiam.net
Designated Western Area SANE sites: University of Massachusetts Amherst Health Center, Baystate Medical Center

Cape Cod and Islands Regional SANE Coordinator: Kathleen Ecker, 508-237-1202; eckerd@aol.com
Designated Cape Cod and Islands SANE sites: Falmouth Hospital, Cape Cod Hospital, Nantucket Hospital

Statewide SANE Director: Lucia Zuniga, 617-624-6085, lucia.zuniga@state.ma.us
Statewide SANE Program Coordinator: Ginhee Sohn, 617-624-5432, ginhee.sohn@state.ma.us

Key Facts about

Emergency Contraception

for

Emergency Department Staff Who Provide Care to Sexual Assault and Rape Survivors[1]

This fact sheet has been prepared by the Massachusetts Department of Public Health pursuant to Chapter 91 of the Acts of 2005 and reflects current medical research and standards of practice. Physicians and staff who provide care to sexual assault and rape survivors remain responsible for providing care in accordance with their professional training, expertise and judgment.

Emergency Contraception (EC) is considered to be a safe and effective way to prevent pregnancy after sexual assault or rape.[2]

Taking EC after a sexual assault or rape decreases a woman's chances of becoming pregnant.

What are Emergency Contraceptive pills?

Emergency Contraceptive pills (EC pills) contain the same medication as regular birth control pills. There are two basic types of pills that are used as Emergency Contraception.

- **Progestin-only pills:** Plan B™ [3] is a dedicated product that is FDA approved for use as EC.
  Dosing: Provide first dose as soon as possible after the sexual assault or rape, second dose 12 hours later.[Error! Bookmark not defined.]
  Recent research shows equal efficacy if both doses are taken simultaneously.[4]

- **Combined Estrogen/Progestin pills:** High doses of Oral Contraceptive Pills (OCPs)[Error! Bookmark not defined.] have been determined by the FDA to be safe and effective for use as Emergency Contraception.[5]
  Dosing: Type of OCP and number varies.[6]

How do EC pills work?

Physiological effects of EC pills result in 3 possible mechanisms of action in preventing pregnancy. They may work by:[7]

- Delaying or inhibiting ovulation;
- Inhibiting fertilization; or
- Preventing implantation of the fertilized egg.

EC pills should be started as soon as possible after the sexual assault.

- The sooner a woman takes EC pills after a sexual assault or rape, the more effective it is.
- EC pills are most effective when taken in the first 12 hours.[8]
- The FDA has approved EC pills to be initiated up to 72 hours (3 days).
- Recent research has shown EC pills initiated up to 120 hours[9] are effective.

EC pills are considered to be safe and effective.

- Progestin-only pills reduce pregnancy risk by 89%[*10] if taken within 72 hours of a sexual assault or rape.
- Combined estrogen/progestin pills reduce pregnancy risk by 75%[*Error! Bookmark not defined.] if taken within 72 hours of a sexual assault or rape.
- Using EC pills will not affect a woman's ability to become pregnant in the future.[11]
- If EC pills are taken when the woman is pregnant or if pregnancy occurs despite use, they will not harm the developing fetus.[12]

Attachement 5

Contraindications and side effects.

- Contraindications:[Error! Bookmark not defined.]
  - Known, established pregnancy reported by the patient.
  - Known hypersensitivity to any component of the product.
- Side Effects:[Error! Bookmark not defined.]
  - Some women may experience nausea and vomiting. These symptoms are more common with the combined estrogen/progestin pills than with progestin only pills.
  - Other side effects may include short term fatigue, headache, dizziness, breast tenderness, or a change in the timing of the next period.

Medical follow up after taking EC pills for sexual assault or rape survivors.

- If patient vomits within 2 hours of taking EC pills, patient should be advised to immediately contact the medical provider for further instructions as a repeat dose may be advised.[ii]
- If menses does not occur within 3 weeks of EC pills use, a pregnancy test is indicated.
- Regular contraception can be started immediately after EC pills, or with the next menses.
- EC pills do not prevent sexually transmitted infections or HIV.

For Additional Information Refer to the Product's Package Insert

*Pregnancy risk reduction based on one time use.

1This fact sheet is pursuant to sections of chapter 91 of the Acts of 2005, *An Act Providing Timely Access to Emergency Contraception*, which will take effect on December 14, 2005.

2 World Health Organization. "Emergency Contraception: A Guide to the Provision of Services." Geneva; WHO, 1998. Hatcher Richard A, et al., Contraceptive Technology, New York; Ardent Media Inc., 1998. Dailard, C. "Increased Awareness Needed to Reach Full Potential of Emergency Contraception." The Guttmacher Report on Public Policy, 2001; 4(3). Task Force on Postovulatory Methods of Fertility Regulation, "Randomized Controlled Trial of Levonorgestral Versus the Yuzpe Regimen of Combined Oral Contraceptives for Emergency," Lancet, 1998; 352: 428-433. Glasier, A, Baird, D S. "The effects of self-administering Emergency Contraception." New England Journal of Medicine, 1998; 339(1): 1-4. Grimes, R, E, & Scott Jones, B. "Emergency Contraception Over-The-Counter: The Medical and Legal Imperatives." Obstetrics & Gynecology, 2001; 98(1): 151-155. The Alan Guttmacher Institute. "Emergency Contraception Improving Access." Issues In Brief, 2003; 3. The Henry J Kaiser Family Foundation, "Fact Sheets: Emergency Contraception," Menlo Park, CA; Kaiser Family Foundation, November 2000.

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4 Recent WHO data (Lancet 2002; 360:1803-1810) for levonorgestrel showed that a 1.5mg single dose can substitute two 0.75mg doses 12h apart. This simplifies the use of levonorgestrel without an increase in side effects. Pregnancy rates were slightly lower for the single dose regimen, but not statistically significant. Similar findings on single dose efficacy were obtained by Arowojulu et al (Contraception 2002; 66:269-273).

5 The Commissioner of the Food and Drug Administration has concluded that combined oral contraceptives, taken initially within 72 hours of unprotected intercourse and providing a total of 0.10 or 0.12 mg of ethinyl estradiol and 0.50 or 0.60 mg of levonorgestrel in each of two doses separated by 12 hours, are safe and effective for use as post-coital emergency contraception (Federal Register 2/25/1997; Vol. 62, No. 37: 8610-8612).

6 Hatcher, Robert A, et al, Managing Contraception 2003-2004. Tiger, GA: Bridging the Gap Foundation, 2003. World Health Organization. "Selected Practice Recommendations for Contraceptive Use, Second Edition 2004." 2004. Geneva: WHO.

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8 Piaggo, G. von Hertzen H, Grimes DA, Van Look PFA. "Timing of emergency contraception with levonorgestrel or the Yuzpe regimen." Lancet. 1999;353;721.

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9 Recent WHO data (Lancet 2002; 360:1803-1810) for levonorgestrel collected from a large (n=2758) randomized trial conducted in 10 developed and developing countries showed that it prevented a high proportion of pregnancies if taken with within five days of unprotected intercourse. Rodrigues et al (Am J Obstet Gynecol 2001;184:531-537) reported similar findings for the Yuzpe regimen. Both studies, however, suggest lower efficacy with longer delay between treatment and unprotected intercourse. World Health Organization. "Selected Practice Recommendations for Contraceptive Use, Second Edition 2004." 2004. Geneva: WHO.

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Attachment 5

Emergency Contraception after Sexual Assault

Key Facts for Survivors

Emergency Contraception (EC) can help prevent pregnancy after sexual assault or rape.

- Taking EC after a sexual assault can lower your chances of getting pregnant from the assault.
- Take EC as soon as you can for it to work best.
- EC is most effective when taken within the first 12 hours after sexual assault.
- Most providers will give you EC up to 3 days (72 hours) after a sexual assault. Others will give it to you up to 5 days (120 hours) after.

What are Emergency Contraceptive pills?

EC pills contain the same medication as regular birth control pills. There are two types of EC pills which help to prevent pregnancy after a sexual assault:

- Plan B™ progestin-only pills
- High doses of regular birth control pills

Not all women may be able to take EC for medical reasons. Talk to the doctor to see if EC is right for you.

Medical research shows that EC is safe and effective.

- EC pills have been used safely by millions of women for emergency birth control.
- Plan B™ progestin-only pills reduce the risk of pregnancy by 89%.*
- Other birth control pills taken for EC reduce the risk of pregnancy by 75%.*

** EC is not meant to be used as a regular birth control method. Other methods are more effective for regular, long-term pregnancy prevention.*

How do EC pills work?

EC pills work in different ways. They may:

- Keep the egg from leaving the ovary
- Keep the sperm from meeting the egg
- Keep the fertilized egg from attaching to the uterus

Medical research shows EC prevents pregnancy:

- If you find out later that you were pregnant when you took EC, it will not harm your body or your pregnancy.
- EC will not affect your ability to become pregnant in the future.

What will happen after I take EC?

- You may experience changes in the timing or flow of your next menstrual period. **If your period is more than 1 week late, you may be pregnant.**
- You may experience non-serious side effects, such as nausea, abdominal pain, and dizziness, similar to the side effects of regular birth control pills.
- **If you vomit within 2 hours of taking a dose, call the medical provider to see if the dose should be repeated.**
- The doctor can answer any questions you may have about EC.

Where can I get EC after a sexual assault?

- Hospitals with emergency departments.
- Medical providers and family planning programs.
- Some pharmacies in Massachusetts dispense EC. Call ahead and ask if your pharmacist can dispense EC.

Don't Wait: The sooner you take EC, the better it works to prevent pregnancy after sexual assault.

If EC was not provided to you at the hospital and you need more help to get EC, you can:

- **Call a Rape Crisis Center** to speak with an advocate for help getting EC after a sexual assault: **1-800-841-8371 (English)** or **1-800-223-5001 (Español)** or visit **www.mass.gov/dph/fch/sapss/sites.htm,** or
- **Call 1-888-Not-2-Late (1-888-668-2528)** or visit **www.not-2-late.com** for help anytime you need EC.

To find low-cost family planning services such as EC, birth control and STD counseling and testing:

- **Call 617-624-6060** or **1-877-414-4447,** or visit **http://www.mass.gov/dph/fch/famplan.htm**

Attachment 6

Contracepción de Emergencia después de una Agresión Sexual
Datos Claves para Sobrievivientes

La Contracepción de Emergencia (EC) puede ayudar a prevenir el embarazo después de una agresión sexual o violación.

- Tomar EC después de una agresión sexual puede reducir sus probabilidades de quedar embarazada a causa de la misma.
- Tome la EC lo más pronto que pueda para que actúe mejor.
- La EC es más eficaz cuando se toma dentro de las primeras 12 horas después de la agresión sexual.
- La mayoría de los proveedores le dará EC hasta 3 días (72 horas) después de la agresión sexual. Otros se la darán hasta 5 días (120 horas) después.

¿Qué son las píldoras contraceptivas de emergencia?

Las píldoras EC contienen la misma medicación que las píldoras contraceptivas regulares. Hay dos tipos de píldoras EC que ayudan a prevenir el embarazo después de una agresión sexual:

- Plan B™ – contienen sólo progestina
- Dosis altas de píldoras contraceptivas regulares

No todas las mujeres pueden tomar EC por razones médicas. Hable con su médico para ver si la EC es lo indicado para usted.

La investigación médica muestra que la EC es segura y eficaz.

- Las píldoras EC han sido usadas en forma segura por millones de mujeres como método de prevención del embarazo de emergencia.
- Las píldoras Plan B™ con sólo progestina reducen el riesgo de embarazo un 89%.*
- Otras píldoras contraceptivas tomadas como EC reducen el riesgo de embarazo un 75%.*

** El propósito de la EC no es que se use como método anticonceptivo regular. Otros métodos son más eficaces para la prevención regular y a largo plazo del embarazo.*

¿Cómo actúan las píldoras EC?
Las píldoras EC actúan de diferentes maneras. Pueden impedir que:

- el óvulo salga del ovario
- el esperma se encuentre con el óvulo
- el óvulo fertilizado se implante en el útero

La investigación médica muestra que la EC previene el embarazo:

- Si usted descubre más adelante que estaba embarazada cuando tomó EC, eso no le hará daño a su cuerpo ni a su embarazo.
- La EC no afectará su capacidad de quedar embarazada en el futuro.

¿Qué pasará después de que tome EC?

- Tal vez note cambios en las fechas o el flujo de su próximo período menstrual. **Si su período tiene más de 1 semana de atraso, tal vez esté embarazada.**
- Puede experimentar efectos secundarios no serios, como náusea, dolor abdominal y mareo, similares a los efectos secundarios de las píldoras contraceptivas regulares.
- **Si vomita durante las primeras 2 horas después de haber tomado una dosis, llame a su proveedor médico para ver si debe repetir la dosis.**
- El médico puede contestar cualquier pregunta que usted tenga sobre la EC.

¿Dónde puedo conseguir EC después de una agresión sexual?

- Los hospitales con salas de emergencia.
- Proveedores médicos y programas de planificación familiar.
- En Massachusetts, algunas farmacias dispensan EC. Llame antes y pregunte si su farmacéutico puede dispensar EC.

No espere: cuanto más pronto se toma la EC, mejor actúa para prevenir el embarazo después de una agresión sexual.

Si no le dieron EC en el hospital y necesita más ayuda para conseguirla, usted puede:

- **llamar al *Rape Crisis Hotline* (línea de asistencia a víctimas de violación)** para hablar con alguien y pedir ayuda para conseguir EC después de una agresión sexual: **1-800-223-5001 (español)** ó **1-800-841-8371 (inglés)** o visitar **www.mass.gov/dph/fch/sapss/sites.htm,** o
- **llamar al 1-888-Not-2-Late (1-888-668-2528)** o visitar **www.not-2-late.com** para pedir ayuda siempre que necesite EC.
- Para encontrar servicios de planificación familiar económicos, incluyendo EC, control de la natalidad, y asesoramiento y pruebas de ETS (enfermedades de transmisión sexual): **llame al 1-877-414-4447 (español)** o al **617-624-6060** o visite **http://www.mass.gov/dph/fch/famplan.htm**

Attachment 7

Anticoncepcional de Emergência após Agressão Sexual

Fatos Básicos para Sobreviventes

O anticoncepcional de emergência (AE, ou EC - Emergency Contraception) pode ajudar a evitar a gravidez após agressão sexual ou estupro.

- Tomar EC após uma agressão sexual pode diminuir a possibilidade de engravidar em decorrência da agressão.
- Tome o EC assim que puder para obter o melhor efeito.
- A maior eficácia do EC ocorre quando é tomado dentro das primeiras 12 horas após a agressão sexual.
- A maioria dos profissionais da saúde lhe darão o EC até 3 dias (72 horas) após a agressão sexual ter ocorrido. Outros lhe darão até 5 dias (120) após a ocorrência.

O que são as pílulas anticoncepcionais de emergência?

As pílulas EC contêm o mesmo fármaco das pílulas de controle da natalidade normais. Existem dois tipos de pílulas EC que podem ajudar a evitar a gravidez após uma agressão sexual:

- Pílulas Plan B™, que contêm apenas progestina
- Altas doses de pílulas de controle da natalidade.

Nem todas as mulheres podem tomar EC por problemas de saúde. Fale com o médico para ver se o EC é adequado para o seu caso.

Pesquisas médicas mostram que o EC é seguro e eficaz.

- As pílulas EC já foram usadas com segurança por milhões de mulheres para o controle de emergência da natalidade.
- As pílulas Plan B™, que contêm apenas progestina, reduzem o risco de gravidez em 89%.*
- Outras pílulas de controle da natalidade tomadas como EC reduzem o risco de gravidez em 75%.*

** O EC não deve ser usado como método normal de controle da natalidade. Existem outros métodos mais eficazes para a prevenção normal da gravidez a longo prazo.*

Como funcionam as pílulas EC?
As pílulas EC funcionam de modos diferentes. Elas podem:

- Impedir o óvulo de sair do ovário
- Impedir que o espermatozóide se encontre com o óvulo
- Impedir que o óvulo fertilizado se fixe no útero

Pesquisas médicas mostram que o EC evita a gravidez:

- Se você descobrir mais tarde que estava grávida quando tomou o EC, ele não prejudicará o seu organismo ou a sua gravidez.
- O EC não afetará a sua capacidade de engravidar no futuro.

O que acontecerá depois que eu tomar o EC?

- Você poderá notar mudanças na data de início ou no fluxo do seu próximo período menstrual. **Se a sua menstruação estiver mais do que uma semana atrasada, pode ser que você esteja grávida.**
- Você pode sentir efeitos colaterais que não são sérios, tais como náusea, dor abdominal e tontura, sintomas semelhantes aos efeitos colaterais das pílulas de controle da natalidade normais.
- **Se você vomitar dentro de até 2 horas após tomar uma dose, telefone para o médico para saber se deve repetir a dose.**
- O médico pode responder todas as perguntas e dúvidas que possa ter sobre o EC.

Onde posso obter o EC após uma agressão sexual?

- Hospitais com departamentos de emergência.
- Médicos e programas de planejamento familiar.
- Algumas farmácias em Massachusetts distribuem EC. Telefone antes e pergunte se o seu farmacêutico pode distribuir EC.

Não espere: Quanto antes tomar o EC, maior a possibilidade de evitar uma gravidez após a agressão sexual.

Se o EC não lhe for dado no hospital e você precisar de mais ajuda para obter o EC, você pode:

- **Telefonar para a *Rape Crisis Hotline* (linha de atendimento a vítimas de estupro)** e falar com alguém que a ajudará a obter o EC após uma agressão sexual: **1-800-841-8371 (inglês)** ou **1-800-223-5001 (espanhol)** ou visite **www.mass.gov/dph/fch/sapss/sites.htm,** ou
- **Telefonar para 1-888-668-2528** ou visitar **www.not-2-late.com** **(inglês e espanhol)** para obter ajuda a qualquer hora em que precisar de EC.

Para encontrar serviços de planejamento familiar de baixo custo que tratam de EC, controle de natalidade, testes e aconselhamento sobre DST:

- **Telefonar para 617-624-6060** ou **1-877-414-4447 (português)** ou visite **http://www.mass.gov/dph/fch/famplan.htm**

Attachment 8

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

* M - P O O R D E R *

PHYSICIAN ORDERS - Medication and Treatment

MEDICAL NUTRITION THERAPY ORDERS

Orders valid only if checked (✓)

A Physicians Signature is Mandatory Prior to Implementation of this Order

ALLERGIES: (If None, so indicate) ❑ **None**

Date:	**Time:**	**Pt. Weight:** _____ ; **Height:** _____

Therapeutic Diet

Therapeutic Diet Recommendations:

❑ Change diet from _____ to _____

Fortify Diets

Add the following nutrition supplement:

√ Oral Liquid Nutritional Supplement per Registered Dietician (RD)/ patient preference

❑ Ensure ___ times per day	❑ Ensure Clinical Strength ___ times per day
❑ Glucerna Shake ___ times per day	❑ Ensure Plus ___ times per day
❑ Mighty Shakes ___ times per day	❑ Mighty Shakes No Sugar Added ___ times per day
❑ Ensure Pudding ___ times per day	❑ Enlive ___ times per day
❑ Juven with breakfast and lunch	❑ Promod Liquid Protein ___ times per day
❑ Nepro ___ times per day	❑ Other _____

Medications: Vitamins and Minerals – For Pharmacy

❑ Multivitamin with minerals one tablet by mouth daily
❑ Renal Vitamin one tablet by mouth daily
❑ Vitamin C ___mg by mouth ___ times per day
❑ Zinc Sulfate 220mg by mouth daily ___ days
❑ Multivitamin one tablet by mouth daily

Enteral Nutrition

Add/Modify the following enteral tube feeding:

❑ Jevity 1.2 Cal	❑ Jevity 1.5 Cal	❑ Promote
❑ Nepro	❑ Osmolite 1.2 Cal	❑ Glucerna 1.2 Cal
❑ Promote w/fiber	❑ Osmolite 1.5 Cal	Other
	❑ Vital AF 1.2 Cal	_____

Additive:

❑ Promod: 30 ml ___ times per day
❑ Juven ___ times per day

Physician /NP/PA Signature **Printed name:** **Beeper #**

MetroWest Medical Center
Framingham Union Hospital • Leonard Morse Hospital

* M - P O O R D E R *

PHYSICIAN ORDERS - Medication and Treatment

MEDICAL NUTRITION THERAPY ORDERS

Orders valid only if checked (✓)

ALLERGIES: (If None, so indicate) ❑ **None**

Date:	**Time:**	**Pt. Weight:** _____ **; Height:** _____

	Administer ❑ Start tube feeding at ___ ml/hour via _____ ❑ Advance by ___ml/hr every ___ hours ___ to goal of ___ml/hour ❑ Bolus with ___ ml (feeding/formula) every ___ hours	❑ Continuous infusion of ___ ml/hr from ___pm to ___ am ❑ Add water flushes of ___ ml every ___ hours ❑ Water flushes per MD ❑ Head of bed 30° to 45° at all times
Labs	**Labs and Other Metabolic Tests**: **Labs to be drawn** _____ ❑ Liver Function Panel (**LF**) ❑ Magnesium (**MG**) ❑ Ionized Calcium (**CAION**) ❑ Vitamin C (**VITC**) ❑ Ferritin (**FER**) ❑ Nitrogen Balance (24 hr urine for urea nit, collect from midnight to midnight) (**TUUN**)	❑ Pre-albumin (**PREALB**) ❑ Phosphorus (**PHOS**) ❑ Vitamin D, 25OH (**VITD**) ❑ Triglycerides (**TRIG**) ❑ Serum B12 (**B12**) ❑ Folate (**FOL**) ❑ Iron (**IRON)** ❑ Serum Zinc (**ZINC**)

Physician /NP/PA Signature **Printed name:** **Beeper #**

NO ORDERS WRITTEN IN THIS AREA WILL BE ACCEPTED

Advance Directives and Health Care Proxy

I. Policy Statement

In accordance with Section 4206 of the Omnibus Budget Reconciliation Act of 1990, and the General Laws of Massachusetts, Chapter 201D, "Health Care Proxies", it is the Hospital's responsibility to involve the patient in making decisions about his or her care and treatment.

II. Purpose

To ensure compliance with the Social Security Act, Section 1866 as amended by OBRA 1990 (PL 101-508), the Patient Self-Determination Act, Health Care Financing Administration (HCFA) Final Rule, applicable standards of Joint Commission and the requirements of the Commonwealth of Massachusetts, the wishes of a patient regarding the type of care desired in the event he or she becomes terminally ill or incapacitated and unable to communicate those desires to the hospital staff will be the responsibility of the proxy and must accord with the scope of the hospitals mission. This policy also aims to protect the patient's right to self-determination by identifying patients who already have a valid advance directive, assisting patients with decision-making capacity in executing an advance directive, and in defining for caregivers the appropriate clinical response to the advance directive that has statutory support in Massachusetts, namely, the Health Care Proxy.

III. Definitions

Attending physician - the physician, selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient in the hospital..

Adult – Person 18 years or older or an Emancipated Minor

Capacity to make health care decisions – An adult, at least 18 years of age or older, who has the ability to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternatives to any proposed health care, and to reach an informed decision.

Health care - any treatment, service or procedure to diagnose or treat the physical or mental condition of a patient.

Health care agent – The individual authorized by the principal to make health care decisions (subject to any limitation stated in the proxy and to prevailing medical standards).

Health care decision made by an agent under a health care proxy - a decision which is made in accordance with the requirements of this policy, is consistent with any limitations in the health care proxy, and is consistent with responsible medical practice.

Health care proxy – In the Commonwealth of Massachusetts, the document legislatively recognized as the means for a patient to communicate their own health care preferences.

Principal – The adult who executes a Massachusetts Health Care Proxy under M.G.L. Chapter 201D. The patient does not have to be a resident of Massachusetts in order to do so.

IV. Procedure

A. Capacity Determination

1. An adult who is deemed to lack the capacity to make health care decisions if he/she lacks the capacity to understand and appreciate the nature and consequences of health care decisions, including the benefits and risks of and alternative to any proposed course of health care treatment and to reach an informed decision.

2. If a patient who was deemed to lack the capacity to make or communicate health care decisions has executed a Health Care Proxy, the following procedures should be followed:

    a. The patient's Attending Physician has the responsibility to make a determination as to the patient's capacity to make or communicate health care decisions in accordance with accepted standards of medical judgment.

    b. The Physician's determination must be documented in the patient's medical record and must contain the Physician's opinion regarding the cause and nature of the patient's incapacity as well as its extent and probable duration.

    c. If the Physician determines that the patient lacks capacity to make health care decisions because of mental illness or a developmental disability, the Physician must consult with a health care professional who has specialized training in diagnosing or treating similar illnesses or disabilities if the Physician has not had such specialized training.

    d. When a medical determination has been made that a patient lacks capacity, the Physician or his/her designee must promptly give oral and written notice of that determination to the patient where there is any indication of the patient's ability to understand such notice; to the Agent; and if the patient was transferred from a mental health facility, to the Facility Director.

B. Decision-Making by the Health Care Agent

1. Under General Massachusetts Laws, a Health Care Proxy is presumed to be valid and properly executed unless a court determines otherwise.

2. If a patient's Health Care Proxy appears to be valid, the patient's Agent may make all decisions concerning the patient's care that fall within the scope of the Agent's informed consent prior to performing any therapeutic or diagnostic procedure. The Agent should be given access to any and all information, including confidential medical information, necessary to make an informed decision.

3. Hospital staff must comply with the Agent's decision to the same extent, as if the decisions were made by the patient, subject only to any limitations set forth in the proxy or in specific court order. If, however, a patient objects to the decision of an Agent, the patient's decision prevails unless a court orders otherwise.

4. If the Attending Physician determines that the patient has regained capacity to make medical decisions, the authority of the Agent shall immediately terminate. The Agent's authority shall recommence if the patient subsequently loses capacity. All capacity determinations shall be made in accordance within the procedure outlined above (see "Capacity Determination"). During any period in which the patient is capable of making health care decisions, the patient's consent to treatment must be obtained.

5. If there are any questions concerning Health Care Proxy, hospital staff and/or physicians should contact the Hospital Administrator on- call.

6. In order for a Health Care Proxy to be valid under Massachusetts Law, it must:

   a. Identify the Principal (patient) and Agent;

   b. Indicate that the Principal intends the Agent to have authority to make health care decisions on the Principal's behalf;

   c. Describe any limitations on the authority that the Principal wishes to impose, if any;

   d. Indicate that the Agent's authority shall become effective if it is determined that the Principal lacks capacity;

   e. Be witnessed by two adults who are present when the Principal signs or directs the signing of the proxy. These witnesses' signatures affirm that the Principal appeared to be at least 18 years of age, of sound mind and under no constraint or undue influence. Of note, it is preferable that hospital medical and nursing staffs not serve as witnesses for the execution of a Health Care Proxy by a patient, but in certain circumstances, may want to facilitate the patient's wishes by providing staff to serve as witness. The Department of Continuing Care and Social Work may be called upon for assistance.

C. Objection to Agent's Decisions on Moral or Religious Grounds

If a Physician or other staff member involved in the patient's care objects to a health care decision of an Agent on moral or religious grounds, the Attending Physician shall attempt to make alternative arrangements for the patient's care so that his/her wishes may be honored. In such circumstances, physicians and other staff are encouraged to consult the Ethics Committee. An individual's refusal to carry out an Agent's decision for moral or religious reasons shall not be grounds for disciplinary action against the individual or affect the individual's employment with or privileges at the Medical Center in any manner.

D. Revocation of Health Care Proxy

A patient may revoke a Health Care Proxy by notifying the Agent or hospital staff orally, in writing, or by any other act evidencing the patient's intent to revoke the proxy. A Health Care Proxy will also be automatically revoked following the divorce or legal separation of the patient and his/her spouse, where the spouse is the Agent. A Physician who is informed of a revocation of a proxy must immediately document the revocation in the patient's medical record and provide oral and written notification of the revocation to the Agent and any health care providers known by the physician to be involved in the patient's care. Any member of the Medical Center's nursing staff who is informed of a revocation must immediately notify the patient's Attending Physician.

E. Documentation

Any staff member who receives a copy of a Massachusetts Health Care Proxy from a patient shall arrange for it to be placed in the patient's current medical record. In addition, all actions taken by physicians or other staff members pursuant to this policy shall be documented in the patient's medical record. For example, if a patient elects to donate organs at the end of life, the hospital has a procedure to honor that directive (refer to Administrative Policy 4.13: Organ & Tissue Donation). **In the absence of the actual Advance Directive, and in accord with applicable state law, the patient's wishes may be documented in the patient's medical record.**

F. Patient Transfer

When a patient is transferred directly from MetroWest Medical Center to another facility, institution, or health care setting, information relative to the patient's Health Care Proxy status should be included with the referral. If a health care Agent has been authorized to act for the person, a copy of the Health Care Proxy, as well as the Attending Physician's determination of incapacity to make or communicate health care decisions **at or before the time of transfer**, should be sent to the appropriate health care provider at the receiving facility.

G. Comfort Care

Nothing contained in this Policy should be construed to preclude the patient's attending physician from administering any procedure deemed necessary by the physician to provide comfort care or pain alleviation, including treatment with sedatives and pain killing drugs, non-artificial oral feeding, suction and hygienic care.

H. Nondiscrimination

No physician or other staff member shall condition the provision of care or otherwise discriminate against a patient because the patient has executed or has failed to execute an Advance Directive.

I. Disqualification of Agent

If there is reason to believe that a patient's health care agent is acting in bad faith, or the agent is not reasonably available, willing, and competent to fulfill his or her obligation, or the agent's decision appears to be inconsistent with the patient's express wishes, the Social Worker, Patient Advocate, Department Manager, Director of Quality and Patient Safety Department and/or Risk Manager should be contacted.

J. Prohibition of Hospital Personnel Serving as Agent

No administrator or employee of the Hospital shall serve as the agent for any individual who is a patient of the Hospital, unless such individual is related to the patient by blood, marriage, or adoption.

K. Education

The Hospital shall, to the extent required by law, provide education for staff and the community on issues relating to Advance Directives.

L. Change/Review of Proxy

At any time during the patient's hospitalization, the patient and/or Health Care Proxy (if appropriate) may review and modify the Health Care Proxy, as they so desire. If changes are made in the Health Care Proxy during the patient's episode of care, the new Proxy will become a part of the medical record and will supersede the "old Proxy" which will be destroyed.

M. Distribution of Health Care Proxy Information

1. It is the initial responsibility of the Admitting/Registration Department to query of, attain from and distribute to patients, Health Care Proxy information. The information sheet, ***"Decisions Concerning Your Medical Care"***, is included in the admission packet and is available in three languages (English, Spanish and Portuguese) to assist with hospital patient population's understanding of this concept (Attachment #1)

2. Inpatient Admissions

Nursing has primary responsibility for further querying the patient on their health care proxy status. Nursing will complete the Clinical Documentation Initial Patient Assessment. If a patient wishes to designate a health care proxy, the formal Massachusetts Health Care Proxy paperwork may be obtained from the Admitting Department (see Attachment #2) and is available in English, Spanish and Portuguese.

3. Surgical Day Care Services

   Depending on the service, campus and point of entry, Pre-Admission Testing, Registration/Outpatient Registration/Admitting has primary responsibility for querying the surgical day patient on their health care proxy status. Should a patient wish to designate a health care proxy, the formal Massachusetts Health Care Proxy paperwork may be obtained from the Admitting Department (see Attachment #2) and is available in English, Spanish and Portuguese.

4. Outpatient Admissions

   Health Care Proxy information is available for our Outpatients at all points of Registration. If an Outpatient (i.e. Laboratory, Imaging Services, Emergency Dept., etc.) desires to complete a Health Care Proxy, the Massachusetts Health Care Proxy paperwork may be obtained in the Admitting and Outpatient Registration Departments of MWMC. If the patient has questions regarding the health care proxy that the Registrar cannot address, the Department of Continuing Care, Patient Advocate, Admitting/Registration Manager or Risk Manager may be contacted for further assistance.

N. Location and Completion of Health Care Proxy Form

1. If the patient indicates **"YES",** he/she does have a Health Care Proxy; the goal is to obtain a copy of the Health Care Proxy from the patient. Oftentimes, to obtain a copy, it is important to ascertain the whereabouts of the Health Care Proxy.

   a. If the patient indicates that their Health Care Proxy is in their old medical record, the nursing completing Clinical Documentation Initial Patient Assessment will direct the unit secretary to call for the old medical record in order to place the Health Care Proxy in the patient's current medical record.

   b. If the patient indicates that their Health Care Proxy is at home, the staff person will request the patient to ask a family member to bring it to the hospital.

   c. If the patient has a copy of their Health Care Proxy with them, the staff person will place the copy in the patient's current medical record. No follow-up is needed if copy of Health Care Proxy is provided initially.

   d. If the inpatient indicates a wish to complete a new Health Care Proxy, the staff person completing the Clinical Documentation Initial Patient Assessment should leave a message with the Continuum of Care Department at ext. 1370, providing the patient's name, room number, and reason for follow-up.

   e. Whether the patient does or does not have their Health Care Proxy with them, it is the staff person's responsibility to obtain and record their contact information (i.e. name and telephone number).

2. If the patient indicates **"NO",** they do not have a Health Care Proxy, the goal is to document the following:

   a. The Admitting staff gives the inpatient the Health Care Proxy information in the Admitting packet. If patient declines the information, there is no need to go further.

b. The Admitting staff will provide the Health Care Proxy form to all outpatients who wish to complete a Health Care Proxy.

c. If the individual is an inpatient, and has indicated a desire to have help in completing the form, or needs additional information, the nursing staff calls the Continuum of Care Department at ext. 1370, leaving the patient's name, room number and reason for follow-up.

O. If the individual is unresponsive, the nursing staff leaves a message for the social worker to follow up, by calling the Continuum of Care Department at ext. 1370, leaving the patient's name, room number and reason for follow-up.

P. Follow-up process of placing the Health Care Proxy form in patient medical records

1. If the patient/family has provided an existing Health Care Proxy, a copy is placed in the record with documentation of date/time and signature of person performing this action. A copy is faxed to the Admitting Department, for MediTech update.

2. The PAT/SDC staff (for outpatients) or the social worker (for inpatients) documents the completion of a new Health Care Proxy, and a copy is placed in the patient's medical record, along with date/time and signature. A copy is faxed to the Admitting Department for MediTech update.

Q. Update of Patient Medical Record/Meditech

1. The Admitting Department enters the Health Care Proxy information into the Meditech system after receiving a faxed copy of the Health Care Proxy, and documents its completion. FAX # 1166, Framingham & FAX# 7101 Natick.

2. Any pertinent comments may be recorded.

V. References

Contact:	Manager, Patient Relations
Reviewed:	7/2002
Revised:	2/1997, 8/2003, 5/2005, 12/2006, 12/2008, 11/18/09, 11/11
Approved by:	Policy Committee 12/21/11

Signatures:

Manager, Patient Relations

Chairperson of Policy Committee

Vice President of Quality & Patient Safety

MASSACHUSETTS HEALTH CARE PROXY
Information, Instructions, and Form

What does the Health Care Proxy Law allow?

The Health Care Proxy is a simple legal document that allows you to name someone you know and trust to make health care decisions for you if, for any reason and at any time, you become unable to make or communicate those decisions. It is an important document, however, because it concerns not only the choices you make about your health care, but also the relationships you have with your physician, family, and others who may be involved with your care. Read this and follow the instructions to ensure that your wishes are honored.

Under the Health Care Proxy Law (Massachusetts General Laws, Chapter 201D), any competent adult 18 years of age or over may use this form to appoint a Health Care Agent. You (known as the "Principal") can appoint any adult EXCEPT the administrator, operator, or employee of a health care facility such as a hospital or nursing home where you are a patient or resident UNLESS that person is also related to you by blood, marriage, or adoption.

What can my Agent do?

Your Agent will make decisions about your health care only when you are, for some reason, unable to do that yourself. This means that your Agent can act for you if you are temporarily unconscious, in a coma, or have some other condition in which you cannot make or communicate health care decisions. Your Agent cannot act for you until your doctor determines, in writing, that you lack the ability to make health care decisions. Your doctor will tell you of this if there is any sign that you would understand it.

Acting with your authority, your Agent can make any health care decision that you could, if you were able. If you give your Agent full authority to act for you, he or she can consent to or refuse any medical treatment, including treatment that could keep you alive.

Your Agent will make decisions for you only after talking with your doctor or health care provider, and after fully considering all the options regarding diagnosis, prognosis, and treatment of your illness or condition. Your Agent has the legal right to get any information, including confidential medical information, necessary to make informed decisions for you.

Your Agent will make health care decisions for you according to your wishes or according to his/her assessment of your wishes, including your religious or moral beliefs. You may wish to talk first with your doctor, religious advisor, or other people before giving instructions to your Agent. It is very important that you talk with your Agent so that he or she knows what is important to you. If your Agent does not know what your wishes would be in a particular situation, your Agent will decide based on what he or she thinks would be in your best interests. After your doctor has determined that you lack the ability to make health care decisions, if you still object to any decision made by your Agent, your own decisions will be honored unless a Court determines that you lack capacity to make health care decisions.

Your Agent's decisions will have the same authority as yours would, if you were able, and will be honored over those of any other person, except for any limitation you yourself made, or except for a Court Order specifically overriding the Proxy.

How do I fill out the form?

1. At the top of the form, print your full name and address. Print the name, address, and phone number of the person you choose as your Health Care Agent. (Optional: If you think your Agent might not be available at any future time, you may name a second person as an Alternate Agent. Your Alternate Agent will be called if your Agent is unwilling or unable to serve.)

   Setting limits on your Agent's authority might make it difficult for your Agent to act for you in an unexpected situation. If you want your Agent to have full authority to act for you, leave the limitations space blank. However, if you want to limit the kinds of decisions you would want your Agent or Alternate Agent to make for you, include them in the blank.

2. **BEFORE** you sign, be sure you have two adults present who can witness you signing the document. The only people who cannot serve as witnesses are your Agent and Alternate Agent. Then sign the document yourself. (Or, if you are physically unable, have someone other than either witness sign your name at your direction. The person who signs your name for you should put his/her own name and address in the spaces provided.)

3. Have your witnesses fill in the date, sign their names and print their names and addresses.

4. **OPTIONAL:** On the back of the form are statements to be signed by your Agent and any Alternate Agent. This is not required by law, but is recommended to ensure that you have talked with the person or persons who may have to make important decisions about your care and that each of them realizes the importance of the task they may have to do.

Who should have the original and copies?

After you have filled in the form, remove this information page and make at least four photocopies of the form. Keep the original yourself where it can be found easily (not in your safe deposit box). Give copies to your doctor and/or health plan to put into your medical record. Give copies to your Agent and any Alternate Agent. You can give additional copies to family members, your clergy and/or lawyer, and other people who may be involved in your health care decision-making.

How can I revoke or cancel the document?

Your Health Care Proxy is revoked when any of the following four things happens:

1. You sign another Health Care Proxy later on.

2. You legally separate from or divorce your spouse who is named in the Proxy as your Agent.

3. You notify your Agent, your doctor, or other health care provider, orally or in writing, that you want to revoke your Health Care Proxy.

4. You do anything else that clearly shows you want to revoke the Proxy, for example, tearing up or destroying the Proxy, crossing it out, telling other people, etc.

MASSACHUSETTS HEALTH CARE PROXY

BIRTH DATE
____/____/____

1. I,_____, residing at
(Principal - PRINT your name)

_____
(Street) (City or town) (State)

Appoint as my Health Care Agent:_____
(Name of person you choose as Agent)

of _____
(Street) (City/town) (State) (Phone)

OPTIONAL: If my Agent is unwilling to serve, then I appoint as my Alternate Agent:

_____of
(Name of person you choose as Alternate Agent)

_____
(Street) (City/town) (State) (Phone)

2. My Agent shall have the authority to make all health care decisions for me, including decisions about life-sustaining treatment, subject to any limitations I state below, if I am unable to make health care decisions myself. My Agent's authority becomes effective if my attending physician determines in writing that I lack the capacity to make or to communicate health care decisions. My Agent is then to have the same authority to make health care decisions as I would if I had the capacity to make them **EXCEPT** (here list the limitations, if any, you wish to place on your Agent's authority):

I direct my Agent to make health care decisions based on my Agent's assessment of my personal wishes. If my personal wishes are unknown, my Agent is to make health care decisions based on my Agent's assessment of my best interests. Photocopies of this Health Care Proxy shall have the same force and effect as the original and may be given to other health care providers.

3. Signed: _____

Complete only if Principal is physically unable to sign: I have signed the Principal's name above at his/her direction in the presence of the Principal and two witnesses.

_____
(Name) (Street)

_____
(City/town) (State)

4. WITNESS STATEMENT: We, the undersigned, each witnessed the signing of this Health Care Proxy by the Principal or at the direction of the Principal and state that the Principal appears to be at least 18 years of age, of sound mind and under no constraint or undue influence. Neither of us is named as the Health Care Agent or Alternate Agent in this document. In our presence, on this _____day of _____, 20____

Witness #1_____ Witness #2_____
(Signature)

Name (print)_____ Name (print)_____

Address_____ Address_____

_____ _____

5. Statements of Health Care Agent and Alternate Agent (OPTIONAL)

Health Care Agent: I have been named by the Principal as the Principal's **Health Care Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Health Care Agent**) _____

Alternate Agent: I have been named by the Principal as the Principal's **Alternate Agent** by this Health Care Proxy. I have read this document carefully, and have personally discussed with the Principal his/her health care wishes at a time of possible incapacity. I know the Principal and accept this appointment freely. I am not an operator, administrator or employee of a hospital, clinic, nursing home, rest home, Soldiers Home or other health facility where the Principal is presently a patient or resident or has applied for admission. Or if I am a person so described, I am also related to the Principal by blood, marriage, or adoption. If called upon and to the best of my ability, I will try to carry out the Principal's wishes.

(Signature of **Alternate Agent**) _____

Model Health Care Proxy form developed by a Task Force of the following organizations:

Boston University Schools of Medicine and Public Health: Law, Medicine, and Ethics Program
Deaconess ElderCare Program
Hospice Federation of Massachusetts
Massachusetts Bar Association
Massachusetts Department of Public Health
Massachusetts Executive Office of Elder Affairs
Massachusetts Federation of Nursing Homes
Massachusetts Health Decisions
Massachusetts Hospital Association
Massachusetts Medical Society
Massachusetts Nurses Association
Medical Center of Central Massachusetts
Suffolk University Law School: Elder Law Clinic
University of Massachusetts at Boston: The Gerontology Institute
Visiting Nurse Associations of Massachusetts

Providers: For prices and information on quantity orders or for non-English language licensing, please contact Massachusetts Health Decisions, PO Box 417, Sharon, MA 02067

rev. 11/2010

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Clinical Ethics Consultation

I. Policy Statement

MetroWest Medical Center is dedicated to providing quality patient care within an ethical framework that includes the perspectives of patients, their families, the community, and the hospital and health care providers.

MetroWest Medical Center Clinical Ethics Committee explores/addresses clinical ethics issues at the Medical Center. This committee is an advisory committee, intended to serve as a mechanism for considering ethical issues arising out of patient care activities and as an education resource for caregivers, patients and families. Consultations are provided on a voluntary basis. Any advice provided by the Ethics Committee is in the form of suggestions rather than mandates.

The Medical Center shall inform all patients admitted to the hospital, caregivers and Medical Center staff about the Clinical Ethics Committee, its functions and how to contact/access the Committee.

II. Purpose

To provide information regarding case consultation, policy and guideline development, input and/or review specific to subjects involving medical ethical decisions.

III. Definitions

IV. Procedure

A. Membership

The Clinical Ethics Committee is comprised of representatives from multi-disciplines including Medicine, Nursing, Administration, Social Services, Chaplaincy, and Interpreter Services, in addition to community members with a background or interest in, (for example/but not limited to) ethics, religion, law or public health. Other members may be appointed as needed. The Clinical Ethics Committee reports to the Medical Executive Committee (MEC). The Chair of the Clinical Ethics Committee is a physician appointed by the President of the Medical Staff on an annual basis.

B. Meetings

The Clinical Ethics Committee meets at least quarterly and at the discretion of the Chairman in addition to any requests to meet as needed. Minutes of each meeting shall be kept and distributed to each member of the Clinical Ethics Committee and to the President of the Medical Staff.

C. Functions

1. Case Consultation/Procedure

a. A patient, a member of the patient's family, or a caregiver may request an Ethics Committee consultation on ethical issues arising out of a patient's care by notifying the Chair of the Ethics Committee or the Medical Center's Patient Advocate. As

directed by the Chair, the Ethics Committee, or its designee, shall interview the relevant parties and review pertinent documents. The Committee shall, as promptly as practicable, consider the issues raised and may issue voluntary, non-binding recommendations to the involved parties. The Chair of the Committee reviews requests and refers as needed to other Hospital committees or personnel as the Chair determines to be appropriate.

b. During off-hours, hospital personnel may expedite a request for an ethical consultation by notifying the Nursing Supervisor and/or Administrator On-Call, who will then initiate notifying the Chair or Designee of the Clinical Ethics Committee.

2. Education

The Clinical Ethics Committee shall periodically sponsor or conduct educational programs on ethical topics in the health care field for Hospital staff, caregivers and the public. The Clinical Ethics Committee shall collect and make available on request materials on ethical topics in health care.

3. Policy Development

The Clinical Ethics Committee, either at its own initiative or on request by Hospital Administration, Medical Staff, or a caregiver, may consider/review Hospital policies that have ethical implications, e.g., policies regarding patient care, patient rights and other issues. The Clinical Ethics Committee shall use its best efforts to consult with all appropriate persons and/or committees when considering hospital policies.

V. References

Contact:	Patient Relations	
Reviewed:	8/2006, 12/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Committee	12/15/10

Signatures:

Susan E. Wilder
Department Head/ Committee Chairperson

Christine Brzezinski
Chairperson of Policy Committee

Linda M Campbell
Director of Quality and Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Palliative Care Committee

I. Policy Statement

This policy defines the roles/responsibilities of the palliative care committee.

II. Purpose

To outline the roles/responsibilities of the palliative care committee.

III. Definitions

IV. Procedure

1. The palliative care committee will report to the chief medical and nursing officers and consist of the following members:
   - Two representatives from the palliative care program—one physician and one nurse
   - One representative from hospital and/or nursing administration
   - One representative from nursing administration
   - One representative from the critical care subcommittee
   - One representative from the ethics committee
   - One representative from each of the following services or administrative committees: critical care committee, cardiovascular medicine service, the neuroscience services, surgical services, consult/liaison psychiatry service, medicine service
   - One representative each from the hospital departments of social services, chaplaincy services, pharmacy and organ procurement
2. The palliative care subcommittee will meet at least quarterly.
3. The palliative care subcommittee will establish and direct efforts to meet or exceed Joint Commission/NQF palliative care/hospice standards, and as part of this effort, is responsible for:
   - Overseeing clinical programs that relate to palliative care, including but not limited to the palliative pare program, the bereavement program and hospital initiatives to improve pain management
   - Monitoring palliative care clinical care practices through evaluation of data concerning pain and symptom control, advance directives, utilization of hospital resources, hospice referrals and patient/family satisfaction
   - Developing and implementing palliative care education initiatives for all staff health professionals to include competency-based metrics for relevant clinical staff
   - Making recommendations to the medical executive committee regarding appropriate changes in patient care policies and procedures

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Assessment and Treatment of Physical/Emotional Symptoms

I. Policy Statement

The medical center ensures that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their hospitalization.

II. Purpose

To ensure that all patients who are experiencing pain, physical symptoms and emotional symptoms are managed with quality and consistency throughout their hospitalization.

III. Definitions

"Physical/emotional symptoms" include the entire range of symptoms associated with serious illness. The most common symptoms include: pain, nausea, dyspnea, anxiety, depression, constipation, anorexia and fatigue.

IV. Procedure

1. The palliative care team completes a comprehensive assessment. The assessment considers:
   - Diagnosis
   - Presenting problems
   - Current treatments, medication profile and side effects
   - Current pain/symptom management regimen
   - Patient concerns
   - Patient/family preferences
   - Spiritual and cultural beliefs and values that influence treatments

2. The patient is asked to characterize his/her symptoms using a hospital-approved assessment scale at the time of initial assessment and at regularly prescribed intervals following the assessment, and after initiation of therapy.

3. The team proposes a comprehensive treatment plan; the team confers with the patient and family and confirms plan elements.

4. The team instructs the patient/family on any self-care procedures.

5. The team works with the nursing staff to ensure the implementation and monitoring of the treatment plan.

6. The nursing staff works with the team to assess the patient's response to treatment, including:
   - Response to medications or nonpharmacological interventions
   - Symptom relief measured on a consistently utilized scale
   - Adverse events/reactions/side effects
   - Satisfaction with intervention

7. The treatment plan is modified based on ongoing assessment.

8. Timely referrals are made to specialists when standard treatments fail to improve physical or psychological symptoms.

9. The team ensures that all assessments, recommendations, interventions and responses to therapy are documented in the medical record, and that changes in the plan of care are communicated to the team and the nursing staff in writing and verbally at the time they occur.

10. Prior to discharge a plan is established for continuing care requirements and family/caregiver education/support (see Policies #5 and #9).

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital · Leonard Morse Hospital

Palliative Care: Continuity of Care

I. Policy Statement

The Palliative Care Service will ensure continuity of care upon discharge for patients receiving palliative care consultative services.

II. Purpose

To ensure continuity of care upon discharge for patients receiving palliative care consultative services.

III. Definitions

"Continuity of care" is the multidisciplinary coordination of care that includes or considers all clinical diagnoses, treatments, psychosocial needs, patient preferences and personal resources.

IV. Procedure

1. A palliative care team member is responsible for working with other health care staff (e.g., social service providers, discharge planners) for coordinating the discharge plan.
2. A team member synthesizes the plan of care and works to convert the patient's treatment goals into medical orders that are transferable across care settings.
3. A team member confirms access to services that can assist following discharge:
   - ☐ Physician specialists
   - ☐ Nursing home/intermediate care facilities
   - ☐ Hospice
   - ☐ Home health care
   - ☐ Outpatient palliative care
   - ☐ Durable medical equipment services
   - ☐ Rehabilitation services
   - ☐ Counseling services
   - ☐ Transportation
   - ☐ Rehabilitation
   - ☐ Medications
4. A team member reviews the legibly written discharge plan with the patient/surrogate and/or caregivers prior to discharge and assesses comprehension using the teach-back method.
5. A team member confirms that the referring agencies receive copies of the discharge planning documents, the physician's orders and any other clinical documentation and relevant information.

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10
Signatures:		

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Scope of Practice

I. Policy Statement

This policy defines the practice of palliative care.

II. Purpose

To define the practice of palliative care.

III. Definitions

1. "Palliative care" is the comprehensive care and management of the physical, psychological, emotional and spiritual needs of patients (of all ages) and their families with serious and/or life-threatening illness. Palliative care may be complementary to curative or life-prolonging therapies that are being used to meet patient-defined goals of care.
2. "Palliative care clinicians" may include some or all of the following—physicians, nurses or advance practice nurses, social workers, chaplains, psychologists, pharmacists

IV. Procedure

A. The palliative care team will work to:
- Optimize symptom control
- Optimize functional status when appropriate
- Promote the highest quality of life for patient and family
- Educate patients and family to promote understanding of the underlying disease process and expected future course of the illness
- Establish an environment that is comforting and healing
- Plan for discharge to the appropriate level of care in a timely manner
- Assist actively dying patients and their families in preparing for and managing life closure
- Serve as educators and mentors for staff
- Promote a system of care that fosters timely access to palliative care services

B. The process of providing palliative care services includes:
1. Initial and subsequent assessments are carried out through patient and family interviews, review of medical records, discussion with other providers, physical examination, and review of laboratory, diagnostic tests and procedures.
2. Assessment includes documentation of:
   - Disease status/treatment history
   - Functional status and expected prognosis
   - Comorbid medical and psychiatric disorders
   - Physical, psychological and spiritual symptoms and concerns
   - Advance care planning preferences/surrogate decision maker(s)
3. All initial and ongoing assessments data are reviewed on a regular basis. Assessment findings are the basis for the care planning process.
4. Reassessment is performed as needed by the clinical situation.

V. References

Center for Advancement of Palliative Care

Revised:

Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Patient Self-Determination

I. Policy Statement

The Medical Center will ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

II. Purpose

To ensure that patients and/or their surrogates make informed decisions about proposed medical treatments.

III. Definitions

"Patient self-determination" includes making treatment decisions, designating a health care proxy, establishing advance directives, deciding to request or refuse to continue or discontinue care and/or choosing whether or not to attempt resuscitation.

IV. Procedure

The attending physician will:

1. Establish ongoing communication and documentation with the patient and surrogate that includes discussions of:
   - Health status
   - Current disease(s) and expected future course, including prognosis
   - Treatment options
   - Patient preferences
   - Spiritual and cultural beliefs and values that influence preferences
   - The right of the patient to choose and to change his/her choices at any time
   - The legal options for expressing desires through advance care planning documents/directives
2. Begin discussion with the patient and/surrogate at the time of diagnosis and continue to communicate with the patient throughout the course of care.
3. Validate the patient's/surrogate's understanding of the information presented and introduce new information and choices as the patient's condition changes.
4. Define terminology, including DNR, power of attorney for health care and living will, and ensure that all choices are documented on appropriate forms.
5. Honor advance directives in accordance with hospital policy and state statutes.
6. Provide empathy and support as patients/surrogates make decisions.
7. Document all communication in the medical record and convey patient/surrogate decisionsto other health care team members.

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

Palliative Care: Referral Process and Guidelines

I. Policy Statement

This policy outlines the procedure for making referrals to the Palliative Care Service.

II. Purpose

To outline procedures for initiating a palliative care consultation.

III. Definitions

IV. Procedure

A. Making a referral:
1. A referral to the palliative care service can come from many sources: physicians, nurses, family members, patients, social workers and clergy.

2. If the referral comes from anyone other than an attending physician, a member of the palliative care team notifies the primary care physician of the referral and requests permission to provide a consultation.

B. Prioritizing requests for palliative care consults:
1. Emergent (Immediate): In the event of an emergent problem (e.g., severe uncontrolled pain), the palliative care team member on call will respond immediately to the consult request.

2. Urgent (2 to 4 hours): In the event of an urgent medical problem, the palliative care team member on call responds as soon as possible or within a one-hour time frame.

3. Nonurgent: All nonurgent consultations are completed within 24 hours.

C. Responding to a consult request:
1. The palliative care team responds to all requests for referrals/consultations.

2. If the palliative care team member determines that an initial assessment or continued follow-up is not appropriate, the palliative care team will work with the attending physician to facilitate patient access to the appropriate resource(s).

D. Role of the palliative care team after initial consultation:
Based on the specific needs of the patient, there is discussion between the palliative care team member and the primary physician to determine the role of the palliative care team. The role may involve:

1. Providing advice to patient/family or staff (e.g., no orders are written by the palliative care team)

2. Consulting with orders (e.g., providing pain management and symptom control; supporting the primary physician during family meetings)

3. Taking total responsibility for the patient (e.g., when the palliative care physician becomes the primary attending)

E. On-call schedule:
To ensure access to palliative care services, an on-call schedule is created for coverage

24 hours per day, 7 days per week.

General Referral Criteria

- ☐ Presence of a serious illness and one or more of the following:
- ☐ New diagnosis of life-limiting illness for symptom control, patient/family support
- ☐ Declining ability to complete activities of daily living
- ☐ Weight loss
- ☐ Progressive metastatic cancer
- ☐ Admission from long-term care facility
- ☐ Two or more hospitalizations for the same illness within three months
- ☐ Difficult-to-control physical or emotional symptoms
- ☐ Patient, family or physician uncertainty regarding prognosis
- ☐ Patient, family or physician uncertainty regarding appropriateness of treatment options
- ☐ Patient or family requests for futile care
- ☐ DNR order uncertainty or conflicts
- ☐ Uncertainty or conflicts regarding the use of nonoral feeding/hydration in cognitively impaired, seriously ill or dying patients
- ☐ Limited social support in setting of a serious illness (e.g., no family support system, lives alone, homeless, chronic mental illness)
- ☐ Patient, family or physician request for information regarding hospice appropriateness
- ☐ Patient or family psychological or spiritual distress

Intensive Care Unit Criteria

- ☐ Admission from a nursing home in the setting of one or more chronic life-limiting conditions (e.g., advanced dementia)
- ☐ Two or more ICU admissions within the same hospitalization
- ☐ Prolonged or failed attempt to wean from ventilator
- ☐ Multiorgan failure
- ☐ Consideration of ventilator withdrawal with expected death
- ☐ Metastatic cancer
- ☐ Anoxic encephalopathy
- ☐ Consideration of patient transfer to a long-term ventilator facility
- ☐ Family distress impairing surrogate decision making
- ☐ Coma or PVS lasting more than two weeks
- ☐ Progressive pleural/peritoneal or pericardial effusions

Neurological Criteria

- ☐ Folstein Mini Mental Score < 20
- ☐ Feeding tube being considered for any neurological condition
- ☐ Status epilepticus > 24 hours
- ☐ ALS or other neuromuscular disease considering mechanical ventilation
- ☐ Any recurrent brain neoplasm
- ☐ Parkinson's disease with poor functional status or dementia
- ☐ Advanced Alzheimer's or other dementia with poor functional status and one or more hospitalizations for infection in the last six months
- ☐ Coma or PVS lasting more than two weeks

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10
Signatures:		

Judith A Edson, RN

Department Head/ Committee Chairperson

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Chairperson of the Policy Review Committee

Linda Mengbell
Director of Quality & Patient Care

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Care Planning

I. Policy Statement

The Palliative Care Service will ensure that care planning is individualized, interdisciplinary and based on the assessed needs of the patient.

II. Purpose

To ensure that care planning is individualized, interdisciplinary and based on the assessed needs of the patient

III. Definitions

IV. Procedure

1. The care plan is based upon an ongoing assessment, determined by goals set with patient and family, and with consideration of the changing benefit/burden assessment at critical decision points during the course of illness.
2. The care plan is developed through the input of patient, family, caregivers, involved health care providers and the palliative care team with the additional input, when indicated, of other specialists and caregivers (e.g., clergy, friends).
3. The care plan process includes structured assessment and documentation to include:
   - Physical and psychological assessment, which addresses the current disease status, treatment options, functional status, expected prognosis, symptom burden and psychological coping
   - Social and spiritual assessment, which addresses the social, practical, religious, spiritual, existential concerns, and legal needs of the patient and caregivers, including but not limited to: relationships, communication, existing social and cultural networks, decision making, work and school settings, finances, sexuality/intimacy, caregiver availability and stress, access to medicines and equipment
   - Cultural assessment, including, but not limited to, locus of decision making, preferences regarding disclosure of information, truth telling and decision making, dietary preferences, language, family communication, desire for complementary and alternative medicine, perspectives on death, suffering and grieving, and funeral/burial rituals
4. Care planning conferences (aka family meetings) with a patient and family will occur regularly to determine the most appropriate goals of care as indicated by the clinical conditions, and are coordinated by the palliative care team in conjunction with the attending physician and other hospital staff.
5. Care plan changes are based on the evolving needs and preferences of the patient and family over time, recognizing the complex, competing and shifting priorities in goals of care.
6. The palliative care team provides support for decision making, develops and carries out the care plan and communicates the plan to patient, family, involved health professionals and to the providers involved with patient transfer to different internal or external care settings.

V. References

Center for Advancement of Palliative Care

Revised:
Approved by: Ethics Committee 12/9/10
Policy Review Committee 12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital · Leonard Morse Hospital

Palliative Care: Patient/Family/Caregiver Education

I. Policy Statement

The medical center will ensure that the patient/family/caregivers receive education and training specific to the patient's needs and abilities.

II. Purpose

To ensure that the patient/family/caregivers receive education and training specific to the patient's needs and abilities.

III. Definitions

IV. Procedure

1. During the assessment process, patient/family/caregiver educational needs and cognition/emotional abilities are assessed and documented. The following is a list of common issues to be addressed, depending on the patient's unique clinical circumstances:
   - Pain and symptom management, including side-effect management
   - Advance care planning and advance directives
   - Anticipated future medical needs
   - Home or institutional support options (e.g., home hospice services)
   - What to expect in the normal course of the disease
   - Signs/symptoms of approaching death
   - Community services (e.g., bereavement, counseling)
   - Whom to call for routine and emergency needs

2. Educational/counseling needs are routinely assessed and reassessed throughout care and treatment.

3. When educational needs are identified, they are incorporated into the plan of care.

4. Age- , language- and educationally appropriate educational materials (written, Internet, oral) will be provided to meet the needs identified in the assessment process.

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

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Chairperson of the Policy Review Committee

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METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: End-of-Life Care

I. Policy Statement

The integration of hospice and palliative care will be a key component of a family centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

II. Purpose

To define the integration of hospice and palliative care as a key component of family centered, compassionate care, guided by a sense of respect, empathy and concern that addresses the unique needs of patients and their families.

III. Definitions

"End-of-life care" is not bounded by a specific prognosis; rather, it involves the recognition of the irreversibility of a life-limiting medical condition(s) that will likely result in death.

IV. Procedure

1. Meeting patient and family needs is the central focus of care when cure or maintaining the continuum of health is no longer possible. Optimal care requires exceptional communication among clinical staff and a recognition that a team approach, inclusive of many health care disciplines, is necessary.
2. Patients are treated with respect to their individual wishes for care and treatment with consideration of their values, religion and philosophy. A request to discontinue treatment will be honored with the same support and respect as the decision to continue treatment.
3. The palliative care consultation service is available to assist with symptom management, prognosis determination, patient and family support, disposition planning and other issues related to end-of-life decisions.
4. Hospice services are recognized as an integral part of the continuum of care. Patients who have an expected prognosis of six months or less, assuming the disease follows its usual course, should be offered hospice services.
5. Bereavement support and chaplaincy services are available to patients and their family members. Nursing, social services and the chaplaincy program are available to provide resources to families. The bereavement services coordinator can assist with the care team and with aftercare.
6. In the event of questions or differences of opinion among the patient, family or health care team members about the treatment goals, consultation is available from the hospital ethics committee.

V. References

Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Pain Management and Opioid Prescribing

I. Policy Statement

The medical center will ensure that all patients who are experiencing pain are managed with Quality and consistency throughout their hospitalization

II. Purpose

To ensure that all patients who are experiencing pain are managed with quality and consistency throughout their hospitalization

III. Definitions

IV. Procedure

A. Standards for assessment

1. The fundamental principles of pain management will be followed as defined in Principles of Analgesic Use in the Treatment of Acute Pain and Cancer Pain of the American Pain Society.

2. The patient's culture and age will be assessed upon admission. This is a joint responsibility of nursing and medical staff members. The assessment and treatment of pain will be consistent with the patient's cultural and age-specific needs. All patients will be assessed for pain by using the Pain Assessment Hierarchy: self-report of pain; presence of pathological condition or procedure that usually causes pain; pain behavior; proxy pain rating; autonomic response. The pain rating tool, Visual Analog Scale (VAS), includes a numeric, face, color and descriptive scoring. The pain assessment includes the quality and location of pain, functional limitations caused by pain and the expectations and perceptions of patients and their significant others.

3. Pain is the fifth vital sign and will be assessed on admission, with vital signs (not exceeding every four hours), upon self-report of pain, and if pain of the nonverbal patient is presumed. Pain will be reassessed after each intervention and documented as a VAS score or behavior change.

4. A plan of care will be established to deal with pain; the plan should involve both pharmacological and nonpharmacological interventions. The patient's pain goal will be identified (functional improvement and/or VAS score) and will be documented as such so that all team members will know the expectations of care and will incorporate the pain goal in discharge planning.

5. If the patient's goal for pain management or significant progress toward the goal is not achieved in a timely manner, a consultation for assistance is encouraged. It is recommended that a guideline of 24 hours be used by the admitting health care team for determining the need for consultation. In the event of questions or differences of opinion among the patient, family or health care team, there is an administrative chain of command to support appropriate ordering of pain medicines (see C below).

B. Standards for opioid therapy

1. Dose ranges and titration doses

Medications ordered by prescribers for a time range (q2–4 hr) will be interpreted and added to the patient's Medication Administration Record (MAR) as the most frequent interval. A maximum twofold dose range is allowed. If the range exceeds a twofold increment in dose, the range will be automatically adjusted to a twofold range based

on the lowest dose ordered. This adjustment will appear on the patient's electronic Medication Administration Record.

2. Product selection
Patients requiring continuous opioid therapy may be on only one continuous or long-acting opioid at a single time. This includes the following:
- ☐ Opioid via PCA with basal rate
- ☐ Opioid via continuous infusion
- ☐ Extended-release morphine
- ☐ Extended-release oxycodone
- ☐ Transdermal fentanyl patch

Patients requiring a short-acting or rapid-onset opioid or opioid-combination product may be prescribed only a single product at any time. These include:
- ☐ Morphine
- ☐ Hydromorphone
- ☐ Oxycodone
- ☐ Oxycodone/acetaminophen (Percocet)
- ☐ Codeine/acetaminophen (Tylenol #3)
- ☐ Hydrocodone/acetaminophen (Vicodin)

Regimens for opioid and acetaminophen-combination products may not be prescribed in such a manner where the dose of acetaminophen could exceed 4000mg in a 24-hour period.
Meperidine use is restricted to the following two situations:
- ☐ Infusion-related reactions (e.g., amphotericin, immune globulin)
- ☐ Short-term, procedure-related use for no more than 48 hours and at doses not to exceed 600mg in a 24-hour period

C. Resources for pain management assistance
1. Administrative chain of command
Staff RN, then house staff, then attending physician, then nursing administration, then hospital chief of staff

2. Pain resource professionals
Pain Resource Nurse and pharmacists with focused pain education

3. Palliative care service
Pain management for patients with serious and/or life-threatening illness and cancer

4. Pain management clinic
Nonemergent inpatient and outpatient consultation for assessment and triage of chronic nonmalignant pain

V. References

Center for Advancement of Palliative Care

Contact:	John R. Edson, RN, MS	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Policy Review Committee	12/15/10

Signatures:

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Linda Mangler
Director of Quality & Patient Safety

METROWEST MEDICAL CENTER
Framingham Union Hospital • Leonard Morse Hospital

Palliative Care: Care of the Imminently Dying

I. Policy Statement

There will be a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern, that addresses the unique needs of patients and their families.

II. Purpose

To provide a standard of care integrating high-quality, family-centered compassionate care, guided by a sense of respect, empathy and concern, that addresses the unique needs of patients and their families.

III. Definitions

"Imminently dying" (*aka* actively dying) specifies the period of a patient's illness when death can be reasonably expected to occur within 14 days. Common signs/symptoms of imminent death include: sedation or delirium, death rattle, no use of oral or artificial hydration/nutrition, and no plans for further life-sustaining treatments.

IV. Procedure

Care will include:

1. Documentation in the medical record that a patient is "imminently" or "actively" dying
2. Communication with the patient, family and surrogate decision makers that death is imminent
3. Preparing patient and family for what to expect during the normal dying process
4. Managing pain and other physical/psychological symptoms effectively
5. Educating/counseling patients and families concerning the appropriate use of pain and symptom treatments
6. Providing treatment of symptoms according to the wishes of the patient or family
7. Providing options for out-of-hospital care, including home or residential hospice services
8. Respecting the patient's privacy, values, religion, culture and philosophy
9. Involving the patient and family in all aspects of care
10. Responding to the psychological, social, emotional, spiritual and cultural concerns of the patient and family, including children and teens affected by the death
11. Treating the body post death with respect according to the cultural and religious practices of the family and in accordance with local law
12. Addressing issues of body or organ donation, autopsy and funeral planning with sensitivity
13. Providing bereavement resources through the hospital and community
14. If, because patient is too ill to transfer to more appropriate level of care non-acute care, patient will be considered for General Inpatient Hospice:
    -Palliative Care Committee representative confirms patient is appropriate for GIP hospice, then patient will require:
    1. Discharge order("Discharge to GIP hospice) and Discharge Summary from attending physician
    2. GIP admission order in conjunction with Palliative Care Admission Order Set completion by attending physician for GIP hospice care.
    3. Re-affirmation of detailed elements of History and Physical from attending physician.
    4. Daily notes and Discharge Summary for GIP episode of care.
15. Patients admitted to GIP hospice who become stable enough for transfer and who have a safe discharge plan will be discharged from GIP hospice to an appropriate alternate level of care.

V. References
Center for Advancement of Palliative Care

Contact:	Metrowest Home Care & Hospice	
Reviewed:	12/14/2010	
Revised:		
Approved by:	Ethics Committee	12/9/10
	Policy Review Committee	12/15/10

Signatures:

Department Head/ Committee Chairperson

Chairperson of the Policy Review Committee

Director of Quality & Patient Safety

EXHIBIT 12: DUE DILIGENCE RESPONSES 11.2 AND 11.3

Vanguard Health Systems, Inc. Completes Sale of Three Orange County Hospitals to Prime Healthcare Services, Inc.

NASHVILLE, Tennessee (October 2, 2006) – Vanguard Health Systems, Inc. ("Vanguard") announced today that it has completed the previously announced sale of three acute care hospitals in Orange County, California to Prime Healthcare Services, Inc. ("PHS") on terms previously disclosed. The sale included 131-bed Huntington Beach Hospital, Huntington Beach, CA; 141-bed La Palma Intercommunity Hospital, La Palma, CA and 219-bed West Anaheim Medical Center, Anaheim, CA.

About Vanguard Health Systems

Vanguard Health Systems, Inc. owns and operates 16 acute care hospitals and complementary facilities and services in Chicago, Illinois; Phoenix, Arizona; San Antonio, Texas and Massachusetts. The Company's strategy is to develop locally branded, comprehensive healthcare delivery networks in urban markets. Vanguard will pursue acquisitions where there are opportunities to partner with leading delivery systems in new urban markets. Upon acquiring a facility or network of facilities, Vanguard implements strategic and operational improvement initiatives, including expanding services, strengthening relationships with physicians and managed care organizations, recruiting new physicians and upgrading information systems and other capital equipment. These strategies improve quality and network coverage in a cost effective and accessible manner for the communities we serve.

This press release contains forward-looking statements within the meaning of the federal securities laws, which are intended to be covered by the safe harbors created thereby. These forward-looking statements include all statements that are not historical statements of fact and those statements regarding the Company's intent, belief or expectations. Do not rely on any forward-looking statements as such statements are subject to numerous factors, risks and uncertainties that could cause the Company's actual outcomes, results, performance or achievements to be materially different from those projected. These factors, risks and uncertainties include, among others, the Company's high degree of leverage; the Company's ability to incur substantially more debt; operating and financial restrictions in the Company's debt agreements; the Company's ability to successfully implement its business strategies; the Company's ability to successfully integrate its recent and any future acquisitions, including the transactions in connection with which this tender offer is being conducted; the highly competitive nature of the health care business; governmental regulation of the industry including Medicare and Medicaid reimbursement levels; changes in Federal, state or local regulation affecting the health care industry; the possible enactment of Federal or state health care reform; the ability to attract and retain qualified management and personnel, including physicians and nurses; claims and legal actions relating to professional liabilities or other matters; changes in accounting practices; changes in general economic conditions; the Company's exposure to the increased amounts of and collection risks associated with uninsured accounts and the co-pay and deductible portions of insured accounts; the impact of changes to the Company's charity care and self-pay discounting policies; the ability to enter into managed care provider and other payer arrangements on acceptable terms; the efforts of insurers, managed care payers, employers and

others to contain health care costs; the availability and terms of capital to fund the expansion of the Company's business; the timeliness of reimbursement payments received under government programs; the potential adverse impact of known and unknown government investigations; and those factors, risks and uncertainties detailed in the Company's filings from time to time with the Securities and Exchange Commission, including, among others, the Company's Annual Reports on Form 10-K and its Quarterly Reports on Form 10-Q.

Although the Company believes that the assumptions underlying the forward-looking statements contained in this press release are reasonable, any of these assumptions could prove to be inaccurate, and, therefore, there can be no assurance that the forward-looking statements included in this press release will prove to be accurate. In light of the significant uncertainties inherent in the forward-looking statements included herein, you should not regard the inclusion of such information as a representation by the Company that its objectives and plans anticipated by the forward-looking statements will occur or be achieved, or if any of them do, what impact they will have on the Company's results of operations or financial condition. The Company undertakes no obligation to publicly release any revisions to any forward-looking statements contained herein to reflect events and circumstances occurring after the date hereof or to reflect the occurrence of unanticipated events.

CONTACT: **Vanguard Health Systems, Inc**.
Aaron Broad, Director Investor Relations (615) 665-6131

11.3 Tufts Affiliation

In New England, we are in exclusive negotiations with Tufts Medical Center ("Tufts MC") and New England Quality Care Alliance ("NEQCA") to create an innovative, game-changing partnership through a series of joint ventures that will establish a third major provider network and integrated delivery system in Massachusetts. Tufts MC is a not-for-profit, tertiary and quaternary referral, teaching, and research hospital with a licensed capacity of 415 beds located in Boston, MA. Tufts MC affiliates with community-based private practice physicians through NEQCA, a network of independent and employed physicians and hospitals based in Braintree, Massachusetts. This partnership and resulting regional network will capitalize upon Tufts MC's brand, academic and clinical affiliations, NEQCA's expertise in population health management and Vanguard's deep national experience in hospital management and risk-based insurance.

The new organization will leverage Vanguard's national network of hospitals, strategic relationships, corporate resources and capital to achieve scale and create competitive advantage for its partners. Vanguard and Tufts MC will offer partnership opportunities to hospitals and physicians throughout the region that share this vision. The new network formed by the partnership will focus on services that improve population health, assist physicians and hospitals in delivering high quality and efficient care and will provide an enhanced partnership option for physicians and hospitals in Massachusetts that are considering affiliations, merger and/or purchase. The Tufts MC/Vanguard/NEQCA network will be flexible in how it meets the needs of hospitals and physicians. It will not push a one-size fits all option onto the market, but instead will offer solutions to meet the needs of its physician and hospital affiliates (e.g., non-profit partnership, for-profit ownership, clinical affiliation, small and large physician group contracting/alignment).

EXHIBIT 13: DUE DILIGENCE RESPONSES 12.1 AND 12.2

Vanguard is a Fortune 500 company publicly traded on the New York Stock Exchange (NYSE: VHS). We have consistently grown the company when opportunities present themselves and have the means and desire to continue to execute on that philosophy. Vanguard's Chairman and CEO, Charlie Martin, began the company in 1997 by putting together an experienced, stable management team and has continued to enhance this team over the years. Our senior leaders, with both not for profit and investor-owned experience, are recognized among the most forward thinking and innovative leaders in the industry. You will see them on boards of directors, speaking panels and in leadership roles in leading industry advisory groups and associations. Our diverse board of directors also consists of industry leaders and experts driving our company to the leading edge of transformation.

Our experience in transactions is unmatched in the industry with our leadership having been involved in hundreds of hospital and health system transactions throughout their careers. From signing a purchase agreement, to closing a transaction to transitioning a new system within our company, our team's experience is unmatched. Our belief is every transaction is unique. Consequently we do not approach our partnership opportunities with a set viewpoint or "cookie cutter" process. Rather, we have a flexible mindset when we structure deals to address the uniqueness of a particular partnership or transaction.

Our system of 28 hospitals across 5 states provides us a platform from which to draw "best in class" ideas and processes and to quickly cascade those throughout the company. We want to be the partner of choice for physicians, hospitals and other providers.

12.2 Financial Access

Vanguard, a Fortune 500 company, is publicly traded on the New York Stock Exchange (NYSE:VHS). The company has grown from the "ground up" by obtaining financing and generating sufficient cash flows from operations to sustain its organic growth and growth through acquisitions. We currently have access to public and private equity, as well as public and private debt, our financial metrics remain strong and we enjoy a long, positive track record with our investors. The path that we are on as a company will allow us to lead the industry as it shifts from a fee-for-service model to a fee-for-value model. With over $6.0B in revenue, we are among the leaders in our industry and we are not stopping here. Our model is to grow organically and through strategic acquisitions that will place the company among the elite in the industry and will allow it to become the partner of choice for those hospitals and health systems looking to partner across the country.

Vanguard also enjoys strong sponsorship in the public debt markets along with a bank group of companies including Bank of America Merrill Lynch, Barclays, Citibank, JP Morgan, Deutsche Bank, Morgan Stanley, Goldman Sachs, Wells Fargo and RBC.

Our Form 10-K for fiscal years ended June 30, 2012 and 2011 and our Form 10-Q for the three months ended September 30, 2012 are publicly available on the SEC Edgar Database which can be accessed directly through the investor section of Vanguard's website at www.vanguardhealth.com.

EXHIBIT 14: WATERBURY HOSPITAL CHARITY CARE POLICY

POLICY: CHARITY CARE		
CATEGORY: MANAGEMENT OF INFORMATION		PAGE (s): 3
OWNER: DIRECTOR, PATIENT ACCOUNTS & FINANCIAL SERVICES		ORIGINATED: 12/5/97 (From PAFS manual)
LAST REVIEWED: 11/11	LAST REVISED: 3/13	RETIRED:

SCOPE: Determination of when charity care is appropriate.
PURPOSE: To make provisions for situations in which charity care is appropriate based on aggregate balance and Encounter review.

POLICY: It is the policy of Waterbury Hospital to appropriately offer charity care in situations where the responsible party for the balance due does not have the financial resources necessary to satisfy their obligation within a reasonable period of time.

1. All patients who request consideration for charity care will be required to apply for public assistance in addition to completing a charity care application unless identified as ineligible by a qualified case worker.

2. In order to be considered for charity care, full financial disclosure is required including:
   a. All sources of income available at the time of application;
   b. Assets excluding;
      i. Primary Residence;
      ii. Vehicles required for commuting to or facilitating employment;
      iii. Retirement Accounts.

3. Responsible parties with assets of $7,500 or less ($15,000 for a couple) will receive the following discounts based on their annual household income and the published federal poverty guidelines in effect at the date of application:

Income as a % of FPL	Discount
<200%	100%
<= 225%	60%
<= 275%	40%
<= 300%	20%
<= 400%	10%

4. Charity care discounts are to be applied after the 50% uninsured discount from charges.

5. Documentation required to validate declarations made on the charity care application shall include:
   a. A credit report;
   b. Most recent 1040 tax return;
   c. Copies of all bank statements to include but not limited to:
      i. Checking accounts;
      ii. Savings accounts;
      iii. Investment accounts;
      iv. Certificates of deposit
   d. Proof of income for the immediate 12 months preceding the application date.
   e. Public assistance determination.

PROCEDURE:

1. The availability of charity care will be disclosed on all dunning notices issued prior to bad debt assignment.

2. Patients who indicate they are unable to pay for services rendered will be offered charity care;

3. Financial Counselors shall evaluate each applicant's eligibility.

4. Accounts determined to be eligible for charity care discounts shall require the following authorization based on amount to be adjusted:
   a. PAFS Manager < $5,000
   b. PAFS Director $5,000 or more
   c. Chief Financial Officer $10,000 or more

5. Patients shall be issued a determination letter within 30 days of receipt of a completed charity care application.

EXHIBIT 15: REVISED FINANCIAL ATTACHMENTS

FINANCIAL ATTACHMENT I (See the two tabs below)

Financial Attachment 1(A) _ Total Hospital Health System (Not-for-P _*To be completed for most recent Actual Completed Year & 3 years of Projections* **without the proposal**

Financial Attachment 1(B) _ Total Hospital Health System (For-Profi _*To be completed for the "new" For-Profit entity created after the proposal takes effect*

Financial Attachment 1(C) _ Hospital ONLY (Prior & Post to the join _*To be completed for most recent Actual Completed Year & Projections for* **years to include prior to and 3 years past the joint venture**

Greater Waterbury Health Network, Inc. **(Not-For Profit)**

Please provide one year of actual results and three years of ***Total Hospital Health System*** projections of revenue, expense, ratios and volume statistics without the CON proposal, in the following reporting format:

Total Hospital Health System: **Description**	**FY 12 Actual Results**	**FY 13 Projected W/out CON**	**FY 14 Projected W/out CON**	**FY 15 Projected W/out CON**	**FY 16 Projected W/out CON**
NET PATIENT REVENUE					
Non-Government	$121,753,453	$122,198,493	$124,586,284	$127,300,702	$130,129,312
Medicare	$112,518,145	$114,124,121	$111,672,718	$109,263,298	$106,937,279
Medicaid and Other Medical Assistance	$39,212,500	$39,557,588	$39,820,651	$40,089,264	$40,358,941
Other Government	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$273,484,098	$275,880,201	$276,079,652	$276,653,264	$277,425,533
Other Operating Revenue	$13,227,694	$8,255,212	$8,066,927	$8,214,018	$8,363,787
Revenue from Operations	$286,711,792	$284,135,413	$284,146,579	$284,867,283	$285,789,320
OPERATING EXPENSES					
Salaries and Fringe Benefits	$164,634,663	$159,684,954	$161,165,114	$162,346,732	$163,592,127
Professional / Contracted Services	$45,267,639	$47,248,357	$46,729,938	$47,222,184	$47,718,764
Supplies and Drugs	$35,319,374	$34,897,946	$35,097,110	$35,208,339	$35,333,031
Bad Debts	$10,966,628	$12,124,534	$12,752,998	$13,172,644	$13,603,693
Other Operating Expense	$16,836,637	$15,337,970	$15,491,881	$15,654,681	$15,819,266
Subtotal	$273,024,941	$269,293,762	$271,237,041	$273,604,579	$276,066,881
Depreciation/Amortization	$9,421,601	$9,211,708	$9,226,325	$9,242,976	$9,259,831
Interest Expense	$1,237,849	$1,544,883	$1,517,668	$1,491,775	$1,466,475
Lease Expense	$2,825,478	$3,450,585	$3,454,346	$3,488,890	$3,523,779
Total Operating Expense	$286,509,869	$283,500,938	$285,435,381	$287,828,220	$290,316,966
Gain/(Loss) from Operations	$201,923	$634,476	($1,288,802)	($2,960,938)	($4,527,646)
Plus: Non-Operating Revenue	$2,087,588	$777,007	$811,030	$845,733	$881,131
Revenue Over/(Under) Expense	$2,289,511	$1,411,483	($477,772)	($2,115,205)	($3,646,516)
Profit Margins:					
Operating	0.1%	0.2%	-0.5%	-1.0%	-1.6%
Non-Operating	0.7%	0.3%	0.3%	0.3%	0.3%
Total Margin	0.8%	0.5%	-0.2%	-0.7%	-1.3%
Debt Principal Payments	$1,030,933	$1,117,820	$1,105,542	$889,461	$790,078
Capital Structure Ratios:					
Capital Expense	372%	379%	376%	373%	369%
Times Interest Earned	2.849588278	1.913650251	0.685193524	-0.417910813	-1.486585647
Debt Service Coverage	5.707450518	4.569820119	3.91361001	3.619777766	3.137436069
FTEs	1,730	1,654	1,648	1,640	1,632
IP Cases	12,364	11,969	11,730	11,495	11,265
OP Cases	184,631	179,206	182,790	186,446	190,175

Projections to be complete prior to and 3 years past the joint venture. Add columns as necessary.

*Volume Statistics:

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposa

Future Joint Venture "LLC" (For Profit)

Please provide three years of ***Total Hospital Health System*** projections of revenue, expense, ratios and volume statistics with the CON and incremental to the proposal in the following reporting format:

Total Hospital Health System:	FY 13 Projected	FY 13 Projected	FY 14 Projected	FY 14 Projected	FY 15 Projected	FY 15 Projected	FY 16 Projected	FY 16 Projected
Description	Incremental	With CON	Incremental	With CON	Incremental	With CON	Incremental	With CON
NET PATIENT REVENUE								
Non-Government	$0	$0	$121,852,393	$121,852,393	$128,571,503	$128,571,503	$135,537,883	$135,537,883
Medicare	$0	$0	$110,553,554	$110,553,554	$111,695,266	$111,695,266	$112,730,753	$112,730,753
Medicaid and Other Medical Assistance	$0	$0	$39,054,849	$39,054,849	$40,600,507	$40,600,507	$42,150,536	$42,150,536
Other Government	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenue	$0	$0	$271,460,796	$271,460,796	$280,867,276	$280,867,276	$290,419,171	$290,419,171
Other Operating Revenue	$0	$0	$12,476,786	$12,476,786	$12,917,897	$12,917,897	$13,108,427	$13,108,427
Revenue from Operations	$0	$0	$283,937,582	$283,937,582	$293,785,173	$293,785,173	$303,527,598	$303,527,598
OPERATING EXPENSES								
Salaries and Fringe Benefits	$0	$0	$166,398,226	$166,398,226	$167,078,854	$167,078,854	$172,110,747	$172,110,747
Professional / Contracted Services	$0	$0	$36,003,209	$36,003,209	$36,724,758	$36,724,758	$37,449,883	$37,449,883
Supplies and Drugs	$0	$0	$36,443,851	$36,443,851	$39,362,664	$39,362,664	$41,142,455	$41,142,455
Bad Debts	$0	$0	$13,541,930	$13,541,930	$14,009,989	$14,009,989	$14,494,185	$14,494,185
Other Operating Expense	$0	$0	$15,198,147	$15,198,147	$16,631,949	$16,631,949	$17,810,323	$17,810,323
Subtotal	$0	$0	$267,585,363	$267,585,363	$273,808,214	$273,808,214	$283,007,593	$283,007,593
Depreciation/Amortization	$0	$0	$5,418,639	$5,418,639	$6,290,067	$6,290,067	$8,032,924	$8,032,924
Interest Expense	$0	$0	$0	$0	$59,556	$59,556	$555,340	$555,340
Lease Expense	$0	$0	$5,619,340	$5,619,340	$5,713,721	$5,713,721	$5,809,945	$5,809,945
Total Operating Expenses	$0	$0	$278,623,342	$278,623,342	$285,871,558	$285,871,558	$297,405,802	$297,405,802
Income (Loss) from Operations	$0	$0	$5,314,241	$5,314,241	$7,913,615	$7,913,615	$6,121,796	$6,121,796
Non-Operating Income	$0	$0	($4,839,985)	($4,839,985)	($4,888,341)	($4,888,341)	($4,929,672)	($4,929,672)
Income before provision for income taxes	$0	$0	$474,255	$474,255	$3,025,274	$3,025,274	$1,192,124	$1,192,124
Provision for income taxes	$0	$0	$151,762	$151,762	$968,088	$968,088	$381,480	$381,480
Net Income	$0	$0	$322,494	$322,494	$2,057,186	$2,057,186	$810,645	$810,645
Retained earnings, beginning of year								
Retained earnings, end of year	$0	$0	$322,494	$322,494	$2,057,186	$2,057,186	$810,645	$810,645
Profit Margins:								
Operating		0.0%		1.9%		2.7%		2.1%
Non-Operating		0.0%		-1.7%		-1.7%		-1.7%
Total Margin		0.0%		0.1%		0.7%		0.3%
Debt Principal Payments	$0	$0	$0	$0	$0	$0	$0	$0
Capital Structure Ratios:								
Capital Expense		0%		194%		222%		289%
Times Interest Earned		0.000		0.000		35.54204008		2.459727447
Debt Service Coverage		0.000		0.000		141.1580248		16.92461239
FTEs	0	0	1,709	1,709	1,717	1,717	1,736	1,736
IP Cases	0	0	11,493	11,493	11,723	11,723	11,957	11,957
OP Cases	0	0	225,954	225,954	230,473	230,473	235,082	235,082

First 3 years of the new joint venture LLC and use the W/O CON from FA1(A)

*Volume Statistics:

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Waterbury Hospital *ONLY* (Prior & Post Joint Venture)

Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:	**FY 12**	**FY 13**	**FY 13**	**FY 13**	**FY 14**	**FY 14**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**
	Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
NET PATIENT REVENUE													
Non-Government	$119,232,708	$119,407,487	$0	$119,407,487	$121,721,343	($1,806,829)	$119,914,514	$124,360,874	$2,154,472	$126,515,346	$127,112,906	$6,328,702	$133,441,608
Medicare	$111,387,190	$112,873,459	$0	$112,873,459	$110,434,656	($1,639,290)	$108,795,366	$108,037,322	$1,871,677	$109,908,999	$105,723,458	$5,263,763	$110,987,221
Medicaid and Other Medical Ass	$38,492,645	$38,760,755	$0	$38,760,755	$39,012,847	($579,106)	$38,433,741	$39,270,869	$680,342	$39,951,211	$39,530,476	$1,968,145	$41,498,621
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenu	$269,112,543	$271,041,701	$0	$271,041,701	$271,168,845	($4,025,224)	$267,143,621	$271,669,065	$4,706,491	$276,375,555	$272,366,840	$13,560,610	$285,927,450
Other Operating Revenue	$11,393,696	$6,154,215	$0	$6,154,215	$6,276,926	$5,983,989	$12,260,915	$6,414,817	$6,287,209	$12,702,026	$6,555,340	$6,337,217	$12,892,556
Revenue from Operations	$280,506,239	$277,195,916	$0	$277,195,916	$277,445,771	$1,958,765	$279,404,536	$278,083,882	$10,993,700	$289,077,581	$278,922,180	$19,897,827	$298,820,007
OPERATING EXPENSES													
Salaries and Fringe Benefits	$160,088,630	$154,975,904	$0	$154,975,904	$156,361,883	$6,701,127	$163,063,009	$157,447,436	$6,178,721	$163,626,157	$158,594,846	$10,063,205	$168,658,051
Professional / Contracted Servic	$44,823,279	$46,599,533	$0	$46,599,533	$46,074,626	($10,772,256)	$35,302,370	$46,553,765	($10,546,863)	$36,006,902	$47,036,977	($10,304,951)	$36,732,026
Supplies and Drugs	$35,006,526	$34,787,246	$0	$34,787,246	$34,985,303	$1,235,918	$36,221,221	$35,094,296	$4,036,386	$39,130,682	$35,216,707	$5,693,766	$40,910,473
Bad Debts	$10,964,528	$12,106,534	$0	$12,106,534	$12,734,998	$804,814	$13,539,812	$13,154,644	$853,143	$14,007,787	$13,585,693	$906,289	$14,491,982
Other Operating Expense	$15,993,084	$14,558,218	$0	$14,558,218	$14,703,800	$289,247	$14,993,047	$14,850,838	$1,576,011	$16,426,849	$14,999,347	$2,605,876	$17,605,223
Subtotal	$266,876,047	$263,027,435	$0	$263,027,435	$264,860,610	($1,741,151)	$263,119,460	$267,100,979	$2,097,397	$269,198,377	$269,433,569	$8,964,186	$278,397,755
Depreciation/Amortization	$9,241,682	$9,024,808	$0	$9,024,808	$9,037,556	($3,705,093)	$5,332,463	$9,050,432	($2,860,957)	$6,189,474	$9,063,436	($1,154,752)	$7,908,684
Interest Expense	$1,160,533	$1,471,508	$0	$1,471,508	$1,443,559	($1,443,559)	$0	$1,416,185	($1,357,581)	$58,604	$1,389,372	($842,622)	$546,751
Lease Expense	$2,825,478	$3,450,585	$0	$3,450,585	$3,454,346	$1,992,831	$5,447,177	$3,488,890	$2,052,668	$5,541,558	$3,523,779	$2,114,004	$5,637,782
Total Operating Expense	$280,103,740	$276,974,336	$0	$276,974,336	$278,796,072	($4,896,972)	$273,899,100	$281,056,485	($68,473)	$280,988,013	$283,410,156	$9,080,816	$292,490,973
Gain/(Loss) from Operations	$402,499	$221,580	$0	$221,580	($1,350,302)	$6,855,737	$5,505,436	($2,972,604)	$11,062,172	$8,089,569	($4,487,976)	$10,817,010	$6,329,034
Plus: Non-Operating Revenue	$1,086,589	$777,007	$0	$777,007	$811,030	($5,564,607)	($4,753,577)	$845,733	($5,644,174)	($4,798,441)	$881,131	($5,720,903)	($4,839,772)
Revenue Over/(Under) Expense	$1,489,088	$998,587	$0	$998,587	($539,272)	$1,291,131	$751,859	($2,126,871)	$5,417,998	$3,291,128	($3,606,846)	$5,096,108	$1,489,262
Profit Margins:													
Operating	0%	0.1%	1.9%	0.1%	-0.5%	3.3%	2.0%	-1.1%	3.2%	2.8%	-1.6%	1.6%	2.2%
Non-Operating	0%	0.3%	-2.0%	0.3%	0.3%	-2.0%	-1.7%	0.3%	-1.9%	-1.7%	0.3%	-0.3%	-1.6%
Total Margin	1%	0.4%	-0.1%	0.4%	-0.2%	1.4%	0.3%	-0.8%	1.3%	1.2%	-1.3%	1.3%	0.5%
Debt Principal Payments	$1,030,933	$1,117,820	($1,117,820)	$0	$1,105,542	($1,105,542)	$0	$889,461	($889,461)	$0	$790,078	($790,078)	$0
Capital Structure Ratios:													
Capital Expense	371%	379%	-184%	379%	376%	-154%	195%	372%	-83%	222%	369%	-369%	289%
Times Interest Earned	2.283106986	1.68	-1.68	1.68	0.63	56.53	0.00	-0.50	4.23	57.16	-1.60	1.60	3.72
Debt Service Coverage	5.426186398	4.44	-4.44	7.81	3.90	158.88	0.00	3.62	14.57	162.78	3.14	-3.14	18.19
FTEs	1,654	1,578	0	1,578	1,572	76	1,648	1,564	91	1,655	1,556	118	1,674
IP Cases	12,364	11,969	0	11,969	11,730	(237)	11,493	11,495	228	11,723	11,265	692	11,957
OP Cases	184,631	179,206	0	179,206	182,790	3,656	186,446	186,446	3,729	190,175	190,175	3,803	193,978

Please complete Actual Year for Hospital and projections for all years of the proposal incuding 3 years post joint venture. Please add columns as necessary.

*Volume Statistics:

Provide projected inpatient and/or outpatient statistics for any new services and provide actual and projected inpatient and/or outpatient statistics for any existing services which will change due to the proposal.

Waterbury Hospital *ONLY* **(Prior & Post Joint Venture)** **REVISED: HOSPITAL ONLY; AFFILIATES EXCLUDED**

Please provide one year of actual results and three years of projections of **Total Facility** revenue, expense and volume statistics without, incremental to and with the CON proposal in the following reporting format:

Total Facility:	**FY 12**	**FY 13**	**FY 13**	**FY 13**	**FY 14**	**FY 14**	**FY 14**	**FY 15**	**FY 15**	**FY 15**	**FY 16**	**FY 16**	**FY 16**
	Actual	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**	**Projected**
Description	**Results**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**	**W/out CON**	**Incremental**	**With CON**
NET PATIENT REVENUE													
Non-Government	$97,170,786	$98,636,472	$0	$98,636,472	$100,452,194	($7,986,198)	$92,465,996	$102,475,466	($4,751,281)	$97,724,186	$104,594,543	($1,340,203)	$103,254,340
Medicare	$101,422,629	$103,373,944	$0	$103,373,944	$101,046,385	($8,033,438)	$93,012,948	$98,714,020	($4,576,881)	$94,137,139	$96,465,914	($1,236,048)	$95,229,866
Medicaid and Other Medical Ass	$32,187,286	$32,815,532	$0	$32,815,532	$32,999,777	($2,623,564)	$30,376,213	$33,162,089	($1,537,562)	$31,624,527	$33,329,152	($427,057)	$32,902,095
Other Government	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
Total Net Patient Patient Revenu	$230,780,700	$234,825,948	$0	$234,825,948	$234,498,356	($18,643,199)	$215,855,157	$234,351,576	($10,865,724)	$223,485,852	$234,389,609	($3,003,308)	$231,386,301
Other Operating Revenue	$10,662,189	$6,346,083	$0	$6,346,083	$6,473,005	$997,584	$7,470,589	$6,602,465	$1,244,083	$7,846,547	$6,734,514	$1,229,732	$7,964,246
Revenue from Operations	$241,442,889	$241,172,031	$0	$241,172,031	$240,971,361	($17,645,615)	$223,325,745	$240,954,041	($9,621,641)	$231,332,400	$241,124,123	($1,773,577)	$239,350,546
OPERATING EXPENSES													
Salaries and Fringe Benefits	$117,842,167	$118,435,595	$0	$118,435,595	$119,090,767	($78,041)	$119,012,726	$119,430,899	($1,407,413)	$118,023,486	$119,817,977	$1,630,301	$121,448,279
Professional / Contracted Servic	$46,903,266	$48,927,654	$0	$48,927,654	$48,406,931	($12,690,250)	$35,716,681	$48,891,000	($12,459,985)	$36,431,014	$49,379,910	($12,220,275)	$37,159,635
Supplies and Drugs	$33,801,228	$33,529,873	$0	$33,529,873	$33,715,357	$1,327,614	$35,042,970	$33,811,650	$4,091,631	$37,903,281	$33,921,234	$5,710,512	$39,631,746
Bad Debts	$10,435,502	$10,993,232	$0	$10,993,232	$11,563,904	($95,857)	$11,468,046	$11,944,959	($71,506)	$11,873,453	$12,336,369	($43,177)	$12,293,192
Other Operating Expense	$10,721,392	$9,968,580	$0	$9,968,580	$10,068,266	($115,417)	$9,952,849	$10,168,948	$1,142,100	$11,311,048	$10,270,638	$2,142,047	$12,412,685
Subtotal	$219,703,555	$221,854,934	$0	$221,854,934	$222,845,224	($11,651,951)	$211,193,273	$224,247,456	($8,705,173)	$215,542,282	$225,726,128	($2,780,592)	$222,945,536
Depreciation/Amortization	$8,028,339	$7,750,000	$0	$7,750,000	$7,750,000	($3,292,187)	$4,457,813	$7,750,000	($2,744,999)	$5,005,001	$7,750,000	($1,349,911)	$6,400,089
Interest Expense	$1,101,603	$1,422,123	$0	$1,422,123	$1,393,681	($1,393,681)	$0	$1,365,807	($1,318,418)	$47,389	$1,338,491	($896,034)	$442,457
Lease Expense	$2,825,478	$3,420,145	$0	$3,420,145	$3,454,346	($571,346)	$2,883,000	$3,488,890	($548,230)	$2,940,660	$3,523,779	($524,305)	$2,999,473
Total Operating Expense	$231,658,975	$234,447,202	$0	$234,447,202	$235,443,251	($16,909,165)	$218,534,086	$236,852,153	($13,316,820)	$223,535,332	$238,338,398	($5,550,842)	$232,787,556
Gain/(Loss) from Operations	$9,783,914	$6,724,829	$0	$6,724,829	$5,528,110	($736,451)	$4,791,659	$4,101,888	$3,695,179	$7,797,068	$2,785,725	$3,777,266	$6,562,991
Plus: Non-Operating Revenue	$2,035,841	$1,701,143	$0	$1,701,143	$1,735,166	($5,592,443)	($3,857,277)	$1,769,869	($5,644,943)	($3,875,073)	$1,805,267	($5,693,785)	($3,888,519)
Revenue Over/(Under) Expense	$11,819,755	$8,425,972	$0	$8,425,972	$7,263,276	($6,328,894)	$934,382	$5,871,757	($1,949,763)	$3,921,994	$4,590,992	($1,916,520)	$2,674,472
Profit Margins:													
Operating	4%	2.8%	-0.6%	2.8%	2.3%	1.2%	2.2%	1.7%	1.1%	3.4%	1.1%	-1.1%	2.8%
Non-Operating	1%	0.7%	-2.5%	0.7%	0.7%	-2.4%	-1.8%	0.7%	-2.4%	-1.7%	0.7%	-0.7%	-1.7%
Total Margin	5%	3.5%	-3.0%	3.5%	3.0%	-1.3%	0.4%	2.4%	-1.3%	1.7%	1.9%	-1.9%	1.1%
Debt Principal Payments	$820,060	$912,905	($912,905)	$0	$821,387	($821,387)	$0	$855,133	($855,133)	$0	$787,541	($787,541)	$0
Capital Structure Ratios:													
Capital Expense	394%	391%	-187%	391%	388%	-162%	204%	385%	-91%	226%	381%	-381%	294%
Times Interest Earned	11.72959587	6.92	-6.92	6.92	6.21	77.55	0.00	5.30	1.75	83.76	4.43	-4.43	7.04
Debt Service Coverage	10.90185792	7.54	-7.54	12.37	7.41	181.97	0.00	6.75	14.76	189.38	6.43	-6.43	21.51
FTEs	1,654	1,578	0	1,578	1,572	(268)	1,304	1,564	(258)	1,306	1,556	(236)	1,319
IP Cases	12,364	11,969	0	11,969	11,730	(237)	11,493	11,495	228	11,723	11,265	692	11,957
OP Cases	184,631	179,206	0	179,206	182,790	3,656	186,446	186,446	3,729	190,175	190,175	3,803	193,978

Please complete Actual Year for Hospital and projections for all years of the proposal incuding 3 years post joint venture. Please add columns as necessary.

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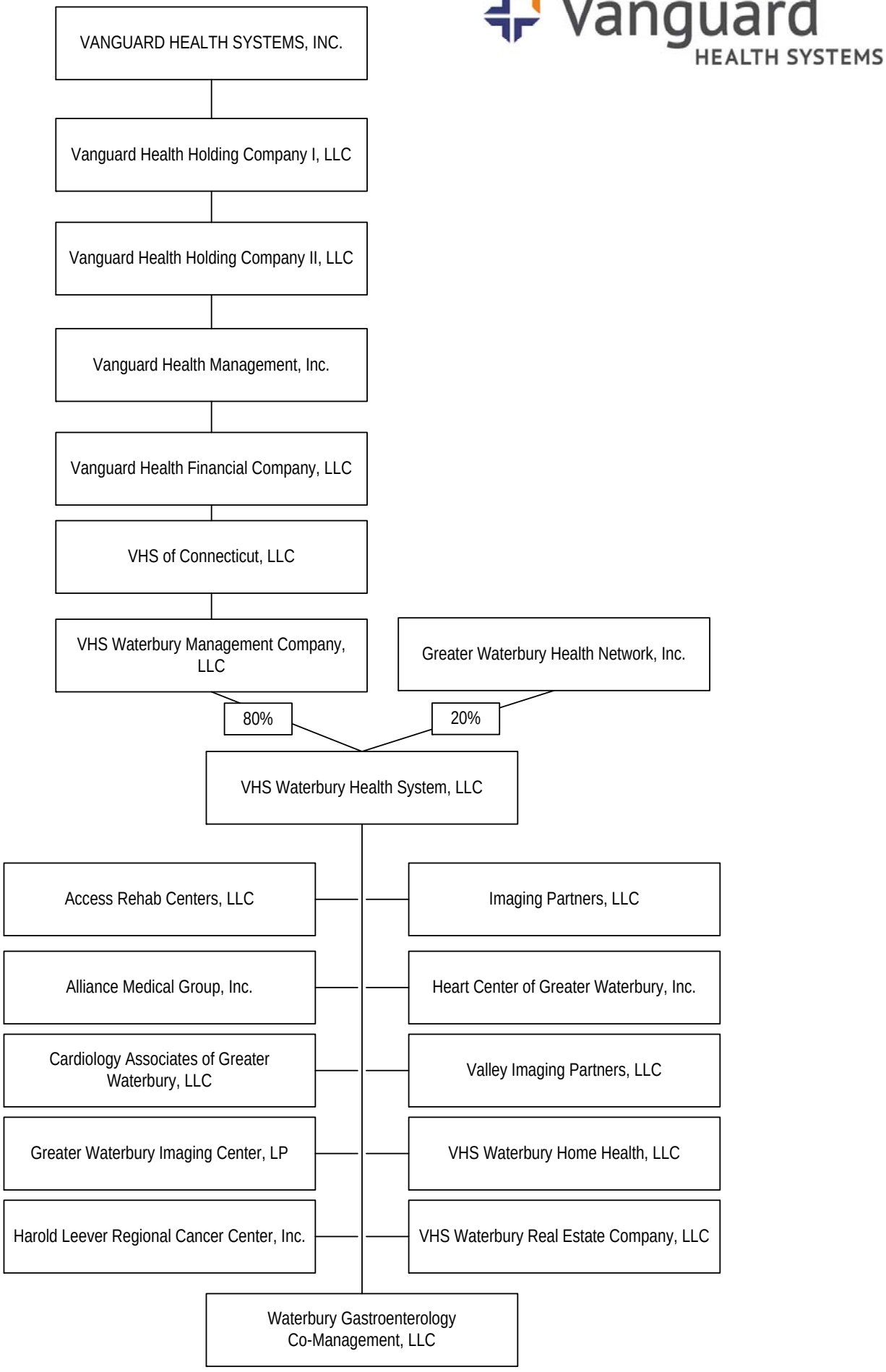
EXHIBIT 16: REVISED ORGANIZATIONAL CHART


VANGUARD HEALTH SYSTEMS, INC.
Vanguard Health Holding Company I, LLC
Vanguard Health Holding Company II, LLC
Vanguard Health Management, Inc.
Vanguard Health Financial Company, LLC
VHS of Connecticut, LLC
VHS Waterbury Management Company, LLC
Greater Waterbury Health Network, Inc.
80%
20%
VHS Waterbury Health System, LLC
Access Rehab Centers, LLC
Imaging Partners, LLC
Alliance Medical Group, Inc.
Heart Center of Greater Waterbury, Inc.
Cardiology Associates of Greater Waterbury, LLC
Valley Imaging Partners, LLC
Greater Waterbury Imaging Center, LP
VHS Waterbury Home Health, LLC
Harold Leever Regional Cancer Center, Inc.
VHS Waterbury Real Estate Company, LLC
Waterbury Gastroenterology Co-Management, LLC