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April 21, 2017

DELIVERED ELECTRONICALLY AND BY FIRST CLASS MAIL

Donna Jerry
Senior Health Policy Analyst
Green Mountain Care Board
89 Main Street, Third Floor City Center
Montpelier, VT 05620

Re: Docket No. GMCB-010-15con, Proposed Ambulatory Surgery Center
Electronic Medical Record Policies and Procedures; Testimony of Andrew Lasser

Dear Donna:

Please find attached 1) ACTD LLC's ("Applicant") policies and procedures that will be implemented relating to use of electronic medical records, which the Green Mountain Care Board ("the Board") requested in its letter dated March 10, 2017; and 2) the written testimony of Andrew Lasser, as authorized pursuant to the Hearing Officer's Ruling on Motions to Continue Hearing (April 17, 2017).

Please let us know if you have any additional questions or need clarification regarding any of these responses.

Sincerely,

Eileen Elliott, Esq.
Dunkiel Saunders Elliott Raubvogel & Hand, PLLC

cc: Judy Henkin, Esq., General Counsel, Green Mountain Care Board
Marisa Melamed, Health Policy Analyst, Green Mountain Care Board
Noel Hudson, Esq., Health Policy Director, Green Mountain Care Board
Lauren Layman, Esq., Vermont Association of Hospitals and Health Systems
Anne Cramer, Esq., Vermont Association of Hospitals and Health Systems
Jill Berry Bowen, CEO, Northwestern Medical Center
Jonathan Billings, V.P. of Planning & Community Relations, Northwestern Medical Center
Lila Richardson, Esq., Office of the Healthcare Advocate
Kaili Kuiper, Esq., Office of the Healthcare Advocate

Surgery Center
Policy & Procedure

Title	MEDICAL RECORDS - PHILOSOPHY STATEMENT	MR	02
Effective date:			

PURPOSE: Medical Records will be created by the Facility for all patients to ensure accurate and timely documentation.

POLICY: The medical records will be documented accurately and in a timely manner, in accordance with the Medical Staff Bylaws, current accreditation standards and State and Federal laws. The records will be maintained in a readily accessible manner and made available for all subsequent continuity of care in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards.

PROCEDURE:

A. The medical record shall be analyzed to ensure there is sufficient information to identify the patient, support the diagnosis and justify the treatment. The record shall be kept confidential and secure, only to be released in accordance with State and Federal laws/HIPAA and within accepted Facility policy/procedures.

B. In addition to record maintenance and the release of medical information, the Facility will be responsible for facilitating the completion and coding of all records, providing transcribed medical records, requesting "minimum information necessary" for medical and patient information, providing "minimum information necessary" statistical data related to patient care, and long-term retention of the medical record along with all necessary information as to the patient and procedural physician. In unique circumstances a contracted service may be utilized for the coding or transcription of medical records.

C. The Medical Record is the property of the Facility. All medical records are under the custodial care of the Facility Administrator.

Surgery Center
Policy & Procedure

Title	MEDICAL RECORD CONFIDENTIALITY	MR	04
Revised:	Authorizing Signature:		

PURPOSE: Staff members are responsible for protecting the privacy and rights of parties concerned, in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards, as the Facility is acutely aware that the confidentiality of patient medical records and patient information is an issue of major concern to patients.

POLICY: The patient has the right to expect that records and all communications pertaining to his/her care will be treated as confidential and will not be freely discussed either within or outside the Facility. Information regarding the patient and/or his/her record shall be discussed only to advance medical/nursing care, and/or through an authorized committee to review that care, to make determinations and/or corrections.

The Facility realizes its obligation to safeguard records against unauthorized or inadvertent disclosures, loss, tampering, alteration or destruction. Information that is considered confidential may not be released to anyone without written permission of the patient unless required by law (prior approval from Administration/Risk Management required). Information which is considered non-confidential is that which is not related to the treatment of the patient (such as names of relatives and friends given orally at the time of registration) or otherwise are deemed common knowledge. However, no information regarding a patient's admission to the Facility should be released unless requested by letter, and after determining the appropriateness of the request. Any requests become a part of the medical record and are subject to the HIPAA privacy standard.

PROCEDURE:

A. The Facility must provide "Privacy Standards" training to any staff members with access to identifiable information. Team members must receive training within one month of joining the Facility and must sign a statement certifying that they received the training and will honor the policies. Training will be required each year at the time of their annual review. (Exhibit I & J – HIPAA Compliance Plan)

B. The Facility must establish and maintain privacy contracts with all "business associates". A "Business Associates" is any person or entity that works on the

Facility's behalf and deals with identifiable health information – such as claims processing, data analysis and anesthesia providers. (Exhibit H – HIPAA Compliance Plan)

C. Medical records are maintained by the EMR system; which is secured by passwords.

D. All privileged patient information that is to be discarded, will be shredded.

E. Efforts shall be taken to restrict access to information by contracted staff or services.

Surgery Center
Policy & Procedure

Title	MEDICAL RECORD CONTENT	MR	06
	Authorizing Signature:		

PURPOSE: Medical records need to be complete and uniform in content for monitoring, compliance, and archival purposes.

POLICY: The Facility will create individual medical records for all patients to ensure completeness and uniformity of content.

PROCEDURE: In accordance with the State licensure rules, all patient records must document and contain, at a minimum, the following:

1. Patient identification.
2. Appropriate medical history and results of a physical examination completed within the time frame, per the state regulations.
3. Pre-operative diagnostic studies recorded in the record before surgery, if performed.
4. Any allergies and abnormal drug reactions.
5. Entries related to anesthesia administration.
6. Evidence of appropriate informed consent for procedures and treatments.
7. Discharge diagnosis.
8. Medical history, chief complaint, and physical examination, including copies of laboratory, x-ray consultations, and other special reports or summary of those same findings by the admitting physician.
9. A written or dictated report describing techniques, findings, and tissue removed or altered.
10. Signatures of physicians and health care workers who treat or cared for the patient.
11. Condition on discharge, disposition of the patient, and time of dismissal.
12. Final progress note, including instructions to the patient and family, with dismissal diagnosis.
13. A copy of the transfer form, if the patient is referred to a hospital or other facility.

Medical record files shall be uniform, which is achieved by using a consistent order as listed below for major and minor surgery and endoscopy (depending on the procedure, not all forms may be applicable):

Left Side of Chart

Registration form
Privacy Notice Acknowledgment
Financial Form
Operative Report
Consent – Facility & Anesthesia

Nursing Data Base & Preop Instructions
Pre-Operative Record
Adult Collaborative Data Base
Perioperative Record
Anesthesia Orders

History & Physical
Pre-OP Lab Work & Radiology
Pre-Anesthesia Record
Anesthesia Record

Right Side of Chart

Physician Order-Intra-op Medical Orders &
Medication Profile
Intra-op Nursing Record
Post-op Nurses' Notes-Phase I
Post-op Nurses' Notes-Phase II
Aldrete Score Flow Sheet
Nurses Notes
Patient Discharge Instructions

Physician's Orders
Pre-Anesthesia Database, Evaluation & Plan
Preoperative Anesthesia Orders
Preoperative Anesthesia Protocol
Surgeon Post-op Progress Notes
Post-operative Follow Up Telephone Call

Surgery Center
Policy & Procedure

Title	PREPARATION & DOCUMENTATION OF MEDICAL RECORD	MR	08
Revised:	Authorizing Signature:		

PURPOSE: Individual medical records shall be documented in a uniform manner.

POLICY: A complete medical record will be maintained on all patients at the Facility with all contained documentation presented in a consistent format.

PROCEDURE:

A. The same medical record will be used for each succeeding admission.
B. The patient's name and patient number will be present on all forms within the medical record.
C. All entries recorded must be complete, with any and all references and referrals noted if necessary, legible, signed and dated by the appropriate, authorized provider of services.
D. Any and all corrections to the medical record need to have a single line drawn through the initial entry, dated and initialed by appropriate and authorized personnel.
E. Allergies, allergic reactions and untoward reactions to drugs and/or anesthetic agents are recorded in the Medical Record File. All allergies must be noted. If no allergy is known, record "NKA".
F. A periodic summary sheet shall be kept in each Medical Record containing three or more admissions. The summary sheet will always be the first sheet in the medical record file. Information will be logged regarding the patient as collected at that admission. The periodic summary sheet shall be included in the chart upon the patient's third admission to the Facility and updated on each visit thereafter.

Surgery Center
Policy & Procedure

Title	COMPLETION OF THE MEDICAL RECORD	MR	14
Revised:	Authorizing Signature:		

PURPOSE: Completed and signed medical record reports will be the final item in the medical record file, signaling completion of the filing process.

POLICY: The medical record reports will be filed in the medical record in a timely manner in order to complete the medical record.

PROCEDURE:

A. The completed and signed medical record reports will be filed in the medical record according to the following guidelines:

   1. History & Physical – At Time of Procedure

   2. Pre-Operative / Intra-Operative Lab & Other Exam Results – At Time of Procedure (if available) – Within 24 Hours for Wet Reads

   3. Surgery / Endoscopy Operative Reports – 30 Days

B. The medical record shall be deemed complete with the filing of final reports and completion of any other known deficiency in the record.

Surgery Center
Policy & Procedure

Title	DELINQUENT MEDICAL RECORDS	MR	16
Revised:	Authorizing Signature:		

PURPOSE: To ensure that all medical records are complete within 30 days of discharge.

POLICY: All medical records generated at the Facility will be completed in 30 days or be subject to administrative action.

PROCEDURE:

A. All medical records will be assembled and analyzed after patient discharge.

B. Any deficiencies in the medical record will be noted and brought to nursing personnel and/or the physician for completion.

C. All incomplete medical record files will be made available to the physician for completion.

D. Physicians will be notified by phone and by letter or posting in the surgery center if reports are not dictated, signed or returned, as required.

E. Records shall be deemed delinquent 30 days after discharge per the Facility's Bylaws.

F. Delinquent records shall be monitored through Quality Plans and reported to the Medical Advisory Committee.

G. Delinquencies will be monitored through Quality Plans. At 30 days, a certified letter, return receipt requested, will be sent to the physician stating the delinquency. If the physician does not complete charting within the week after confirmation has been received, appropriate action per Facility Bylaws will be taken.

H. Vacations, leaves of absence, and illness will excuse physicians from the penalty process.

Surgery Center
Policy & Procedure

Title	RETRIEVAL OF MEDICAL RECORD CHARTS	MR	18
Revised:	Authorizing Signature:		

PURPOSE: To enable fast and accurate retrieval of medical record charts.

POLICY: All medical records will be subject to uniform storage, retrieval, and interim management.

PROCEDURE:

A. Completed medical record charts are stored in the locked permanent file storage area, in a logical and sequential manner.

B. Incomplete records are stored in the medical record room, filed in alphabetical order.

C. Any charts leaving the medical records room, post-date of service, should be signed out on the Medical Records Sign Out Log.

Surgery Center
Policy & Procedure

Title	OUTPATIENT ICD-10-CM & CPT-4 CODING	MR	20
Revised:	Authorizing Signature:		

PURPOSE:

A. STATISTICAL USES:

1. Studying the etiology and incidence of disease
2. Providing for future health care needs
3. Controlling and improving the quality of care rendered to patients
4. Controlling and improving the utilization of health care facilities and services
5. Establishing reimbursement rates for care rendered to patients

B. CLINICAL USES:

1. Monitoring care rendered to patients
2. Indexing the content of medical records so they are retrievable for medical research

C. MATERIALS:

1. Discharged records
2. Assorted reference books/articles

POLICY: Coded data will accurately reflect the patient's condition and management in the Facility to the extent necessary for the intended use of the data within the constraints of the classification needed.

PROCEDURE:

A. All records will be coded within 72 hours of discharge. The records will be coded using the ICD-10-CM coding principles and assigned a CPT code and ICD-10-CM code accordingly. When all codes are completed, the codes are to be written on the face sheet of the record and charges are to be entered in the practice management system and processed. Completed records are sent to the permanent file. The incomplete records are routed to the appropriate areas (i.e., dictation, physician signature, nursing) for completion.

Surgery Center
Policy & Procedure

Title	MAINTAINING MEDICAL RECORDS	MR	22
Revised:	Authorizing Signature:		

PURPOSE: To provide that medical records will be secured in designated areas for specific periods of time. This policy also addresses medical records removal and replacement in the event of potentially catastrophic events.

POLICY: Medical records will be maintained in a uniform manner to ensure accessibility, protection and appropriate retention.

PROCEDURE:

A. FILING OF MEDICAL RECORDS: Medical records will be filed in a logical, sequential, uniform manner in a secured area.

B. LOCATION: The Facility's medical records, when deemed complete, will be securely filed in the medical record storage area. Medical records awaiting completion will be filed securely.

C. FIRE / DISASTER PROTECTION: In the event of notification of the need to evacuate the Facility due to the threat of fire or disaster and that such notification is timely enough, the medical records of the facility will be placed in boxes and removed to a safe place. The records will then be transported to a secure storage area until such time that it is safe to return them to the Facility. If time permits, the secondary records, including indexes, registers, log books and files, will be treated in the same manner.

D. ACCESSIBILITY:

1. HOURS OF OPERATION:
    a. The Facility Medical Records Department is open, Monday-Friday, 8 AM - 5 PM

E. AFTER HOURS: In the event a request for a medical record is received after hours, authorized healthcare professionals will have access to medical records via an On-Call system set by the Administrator.

F. REMOVAL OF MEDICAL RECORDS: Medical records can be taken out of the medical records area for the following reasons only:
    1. Readmission of the patient.

2. On-site interview / conference
3. Medical conferences
4. Chart review

Any charts leaving the medical records room, post-date of service, should be signed out on the Medical Records Sign Out Log.

G. RETENTION: The Facility will retain all medical records for at least one year from date of last occurrence at the facility. The records will then be transferred to a secure storage area, where they will be maintained until seven years from the date of the last occurrence for adults and seven years beyond the age of majority for minors or according to state regulations.

H. TRANSFER OF PATIENT INFORMATION: If a patient is to be transferred from the Facility to another facility, the entire medical record will be copied and sent with the patient.

Surgery Center
Policy & Procedure

Title	MEDICAL RECORDS REVIEW	MR	26
Revised:	Authorizing Signature:		

PURPOSE: To determine that the chart forms utilized in the Facility provide adequate documentation and that these tools are being properly completed to include all pertinent information.

POLICY: The Quality Plan is the quality assessment and quality improvement tool used to ensure completeness and clinical pertinence of medical records for the entire staff.

PROCEDURE:

A. Quality Planning: Annually, the designated team develops, with the approval of the Medical Staff, quality indicators to measure completeness and clinical pertinence of the medical records. Goals are established to improve performance from the following year.

1. Medical record indicators must accurately measure, but not be limited to the following:

    a. Medical staff: Clinical pertinence
    b. Medical staff: Clinical completeness
    c. Nursing: Clinical pertinence
    d. Nursing: Clinical documentation

2. Medical Record Chart Evaluation forms (see attached) have been developed by the Facility and approved by the Medical Staff to measure good performance and identify non-compliance with the indicators. These tools may also be revised annually with the approval of the Medical Staff.

B. Quality Assessment: A monthly chart review will be conducted by the Facility's staff members to include a random sample of 10% of the charts or 20 individual charts from two months prior to the review. The random review should include charts representing all procedure physicians.

    1. Patient Medical Record will be randomly reviewed thru the EMR system by appropriate staff for evaluation and/or assessment.
    2. The Facility completes a Medical Record Chart Evaluation form for each chart.
    3. The Facility summarizes the results of all charts in the Medical Record Chart Evaluation Summary form.

4. The completed Medical Record Chart Evaluation Forms are organized and maintained by the Facility.

C. Quality Improvement: It will be the responsibility of the appropriate designated team to monitor and coordinate the improvement process for medical records.
   1. Facility staff:
      a. The appropriate designated staff member will follow the steps as defined in the Quality Plan to identify necessary improvements to nursing clinical pertinence and documentation.
   2. Anesthesia staff:
      a. The Director of Nursing/Administrator will assist the Medical Director in identifying opportunities for improvement in anesthesia clinical pertinence and documentation. It will be the responsibility of anesthesia to maintain clinical pertinence and documentation guidelines established by the Medical Staff.
   3. Medical staff:
      a. The Medical Advisory Committee will determine the Medical Staff's compliance with the indicators and lead the improvement process.
      b. The Medical Records Chart Evaluation form is used to combine the required peer review process with the staff improvement process.
         1. If an individual physician is identified to continually fall short of the guidelines in the Medical Record Chart Evaluation Tool, this result plus past performance results are presented to the Medical Director.
         2. It will be the responsibility of the Medical Director and Director of Nursing/Administrator to ensure physician compliance with the established guidelines.
         3. If action is taken to notify the physician of a problem, this is reported in the individual physician's activity report.

D. Quality Reporting: The Medical Record Chart Evaluation Forms & Summary are completed monthly and reported quarterly to the Medical Advisory Committee and Board (as requested).

Surgery Center
Policy & Procedure

Title	RELEASE OF MEDICAL INFORMATION (also reference HIPAA policies & exhibits)	MR	28
Revised:	Authorizing Signature:		

PURPOSE: To protect patient confidentiality and ensure proper release of medical information.

POLICY: In order to protect patient confidentiality and ensure proper release of medical information, it shall be the policy of the Facility to follow the guidelines established in its Release of Medical Information procedure. Guidelines are established in accordance with the Health Insurance Portability and Accountability Act (HIPAA) privacy standards, State Statutes, American Health Information Management Association (AHIMA) guidelines, and the organization's legal counsel.

DEFINITIONS:

A. Medical information: Any information contained within an outpatient medical record including patient identification, dates of services and ancillary reports. Although the medical record is the property of the Facility, medical information will only be released through proper authorization by the patient and/or legal representative.

B. "Notice of Privacy Practices for Protected Health Information": (Exhibit C- HIPAA Compliance Plan) All patients must be given a clear, written explanation of how the Facility will use or disclose his/her information via a Notice of Privacy Practices.

C. Minimum necessary requirement: When sharing identifiable medical information, the Facility shall disclose the minimum information necessary.

D. Patient **Consent** (Exhibit A – HIPAA Compliance Plan) : The Facility must obtain consent in the context of usual practice (treatment, payment, regular facility operations).

E. Patient written **authorization** (Exhibit B- HIPAA Compliance Plan): Written authorization is required of use or disclosure outside the context of usual practice, including training programs, marketing/fundraising materials that identify patients, and as a defense against the patient in a legal action.

Unlike a consent, the Facility cannot condition treatment on an authorization. Also, an authorization differs from a consent in that it must contain eight specific elements as follows:

a) Statement that the recipients may further disclose the information and, in such a case, the information loses its HIPAA privacy protections
b) Name or other identification of the recipients of the information
c) Name or other identification of the authorizing patient(s)
d) Specific, meaningful description of information to be used/disclosed.
e) Authorization will expire 60 days from date of signature
f) Description of representative, if patient cannot sign the authorization
g) Signature of patient or legal representative/date
h) Statement of patient's right to revoke the authorization in writing, with an explanation of how to do so

F. Legal representative: Healthcare representative or healthcare power of attorney, guardian, spouse, parent, adult children and siblings may serve as a proxy for health care decisions. The Facility should contact legal counsel if questions arise regarding the ability of the above to consent.

G. Super confidential information: In accordance with Federal and State regulations, there are three categories of patients whose medical information requires strict confidentiality. These records are to be released solely under the direction of the Medical Records Department, Release of Information Section.

1. CATEGORIES OF SUPER CONFIDENTIAL INFORMATION:
   a) Psychiatry/Mental Health Information
   b) Drug/Alcohol Records
   c) HIV/AIDS: State Statutes strictly prohibits release of HIV antibody test results without proper consent and authorization. All AIDS related information documented in the medical record shall be protected.

PROCEDURE:

A. Disclosure (any communication) of patient identifying information is considered a violation. Patient identifying information is considered:

1. Patient name
2. Address
3. Dates of service

4. Age
5. Medical Record Number
6. Clinical Information

B. The information released shall be strictly limited to that information required to fulfill the purpose stated in the authorization (minimum information necessary).

C. RULES FOR RELEASE OF INFORMATION:

1. Persons Who Are Authorized to Sign a Release Include:
    1. The patient, if the patient has reached the age of majority and is of sound mind.
    2. The patient's parent may sign the release if the patient is not of the age of majority. A certified copy of the court order appointing the guardian must be present in the record.
    3. Power of Attorney: The designated person must present a notarized copy of the original document declaring Power of Attorney. The notarized copy should be endorsed indicating that the authority is still in effect at the time it is presented. A copy shall be made and will be put into the medical record file along with the release form.
    4. NOTE: A husband may not sign for his wife, nor a wife for her husband, except if the patient is physically unable to sign or spouse has Power of Attorney or unless in an emergency situation.
    5. Medical information may be released when not meeting the above conditions:
        1. With authorization from the Medical Examiner
        2. To a government authority accessing information for the protection of the general health of a community, but only in sufficient detail to permit the authority to protect the general public

D. Clinical records may not be viewed without the written consent of the patient and/or legal representative except:

1. Those persons who have been responsible for documenting medical information within the medical record.
2. Records used for study or research purposes, provided authorization waiver is IRB – or privacy board-approved.

3. Administrative authority accessing information in the interest or protection of the patient or public (deaths, child abuse, neglect, domestic violence, disease/infection exposure).
4. Clinical information subpoenaed for trial.
5. When required by law.
6. Appropriate law enforcement requests (to identify or locate a suspect, fugitive, material witness or missing person)
7. Deceased person information to coroners, medical examiners, funeral directors
8. Organ and tissue donation
9. Emergencies, or to avert serious threat to health or safety
10. Specialized government functions (military, inmates)
11. Worker's Compensation

E. SPECIFIED RELEASE POLICIES BY REQUESTOR:

1. INSURANCE COMPANIES: No information is to be released without a valid written consent form from the patient. The information released to authorized companies is strictly limited to that which is requested/stated on the patient's authorization.

2. EMERGENCY MEDICAL TECHNICIANS: Under COBRA rules, the transferring facility is required to provide copies of medical records to accompany the patient during transfer to a receiving facility. Emergency Medical Services personnel may access medical information from the medical record for billing purposes. Copies of the medical record will not be released without proper patient authorization.

3. ATTORNEYS: All attorney requests should be referred to Administration / Risk Management for surgery/endoscopy cases.

4. PHYSICIANS: Physicians may have access to patient records under the following circumstances:
   a) Members of the Medical Staff may always see the medical record of their own patients or records to whom they have rendered emergency care
   b) Physicians requesting information for purposes other than patient care must submit a proper authorization signed by the patient for release of information
   c) Physicians who are not a part of the Medical Staff may obtain information from medical records only by written request and written authorization from the specified patient

d) All appropriate records are made available with patient "consent" to the various organized staff committees entrusted with reviewing the quality of care within the Facility.

5. HOSPITALS: If emergency medical information is requested from a hospital, such information shall be made available without the patient's consent. In emergency situations, it is advisable to request that an authorization be forwarded when possible. An Emergency Release of Information note indicating the current date, name of the requesting institution, name and title of caller and the nature of the information released should be documented in the patient's record. Verification of requestor should be confirmed through follow-up phone call prior to the actual release of information.

6. WORKERS COMPENSATION: Record requests will be honored without specific authorization from the patient. Request forms will vary from written to legal subpoena for trial.

7. TELEPHONE REQUESTS FOR MEDICAL INFORMATION: Medical information is released by telephone only after specific procedures have been carried out and only to physicians, their offices or other health care facilities.

a) The physician office requesting the medical information will be asked to recite their UPIN# or NPI # to allow the Facility to verify their identity. If a physician's office calls that is not the ordering physician or a physician indicated to receive a copy of report, he/she will be asked to provide a medical release of information signed by the patient allowing the Facility to release requested information.

8. ADMINISTRATION / RISK MANAGEMENT: Administration and/or Risk Management may review and/or request copies of medical records when they involve an incident, a lawsuit, or claim of possible litigation against the Facility or its staff members.

9. MEDICARE/CHAMPUS/MEDICAID PRO REVIEW: In accordance with rules of participation in the Medicare, Medicaid and Champus programs, records will be provided upon request for review.

10. MEDICAL RECORD SUBPOENAED FOR DEPOSITION (This procedure is to be encouraged in lieu of a court appearance):

a) A call should be made to the requesting attorney to verify the place and date for the deposition and to issue a time for appearing in court as close to the time as he/she plans to introduce the record or will he/she permit a sealed certified copy of the record to be sent five days prior to the date specified.

b) The subpoena should be logged in the "Release of Information" log for all records, procedures and exams.

c) The attending physician who was responsible for the case will be notified that a subpoena has been served via letter or phone call.

d) Regardless of the manner in which the subpoena is to be answered, the record must be reviewed to assure that it is accurate and complete, removing all correspondence and authorizations that do not pertain to the medical care. It is especially important to remove all data or photocopies from other health care providers that may be part of the Facility record.

e) In the event a medical record is taken to court and requested by the judge to be kept by the court and entered as evidence, a receipt must be obtained documenting the following:

1. Date retained
2. Name of judge requesting record
3. Patient name
4. Patient's medical record number
5. A written commitment to return the record to The Facility
6. Number of sheets in the record
7. Name, address and telephone number of the person assuming responsibility of the record (usually clerk of the court)

f) Follow up is to be initiated if the requested medical record is not returned after 30 days. Risk Management should contact the staff attorney and request records be returned.

g) Upon receipt, the record will be restored to its original format and returned to the file.

11. RELEASE OF MEDICAL INFORMATION BY PHONE: Medical information is released by telephone only after specific procedures have been carried out (see Telephone Requests for Information Section) and only to Facility

physicians and their office staff. (Refer patient calls to their primary care physician.)

a) During regular office hours, the responsible staff member must handle the procedure for release of medical information by telephone. During the evening or weekend, this procedure should be handled only when a true emergency exists and by a designated call team member.

b) To ensure the correct information is released to the proper individual, it is necessary to verify the identity of the physician's office by asking the caller to recite the physician's UPIN or NPI number.

1. Upon locating the patient's chart, requested information will be released via fax with confidential fax transmittal sheet or via mail
2. Documentation of the request will be placed in the appropriate medical record folder/film folder.

12. ROUTINE PROCESSING & HANDLING OF REQUESTS FOR INFORMATION:

a) Mail is opened and stamped with date of the department's receipt.
b) Team member will obtain the patient's medical record.
c) Team member will check to see if proper authorization has been received.
d) If proper authorization has not been received and additional information is needed, request is returned to sender with a cover letter outlining needed information.
e) Patient's chart is located, the requested information is copied, and the release of medical information sheet is placed in patient's folder.
f) The appropriate team member performs second check before mailing the requested information to ensure that the request sheet matches the records copied.
g) The requested information is sent to the requestor.
h) A copy of the request letter is given to the Risk Manager for all cases.

Surgery Center
Policy & Procedure

Title	Standing Orders Procedure	MR	34
Revised:	Authorizing Signature:		

POLICY: Standing medication orders are available to facilitate standardized patient treatment.

PROCEDURE:
Standing orders are written and approved by the Medical Advisory Committee. When used the order shall be dated, promptly signed by the practitioner, and included in the patient's medical record.

All standing orders for drugs shall specify the circumstances under which the drug is to be administered and shall also specify the types of medical conditions of patients for whom the standing orders are intended.

All standing orders for medications must be approved by the Medical Advisory Committee and reviewed annually.

The standing orders for drugs shall be specific as to the name of the drug, the dosage, route and frequency of administration. Sedatives, analgesics, and ketorolac doses shall be left blank to allow dose adjustments for the patient's age and or medical condition.

Form A – Verification Form

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: ACTD LLC MULTI-SPECIALTY AMBULATORY SURGERY CENTER	)	Docket No. GMCB-010-15con

Verification Under Oath – Policies and Procedures

Amy Cooper, being duly sworn, states on oath as follows:

1. My name is Amy Cooper. I am the manager of ACTD LLC. I have reviewed the following policies and procedures for the proposed Green Mountain Surgery Center: Medical Record Content; Medical Record Confidentiality; Release of Medical Information; Medical Records – Philosophy Statement; Standing Orders Procedure; Medical Records Review; Maintaining Medical Records; Outpatient ICD-CM & CPT-4 Coding; Retrieval of Medical Record Charts; Delinquent Medical Records; Completion of the Medical Record; and Preparation & Documentation of Medical Record ("Policies and Procedures") being submitted with this Verification to support the Certificate of Need Application for the Green Mountain Surgery Center.

2. Based on my personal knowledge, after diligent inquiry, the information contained in the Policies and Procedures is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading, except as specifically noted in the Policies and Procedures.

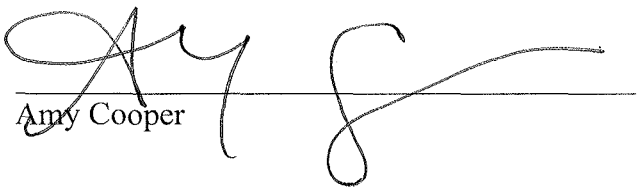
3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Policies and Procedures is based upon either my actual knowledge of the subject information or, where identified below, upon information reasonably believed by me to be reliable and provided to me by the individuals identified below who have certified that the information they have provided is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading.

4. I have evaluated, within the 12 months preceding the date of this affidavit, the policies and procedures by which information has been provided by the certifying individual identified below, and I have determined that such policies and procedures are effective in ensuring that all information submitted or used by ACTD LLC in connection with the Certificate of Need program is true, accurate and complete. I have disclosed to ACTD LLC all significant deficiencies, of which I have personal knowledge after diligent inquiry, in such policies and procedures, and I have disclosed to ACTD LLC any misrepresentation of facts, whether or not material, that involves management or any other employee participating in providing information submitted or used by ACTD LLC in connection with the Certificate of Need program.

5. The following certifying individual has provided information or documents to me in connection with the Policies and Procedures, and said individual has certified, based on her actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the certifying individual to be reliable, that the information or documents she has provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact necessary to make the statement made therein not misleading:

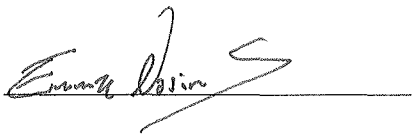
   a. Joan Dentler, Avanza Strategies – Provided all of the above listed Policies and Procedures.

6. In the event that the information contained in the Policies and Procedures becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board and to supplement the Policies and Procedures, as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.



Amy Cooper

On April 21, 2017, Amy Cooper appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Notary Public 

My commission expires February 10, 2019

Testimony in Support of the Certificate of Need Application of ACTD LLC to Develop the Green Mountain Surgery Center

My name is Andrew Lasser, DrPH. I was sworn in as a witness at the original hearing on April 13, 2017. I have been a health care executive for over 40 years. My first hospital CEO position was in 1975. I have lead academic medical center hospitals, children's hospitals, Catholic hospitals, and community and rural hospitals. I have also worked in the consulting environment, mostly helping hospitals and physicians develop joint venture ambulatory surgery centers (ASCs) for the last six years. I have worked in and understand both sides of the issues at hand in this application and come in support of the Applicant as a consultant because I've seen the benefits to communities of ASCs and I don't believe the negative effects purported by the hospitals involved will come to pass.

What I have observed in Vermont over the past three years of being involved with the Green Mountain Surgery Center Project:

- It appears that the hospital leaders in Vermont feel that the Certificate of Need is designed to protect and preserve the historic status quo. Rather, it is to determine the need for services to provide safe, cost-effective services in the right settings.
- Hospitals talked about performing community needs assessments. These assessments are required, not voluntary, and they involve assessing the community's capacity to effectively deliver care. This suggests that they should survey patient and health care needs and how they are addressed in the many organizations that deliver health care services inside and outside the hospital. That assessment would uncover the need for lower-cost surgical services, where appropriate, to meet the needs of increasingly cost-conscious consumers of care. ASCs should be part of that needs assessment.
- Throughout my lifetime of experience, hospitals have been continuously confronted with a volatile and changing marketplace. Those hospitals that realize the need to make effective change and do so will be well positioned in the future to ensure their role in the evolving health care system. The health care system that the Green Mountain Care Board is deigned to govern must continually evolve

and innovate to be successful. You have created a well-regulated structure squarely facing the needs of Vermonters for the future with leading edge thought and purpose. This is another opportunity for you to make change for the greater good of the needs of your citizens, not just the old fashioned, hospital-centric needs of the acute care providers.

- Hospital witnesses suggested that the ASC was an unregulated, fee-for-service dinosaur. Rest assured that the Centers for Medicare & Medicaid Services regulatory structure, the Facility Guidelines Institute guidelines, standards of private accrediting bodies (e.g., The Joint Commission and Accreditation Association of Ambulatory Health Care) and the responsible oversight of the physician leaders will assure a safe, cost-effective, high-performing service. As reimbursement changes from volume to value so will the payment systems that currently pay all providers (including hospitals). The ASC will be paid in the prevailing payment systems, as everyone will.
- ASCs are reimbursed at about 55% of what Medicare pays hospitals for the same procedures. The higher reimbursement for hospitals recognizes the higher costs involved in providing outpatient surgery within a hospital. The savings that will accrue from this new ASC come from the government, private payors and patients who seek lower-cost alternatives. Patients should not be penalized because hospitals have underutilized high-cost space.
- Hospital witnesses talked about existing capacity to meet demand for services within their facilities. That only shows that there may be overcapacity in the high-cost, hospital-focused world. Capacity and access mean different things to different audiences. The availability of high-cost services does not address the need from patients and others for lower-cost alternatives.
- Hospital witnesses also suggested that losing some outpatient surgical revenue would reduce their ability to cross-subsidize services. While that may be true on the surface, real adaptation to change means sometimes having to figure how to operate in a changing environment that does not allow cross subsidy but rather suggests new innovative responses to revenue and expense challenges as all businesses must.

- When I was a hospital executive we responded to changes in volume for certain services by looking for new opportunities to grow new services, by examining our cost structure to see if any reductions could occur and by eliminating some services that could be better served in alternative environments.

Health care in Vermont, as in the greater United States, is undergoing constant change. This change is brought about by pressure from the health care system to adapt to the changing realities of health care delivery. During my 40 years as a hospital executive, the only constant has been change. As the government began to get deeply involved in paying for health care through its two major programs of Medicare and Medicaid, the substantial dollar outlays at stake caused payors to question the models of health care delivery in place and to push for more innovative ways to deliver health care. Government at the state and federal level realized the power in their hands to try to create changes that could increase the quality of care while at the same time reducing the growing cost of health care. New programs and regulations were created to reduce the burdens needed to support this growing system.

After World War II, the government realized that saving lives closer to home, as they had done during the war, required the building of more hospitals in communities closer to people's homes. As the system expanded, it was focused on the hospital as the center of the health care delivery system. That model still is dominant today, but times are changing due to fiscal pressures plus the realization that focusing all care at the hospital level emphasized expensive "medical care" and not primary and preventive services that provide "health care." The new models being created today reflect the need for "health care" that will support healthier Americans while reducing the cost of services. Accountable care organizations, bundled care pricing, all payor structures and population health strategies focus on the ability to prevent disease and manage health. They not only provide acute hospital services at the high prices that result from the high cost of creating hospitals that can care for the most acute needs of the sickest patients, but they also encourage developing alternative models of care such as in ASCs. The hospital that once was the central dominant focus of the health care system is now an important

piece, but just a piece of the coordinated and integrated system that health care must become.

The Green Mountain Care Board (GMCB) has a tripartite role to regulate, innovate and evaluate the health care system in Vermont. It has led the charge to try to insist on a system that can develop and support the right services at the right costs at the right places. This laudable effort requires that Vermonters seek to understand how health care services can be best positioned to accomplish the goals of having high quality services within easy access to Vermonters. Not all health care services can or should be provided in the acute care hospital setting.

In a recent special report from *Modern Healthcare*, the headline read "The Transformation Imperative: Why the social and economic forces disrupting healthcare are here to stay"(1). It discussed the pressure of cost and consumerism that were driving innovation. In these cases, innovation is focused on the need to drive health care costs down while improving quality and emphasizing preventive as well as chronic care management. ASCs are an effective and proven way to deliver appropriate outpatient surgical services in a setting that is less costly than the same cases done in an acute care hospital. The first ASC was opened in the United States in 1970. There are now over 5,400 ASCs providing safe and effective care around the country. In those ASCs, over 20 million surgeries have been performed safely and with high-quality outcomes and with patient satisfaction that is higher than in most hospital outpatient settings. The cost savings to the patient, insurers and self-insured employers can be seen by how Medicare has chosen to pay ASCs for those services (because as Medicare pays, so others pay). Medicare pays an ASC roughly half of what it pays for the same service provided in a hospital outpatient surgical department. This means that for the government, which pays for Medicare and Medicaid, the cost for the same service is half of the cost in the hospital. Pressure from government payors and insurers alike are causing the innovations in ASCs that are reducing the costs of care. For patients that are increasingly subjected to health insurance policies with higher out-of-pocket deductibles and co-pays, the need to have lower cost alternatives for care is imperative!

The GMCB has the opportunity to approve this application and join every other of the 50 states that have multi-specialty ASCs serving their patients' needs. The success of the Eye Center has shown that the ASC services are safe and needed. ASCs are not in competition with hospitals. They stand in addition to the hospitals as another place to receive safe, highly regulated and monitored services. Many hospital leaders across the country feel that hospitals are no longer the most appropriate place to provide outpatient surgery to healthy patients. In those situations, hospitals and ASCs co-exist without issue or duplication of costs. ASCs serve healthy patients in need of elective services — an entirely different consumer and service than should be the focus of an acute care hospital.

Hospitals are high-cost and intricate systems for delivering much needed acute care services. That same high-cost structure is not needed to provide services that do not require an elaborate acute care structure to work.

Certificate of Need should review the needs of patients, insurers and employers and not just protect the needs of acute care hospitals to survive in a market that is changing the role of the hospital. Consumer demand for "choice" is a growing force. ASCs provide such a choice

While hospitals will always be needed, ASCs are needed, too. Together they help better create a system of care that is coordinated and integrated throughout the community.

Our community hospitals play a strong and valuable role in the evolving health care system. That system must also include new and alternative models of delivery. Your role is not to "protect and preserve" the old, but to innovate and evaluate new technologies as they apply to the needs of Vermonters and the evolving health care regulatory and reimbursement environment. Please approve this Certificate of Need application.

My recommendation:

Approve this application – Regulate
Recognize and support this new delivery technology – Innovate
Review its performance over time – Evaluate

References

1. www.modernhealthcare.com/reports/transformationimperative

Form A – Verification Form

STATE OF VERMONT
GREEN MOUNTAIN CARE BOARD

In re: ACTD LLC MULTI-SPECIALTY AMBULATORY SURGERY CENTER	)))))	Docket No. GMCB-010-15con

Verification Under Oath – Lasser Testimony in Support of the Certificate of Need Application of ACTD LLC to Develop the Green Mountain Surgery Center

Amy Cooper, being duly sworn, states on oath as follows:

1. My name is Amy Cooper. I am the manager of ACTD LLC. Andrew Lasser was sworn in as a witness at the April 13, 2017 Green Mountain Care Board hearing. As there was not time for his in-person testimony on that day, with leave of the Board, he is submitting the attached written Testimony in Support of the Certificate of Need Application of ACTD LLC to Develop the Green Mountain Surgery Center ("Testimony"), which I have reviewed.

2. Based on my personal knowledge, after diligent inquiry, the information contained in the Testimony is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading, except as specifically noted in the Testimony.

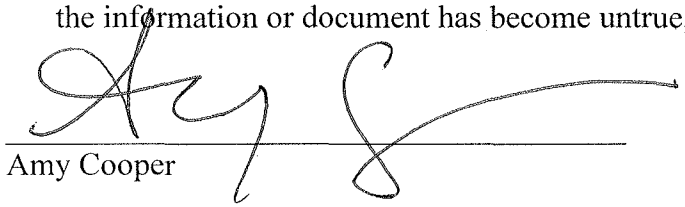
3. My personal knowledge of the truth, accuracy and completeness of the information contained in the Testimony is based upon either my actual knowledge of the subject information or, where identified below, upon information reasonably believed by me to be reliable and provided to me by the individual identified below who has certified that the information he has provided is true, accurate and complete, does not contain any untrue statement of a material fact, and does not omit to state a material fact necessary to make the statement made therein not misleading.

4. I have evaluated, within the 12 months preceding the date of this affidavit, the policies and procedures by which information has been provided by the certifying individual identified below, and I have determined that such policies and procedures are effective in ensuring that all information submitted or used by ACTD LLC in connection with the Certificate of Need program is true, accurate and complete. I have disclosed to ACTD LLC all significant deficiencies, of which I have personal knowledge after diligent inquiry, in such policies and procedures, and I have disclosed to ACTD LLC any misrepresentation of facts, whether or not material, that involves management or any other employee participating in providing information submitted or used by ACTD LLC in connection with the Certificate of Need program.

5. The following certifying individual has provided information or documents to me in connection with the Testimony , and said individual has certified, based on his actual knowledge of the subject information or, where specifically identified in such certification, based on information reasonably believed by the certifying individual to be reliable, that the information or documents he has provided are true, accurate and complete, do not contain any untrue statement of a material fact, and do not omit to state a material fact necessary to make the statement made therein not misleading:

   a. Andrew Lasser, Executive Vice President, Avanza Healthcare Strategies/ASC Strategies, provided all the information contained in Testimony.

6. In the event that the information contained in the Testimony becomes untrue, inaccurate or incomplete in any material respect, I acknowledge my obligation to notify the Green Mountain Care Board and to supplement the Testimony, as soon as I know, or reasonably should know, that the information or document has become untrue, inaccurate or incomplete in any material respect.



Amy Cooper

On April 21, 2017, Amy Cooper appeared before me and swore to the truth, accuracy and completeness of the foregoing.

Notary public 

My commission expires February 10, 2019