

LEXINGTON INSURANCE COMPANY
ADMINISTRATIVE OFFICE: 100 Summer Street, Boston, MA 02110
(a capital stock insurance company, herein called the Insurer)
APPLICATION FOR
HOSPITAL PROFESSIONAL LIABILITY/GENERAL LIABILITY
AND
UMBRELLA EXCESS LIABILITY INSURANCE

Please review this application carefully and discuss it with your insurance representative. If a policy is issued, the application will become part of the policy as if physically attached. Therefore, it is necessary that all questions be answered accurately and completely.

Instructions:

1. Please use Microsoft Word to type text directly onto the application.
2. Answer **ALL** questions completely, leaving no blanks. If any questions, or part thereof, do not apply, state "N/A."
3. If you need more space for your responses, continue on a separate sheet of your letterhead and indicate question number.
4. When necessary, check all boxes that apply.

SECTION I

Please attach the following:

1. Loss History, hard copy carrier loss runs and, when available, in electronic format:
 - a. Ten years of historical PL and GL losses including current year, ground-up and unlimited, including all self insured, insured, and uninsured losses.
 - b. Date of loss valuation must be within past ninety days.
 - c. Lost run must include: carrier, claimant name, date of loss, report date, indemnity paid, indemnity reserved, expenses paid, expenses reserved, total incurred, status (open or closed), type (PL or GL), and narrative of claim.
 - d. Full details of allegations on all losses paid or outstanding in excess of \$50,000 even if greater than 10 years old.
2. Most recent accrediting agency report (JCAHO, AOA, CARF, etc.) or if accrediting agency reports are unavailable please submit the state licensure report with recommendations and the institution's response to any contingencies.
3. CPA prepared and audited financial statement, including balance sheet, income statement, and cash flow.
4. Identity of each employed physician, indicating name, specialty, date of hire, retro date, primary PL carrier, primary occurrence or claims made, PL limits. See Section IV, B 2 for table.
5. Identity of each Named Insured on the policy including a brief explanation of their relationship to the applicant and their retro date (if historically written on claims made basis).
6. Copy of current risk management and quality improvement plan.
7. Recent actuarial review supporting the funding of any self insured retention.
8. Copy of current Organizational Chart (Corporate and Risk Management)
9. Copy of Claim Management Procedures.
10. Completed Hospital Addendum. Please request addendum from your broker.
11. Completed Bariatric Surgery Addendum, if applicable. Please request addendum from your broker.

D. Accreditation:

1. Accredited Programs:
2. Please provide date of most recent JCAHO accreditation.
3. Accreditation Decision:
 Accredited Provisional Accreditation Conditional Accreditation Preliminary Denial of Accreditation
 Denial of Accreditation Preliminary Accreditation
4. Requirements for Improvement? Yes No
 If yes, please provide list of standards scored as non-compliant:
5. Did the survey identify any life safety issues? Yes No
 If yes, please explain
6. Were partially compliant standards identified in the supplemental findings? Yes No
 If yes, please explain

E. Current Insurance Coverage: (expand the table with additional rows as needed, or attach separate page)

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	**Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Premium
Professional Liab PL							
General Liab GL							
Employee Benefits							
Excess/Umbrella							
Underlying PL							
Underlying GL							
Auto Liab.							
Employers' Liab.							
Employee Benefits							
Helipad/Aviation							
Other:							

1. Are defense/expenses within policy limits? Yes No
2. Is underlying/retention eroded by indemnity only or indemnity plus defense/expenses?

*Please specify by layer if more than one Retroactive Date applies.
 **Deductibles require Insurer approved Letter of Credit.

F. Prior Insurance History:

If commercially insured, please provide the following primary and excess/umbrella PL coverage information for each of the past 5 years.

Policy Period	Carrier	PL Limits Per Occ/Agg Primary	PL Limits Per Occ/Agg Excess/Umbrella	**Ded <input type="checkbox"/> or SIR <input type="checkbox"/>	Occ. or Claims Made	Premium
Current						

*Please specify by layer if more than one Retroactive Date applies.
 **Deductibles require Insurer approved Letter of Credit.

G. Insurance Coverage Desired:

Primary	Carrier or Self Insured	Effective Date	Occ. or Claims Made	*Retro Date	Limits Per Occ/Agg	**Ded or SIR <input type="checkbox"/>
Professional Liab PL						
General Liab PL						
Employee Benefits						
Excess/Umbrella						
Underlying PL						
Underlying GL						
Auto Liab.						
Employee Benefits						
Employers' Liab.						
Helipad/Aviation						
Other:						

- Will defense/expenses be within policy limits? Yes No
- Will underlying/retention be eroded by indemnity only or indemnity plus defense/expenses?

*Please specify by layer if more than one Retroactive Date applies.

**Deductibles require Insurer approved Letter of Credit.

H. SIR Accounts:

- To what line(s) of coverage will the SIR apply?
- What are the limits of liability for the SIR? \$ _____ per occurrence, \$ _____ aggregate.
- Are loss adjustment expenses part of or outside the SIR limit?
- Is there a dedicated trust? Yes No.
If yes, what financial institution manages the trust?
If not, is there a captive? Yes No.
Details.
- Has an independent actuarial review been completed? Yes No
If yes, please provide the name of the firm _____ Date: _____

I. Claims Management:

- Who, within the organization, is responsible for claims management activities?
Name: _____ Title: _____ Phone Number: _____
No
- Do you have written claims management procedures: Yes , please attach. No
- Does a Third Party Administrator manage claims within the SIR? Yes No
If yes, please provide name of TPA Firm and Contact: _____ Phone Number: _____
- Please provide names of defense firms who currently represent you in professional liability matters:

SECTION III

A. Services Provided (check all that apply):

☛ If checked below, please answer applicable questions in Sections B-I .

<input type="checkbox"/> Abortion	<input type="checkbox"/> Home Health	<input type="checkbox"/> Open Heart
<input type="checkbox"/> Ambulance ☛	<input type="checkbox"/> ICU	<input type="checkbox"/> Operating Rooms
<input type="checkbox"/> Bariatric Surgery ☛	<input type="checkbox"/> Inhalation Therapy	<input type="checkbox"/> Pathology
<input type="checkbox"/> Blood Bank ☛	<input type="checkbox"/> Laboratory	<input type="checkbox"/> Pharmacy ☛
<input type="checkbox"/> Burn Unit	<input type="checkbox"/> Laser Assisted Surgery	<input type="checkbox"/> Physical Therapy
<input type="checkbox"/> Cath Lab	<input type="checkbox"/> Lithotripsy	<input type="checkbox"/> Plastic / Cosmetic Surgery
<input type="checkbox"/> CCU	<input type="checkbox"/> Long Term Care	<input type="checkbox"/> Psychiatric
<input type="checkbox"/> Clinical Trials	<input type="checkbox"/> Morgue	<input type="checkbox"/> Radiation Therapy
<input type="checkbox"/> Coronary Rescue	<input type="checkbox"/> Neonatal	<input type="checkbox"/> Radiology
<input type="checkbox"/> Day Care ☛	<input type="checkbox"/> Neurosurgery	<input type="checkbox"/> Research
<input type="checkbox"/> Dialysis	<input type="checkbox"/> NICU	<input type="checkbox"/> Self-Care
<input type="checkbox"/> Dietary	<input type="checkbox"/> Nurse Call	<input type="checkbox"/> Sex Change

<input type="checkbox"/> Emergency	<input type="checkbox"/> Nursery	<input type="checkbox"/> Shock Trauma
<input type="checkbox"/> Fitness Center ☺	<input type="checkbox"/> OB/Gyn	<input type="checkbox"/> Surgery
<input type="checkbox"/> Gift Shop	<input type="checkbox"/> Oncology	<input type="checkbox"/> Transplant ☺

- Does the hospital intend to commence a service identified above within the next 12 months? Yes No
If yes, please explain.
- Does the hospital intend to cease a service identified above within the next 12 months? Yes No
If yes, please explain.

B. Ambulances:

- Is excess/umbrella AL coverage desired for ambulance(s)? Yes No
- Are ambulances used as: first responders , patient transport , or both ?
- Number of ambulances in fleet:
- Service radius: _____ miles.
- Number of emergency runs in the past 12 months:

C. Bariatric Surgery:

A completed supplemental application is required for Bariatric Surgery Programs. Please request the addendum from your broker.

D. Blood Banks:

- Please identify the screening test(s) utilized by the hospital.
- Accredited by AABB , ARC , ABC , CAP , JCAHO , Other _____
- Is any blood or blood product bought or obtained from outside the U.S.? Yes No
If yes, please explain.
- Does the blood bank outsource its blood testing? Yes No
If yes, please provide details:
- Number of volunteer and paid donations in the past 12 months:
- Number of pheresis procedures in the past 12 months:
- Number of outpatient transfusions in the past 12 months:
- Number of therapeutic plasma exchanges in the past 12 months:

E. Day Care:

- Is the day care center on the hospital premises? Yes No
- Is the day care center open to the public? Yes No
- Number of children enrolled in the past 12 months:

F. Fitness Center:

- Is the fitness center on the hospital premises? Yes No
- Is the fitness center open to the public? Yes No
- Number of members enrolled in the past 12 months:

G. Long Term Care:

- Are the long term care beds located within the hospital or in a stand-alone facility?
- Is the stand-alone facility on the hospital premises? Yes No
- Does the stand-alone facility fall under the hospital's Risk Management? Yes No
- Does the stand-alone facility follow policies established by the hospital? Yes No

H. Pharmacy:

- Does the hospital utilize the unit dose system of dispensing medicine? Yes No
- Is the pharmacy for patient use only? Yes No
If no, annual receipts for non-patients medications are \$ _____
- Is the pharmacy staffed by a contract group? Yes No
If yes, please explain:

I. Transplant:

1. Number of tissue donations in the past 12 months: _____ and projected next 12 months: _____
2. Number of organ donations in the past 12 months: _____ and projected next 12 months: _____
3. Accredited by AOPO , AATB , EBAA , Other _____
4. Does the hospital have a formal policy regarding the informed consent process? Yes No
5. Has the hospital been involved in any tissue FDA recalls? Yes No
If yes, please explain.
6. Has the hospital initiated any voluntary tissue recalls in the past 5 years? Yes No
If yes, please explain.
7. Are any tissues procured/recovered from outside the U.S.? Yes No
If yes, please explain.
8. Are any non-human tissues used in any way at the hospital? Yes No
If yes, please explain.
9. Do you accept John Doe Donors? Yes No
10. Do you participate in a living donor program? Yes No
11. Has the hospital agreed to unilaterally hold harmless or indemnify others under contract? Yes No
12. Does the hospital place all organs through UNOS? Yes No
If no, do you have a protocol for ensuring compatibility? Yes No
13. Please indicate all of the transplant operations at the hospital:

<input type="checkbox"/> OPO	<input type="checkbox"/> Eye Procurement	<input type="checkbox"/> Tissue Procurement	<input type="checkbox"/> Tissue Processing
<input type="checkbox"/> Tissue Labeling	<input type="checkbox"/> Tissue Distribution	<input type="checkbox"/> Tissue Storage	<input type="checkbox"/> Lab Testing
<input type="checkbox"/> OR for Procurement	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:	<input type="checkbox"/> Other:

SECTION IV

A. Professional Liability Exposures:

Beds	No. of Licensed Beds	No. of Occupied Beds Projected Next 12 months	No. of Occupied Beds Current Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Acute Care							
Cribs & Bassinets							
Psychiatric							
Chemical Dependency							
Rehabilitation							
Long Term Care							
Hospice							
Swing Beds							
Other:							
Other:							
Other:							
Other:							
Total							

Inpatient Services	No. Projected 12 Mos.	No. in Current Policy Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Inpatient Surgeries						
Bariatric Surgeries						
Births-no Csection/VBACs						
C-Sections						
VBACs						
Other:						
Total						

Outpatient Services	No. Projected 12 Mos.	No. in Current Policy Year	1 st Year Prior	2 nd Year Prior	3 rd Year Prior	4 th Year Prior
Outpatient Surgeries						
Chemical Dependency						
Rehab/Therapy OPVs						
Psychiatric OPVs						
Home Health Visits						
Outpatient Clinic Visits						
Emergency Visits						
Other:						
Total						

B. Professional Employees:

1. Please provide the number of professionals employed by the hospital:

Type	No. of Full Time Equivalents	Employed Full Time Equivalents	Contracted Full Time Equivalents
Physicians			
Fellows			
Residents			
Interns			
Podiatrists			
Chiropractors			
Physicians Assistants			
Midwives			
Nurse Practitioners			
CRNAs			
Registered Nurses			
Licensed Practical Nurses			
Student Nurses			
X-Ray Technicians			
Lab Technicians			
Pharmacists			
Paramedics			
Perfusionists			
Dentists			
Oral Surgeons			
Other: _____			
Other: _____			
Total Number of			

2. Please complete the following information for each physician or surgeon for whom primary and/or excess (sharing limits with the hospital) coverage is requested. (Expand the table with additional rows as needed, or attach additional page):

Complete when coverage is requested for Excess only:

Name	Specialty	Surgery, No Surgery, or Minor Surgery	Retro Date	Employed or Contracted	Primary PL Carrier	Limits of Liability

3. Please complete the following information for each terminated physician or surgeon for whom coverage should be continued (sharing limits with the hospital) (Expand the table with additional rows as needed, or attach separate page):

Name	Date of Hire	Retro Date	Termination Date

B. Medical Credentialing / Staffing:

1. Is history of previous employment verified? Yes No
2. Are references checked? Yes No
3. Has the license of any physician ever been restricted or suspended? Yes No
If yes, please provide details:
4. Has the institution been required to notify the National Practitioner Data Bank of any suspension, peer review action, or professional liability payment involving any member of the medical or dental staff? Yes No
If yes, please explain:
5. How many physicians are board certified or board eligible?
6. Do physicians, residents, and interns carry their own insurance? Yes No
7. Are credentials of physicians approved by the medical staff and/or hospital review board before privileges are granted? Yes No
8. Is there a probationary period of at least six months for all physicians? Yes No
9. Are physicians' performance periodically reviewed by medical staff and/or hospital review board? Yes No
10. Do hospital by-laws require staff physicians to carry medical malpractice insurance? Yes No
If not, please identify on a separate sheet of paper those physicians that are "bare."
If yes, what are the required limits? \$ _____ per occurrence, \$ _____ aggregate.
If yes, is evidence of compliance required by certificate of insurance? Yes No
If yes, are there any exceptions to this requirement? Yes No
If yes, please provide details:
11. Are all privileges granted to staff physicians detailed in writing? Yes No
12. Number of current Staff MD's: _____

SECTION V

A. Anesthesia:

1. The anesthesia department is staffed by: Empl Physicians , CRNAs , Staff Physicians , Contract Group .
2. If service provided by a contract group:
Name of group: _____
Does the hospital require the contract group to carry professional liability insurance? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
Are the limits shared or per physician ?
Does the hospital require contract physicians to furnish certificates of insurance? Yes No
3. If service provided by CRNAs:
Is each CRNA's anesthesia care supervised and reviewed by an Anesthesiologist? Yes No
If no, please explain:
Are the CRNAs employed by the hospital , the anesthesiologists , the surgeons , or are they independent contractors ?
4. Are the anesthesiologists required to be board certified or board eligible in Anesthesiology? Yes No
5. Is an Anesthesiologist on the premises 24 hours a day? Yes No
6. Do any of the anesthesia department staff routinely work more than a 12-hour shift? Yes No
If yes, please explain:

B. Radiology:

1. The radiology department is staffed by: Employed Physicians , Staff Physicians , Contract Group .
2. If service provided by a contract group:
Name of group: _____
Does the hospital require the contract group to carry professional liability insurance? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
Are the limits shared or per physician ?
Does the hospital require contract physicians to furnish certificates of insurance? Yes No
3. Are the radiologists required to be board certified or board eligible in Radiology and/or Nuclear Medicine? _____

Yes No

4. Is a Radiologist on the premises 24 hours a day? Yes No

C. Emergency Department:

1. The emergency department is staffed by: Empl Physicians , Rotating Staff Physicians , Contract Group .
2. If service provided by a contract group:
Name of group:
Does the hospital require the contract group to carry professional liability insurance? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
Are the limits shared or per physician ?
Does the hospital require contract physicians to furnish certificates of insurance? Yes No
3. Are the emergency department physicians required to be board certified or board eligible in Emergency Medicine?
 Yes No
4. The emergency department is JCAHO classified as: Level I (Tertiary) , Level II (Comprehensive) , Level III (Basic) , None (Standby) , or Other
5. Are the emergency department physicians required to respond to cardiac/respiratory arrests or other medical emergencies occurring in the institution? Yes No
6. Is the emergency room equipped with the following:
Emergency resuscitation care equipped with defibrillator? Yes No
Electrocardiograph machine? Yes No
Staffed radiology room(s)? Yes No
Dedicated triage area and staff? Yes No
Dedicated trauma room(s)? Yes No
Dedicated laboratory personnel? Yes No
7. Do any of the emergency department staff routinely work more than a 12-hour shift? Yes No
If yes, please explain:

D. Obstetrics:

1. Is the hospital a regional referral center for high risk pregnancies or newborns requiring intensive care? Yes No
If no, does a written procedure exist for transferring all high-risk mothers and/or babies which the hospital is not qualified to treat? Yes No
2. Does the hospital have the following nurseries:
Level I: Well baby? Yes No If yes, number of bassinets:
Level II: Intermediate care? Yes No If yes, number of bassinets:
Level III: Neonatal intensive care? Yes No If yes, number of bassinets:
3. Are all C-sections performed by Obstetricians? Yes No
If no, please identify the specialties of the physicians performing C-sections:
4. Is continuous electronic fetal monitoring performed on all patients in active labor? Yes No
If no, please explain:
5. Do nurse midwives practice at the hospital? Yes No
If yes, how many?
6. Are nurse midwives subject to the hospital's credentialing process? Yes No
7. Do nurse midwives deliver babies in patients' homes? Yes No
8. Is an Obstetrician on the premises 24 hours a day? Yes No

E. Surgery:

1. Are sponge, needle and instrument counts performed in the course of a surgical procedure? Yes No
If yes, at what intervals of the operation?
2. Are any of the following performed at the hospital?
Experimental Surgery Yes No
Sex Change Operations Yes No
Bariatric Surgery Yes No
Laser Assisted Surgery Yes No
3. Is there a surgeon on the premises 24 hours a day? Yes No

SECTION VI

A. Other Exposures:

1. How many patient care buildings does the hospital own, lease, or operate?
2. How many other, non-patient care buildings does the hospital own, lease, or operate?
3. Do all the patient care buildings have:
 - Sprinklers? Yes No
 - Smoke detectors? Yes No
 - Heat detectors? Yes No
 - Automatic alarms? Yes No
4. Does the hospital conduct period evacuation drills? Yes No
If yes, how often?
5. Does the hospital conduct period fire drills? Yes No
If yes, how often?
6. Does the hospital have a written Emergency Management Preparedness Plan? Yes No
If yes, please provide a copy.
7. Is new construction and/or abatement contemplated or pending ? Yes No
If yes, please explain:
8. Does the hospital have a heliport or helipad? Yes No
If yes:
 - How many landings in the past 12 months?
 - Where is it located?
 - What is the distance between the heliport or helipad and the closest hospital building?
 - Does the hospital require the heliport or helipad to carry liability coverage? Yes No
If yes, what limits are required? \$ _____ per occurrence, \$ _____ aggregate.
 - What is the name of the commercial carrier?
9. Does the hospital own, lease, or operate any aircraft? Yes No
If yes, how many of each:
Please describe purpose:
10. Does the hospital own, lease, or operate any watercraft? Yes No
If yes, how many of each:
Please describe purpose:
11. Is the hospital's administration managed by an outside vendor? Yes No
If yes:
 - Please identify the name of the management company:
 - Please describe the nature of the contract between the hospital and the management company:

 - Is the management company to be named as an Additional Insured under the hospital's insurance policy?
 Yes No
 - Is the management company also involved in the management of clinical services at the hospital?
 Yes No
 - If yes, please explain:
12. Who coordinates your risk management program?
Name: _____ Title: _____
Telephone: _____
13. Is there a written risk management program that has been approved by a governing body? Yes No
14. Does the governing body review the effectiveness of the risk management program and approve necessary changes? Yes No
15. Is the risk manager accountable and solely responsible for risk management? Yes No
If not, explain other responsibilities:
16. Does the risk management program include the following:

Occurrence reporting	<input type="checkbox"/> Yes <input type="checkbox"/> No
Claim management	<input type="checkbox"/> Yes <input type="checkbox"/> No
Formal link to quality management	<input type="checkbox"/> Yes <input type="checkbox"/> No
Safety program and safety committee	<input type="checkbox"/> Yes <input type="checkbox"/> No
Review and participation in medical staff committees	<input type="checkbox"/> Yes <input type="checkbox"/> No
Contract review and evaluation	<input type="checkbox"/> Yes <input type="checkbox"/> No
17. Has the hospital agreed to hold harmless or indemnify others under contract? Yes No
If yes, please explain:
18. Does the hospital rent or lease any equipment from an outside vendor? Yes No
If yes, please explain:

19. Does the hospital conduct formal clinical research under the auspices of an Institutional Review Board (IRB)?
 If yes, Internal IRB External IRB

B. Excess Automobile Liability:

Vehicle Type	Service Radius (in miles per vehicle)	Number of Urban Use Vehicles	Number of Non Urban Use Vehicles	Used for Patient Transport?
Private Passenger Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Private Passenger Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Emergency Ambulance				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (< 8 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Non Emergency Van (8-15 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Delivery				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Service				<input type="checkbox"/> Yes <input type="checkbox"/> No
Light Truck Other				<input type="checkbox"/> Yes <input type="checkbox"/> No
Medium Truck				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (15-30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Bus (> 30 passengers)				<input type="checkbox"/> Yes <input type="checkbox"/> No
Hired & non-Owned Autos				<input type="checkbox"/> Yes <input type="checkbox"/> No
Other:				<input type="checkbox"/> Yes <input type="checkbox"/> No

C. Employer's Liability and Employee Benefit Liability:

- Number of employees:
- Are employee benefits self-administered? Yes No
 If not, are they administered by an outside vendor? Yes No
 If yes, what is the name of the vendor:

THE APPLICANT REPRESENTS THE ABOVE STATEMENTS AND FACTS ARE TRUE AND THAT NO MATERIAL FACTS HAVE BEEN SUPPRESSED OR MISSTATED. COMPLETION OF THIS FORM DOES NOT BIND COVERAGE. APPLICANT'S ACCEPTANCE OF COMPANY'S QUOTATION IS REQUIRED BEFORE APPLICANT MAY BE BOUND AND A POLICY ISSUED.

THE HOSPITAL AGREES TO COOPERATE WITH THE COMPANY IN IMPLEMENTING AN ONGOING PROGRAM OF LOSS-CONTROL AND WILL ALLOW THE COMPANY TO REVIEW AND MONITOR SUCH PROGRAMS THAT THE HOSPITAL UNDERTAKES IN MANAGING ITS MEDICAL PROFESSIONAL EXPOSURES.

NOTICE TO APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH IS A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO ARKANSAS, NEW MEXICO AND WEST VIRGINIA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT, OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO COLORADO APPLICANTS: IT IS UNLAWFUL TO KNOWINGLY PROVIDE FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES, DENIAL OF INSURANCE, AND CIVIL DAMAGES. ANY INSURANCE COMPANY OR AGENT OF AN INSURANCE COMPANY WHO KNOWINGLY PROVIDES FALSE, INCOMPLETE, OR MISLEADING FACTS OR INFORMATION TO A POLICYHOLDER OR CLAIMANT FOR THE PURPOSE OF DEFRAUDING OR ATTEMPTING TO DEFRAUD THE POLICYHOLDER OR CLAIMANT WITH REGARD TO A SETTLEMENT OR AWARD PAYABLE FROM INSURANCE

PROCEEDS SHALL BE REPORTED TO THE COLORADO DIVISION OF INSURANCE WITHIN THE DEPARTMENT OF REGULATORY AUTHORITIES

NOTICE TO DISTRICT OF COLUMBIA APPLICANTS: WARNING: IT IS A CRIME TO PROVIDE FALSE OR MISLEADING INFORMATION TO AN INSURER FOR THE PURPOSE OF DEFRAUDING THE INSURER OR ANY OTHER PERSON. PENALTIES INCLUDE IMPRISONMENT AND/OR FINES. IN ADDITION, AN INSURER MAY DENY INSURANCE BENEFITS IF FALSE INFORMATION MATERIALLY RELATED TO A CLAIM WAS PROVIDED BY THE APPLICANT.

NOTICE TO FLORIDA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY IN THE THIRD DEGREE.

NOTICE TO KENTUCKY APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME.

NOTICE TO LOUISIANA APPLICANTS: ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MAINE APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

NOTICE TO MARYLAND APPLICANTS: ANY PERSON WHO KNOWINGLY AND WILLFULLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR WHO KNOWINGLY AND WILLFULLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

NOTICE TO MINNESOTA APPLICANTS: A PERSON WHO FILES A CLAIM WITH INTENT TO DEFRAUD OR HELPS COMMIT A FRAUD AGAINST AN INSURER IS GUILTY OF A CRIME.

NOTICE TO NEW JERSEY APPLICANTS: ANY PERSON WHO INCLUDES ANY FALSE OR MISLEADING INFORMATION ON AN APPLICATION FOR AN INSURANCE POLICY IS SUBJECT TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO NEW YORK APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

NOTICE TO OHIO APPLICANTS: ANY PERSON WHO, WITH INTENT TO DEFRAUD OR KNOWING THAT HE IS FACILITATING A FRAUD AGAINST AN INSURER, SUBMITS AN APPLICATION OR FILES A CLAIM CONTAINING A FALSE OR DECEPTIVE STATEMENT IS GUILTY OF INSURANCE FRAUD.

NOTICE TO OKLAHOMA APPLICANTS: WARNING: ANY PERSON WHO KNOWINGLY, AND WITH INTENT TO INJURE, DEFRAUD OR DECEIVE ANY INSURER, MAKES ANY CLAIM FOR THE PROCEEDS OF AN INSURANCE POLICY CONTAINING ANY FALSE, INCOMPLETE OR MISLEADING INFORMATION IS GUILTY OF A FELONY (365:15-1-10, 36 §3613.1).

NOTICE TO OREGON APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO PENNSYLVANIA APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME AND SUBJECTS SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

NOTICE TO TENNESSEE, VIRGINIA AND WASHINGTON APPLICANTS: IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES INCLUDE IMPRISONMENT, FINES AND DENIAL OF INSURANCE BENEFITS.

NOTICE TO VERMONT APPLICANTS: ANY PERSON WHO KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION OR, CONCEALS, FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT ACT, WHICH MAY BE A CRIME AND MAY SUBJECT SUCH PERSON TO CRIMINAL AND CIVIL PENALTIES.

Signature of Applicant: _____
(must be an officer or principal of the Insured)

Print Name:

Title:

Date:

Signature of Producer: _____

Print Name:

Company:

License #:

Date:

NJ SLA# (if a NJ Risk):

Broker responsible for Surplus Lines
Filings Agreement:

Hospital Addendum

This addendum is intended for **acute care hospitals with more than 50 beds**. For small and rural hospitals or critical access hospitals with 50 or fewer beds, please request the Small, Rural and Critical Access Hospital Addendum from your broker.

The addendum is also intended for hospitals that provide – at least – **Emergency Department and Surgical/Anesthesia Services**. If either Service is not offered, please do not complete the addendum.

S1 - Demographic Information

Q1.1 - Facility Name:

Q1.2 - Corporate Name:

Not Applicable

Q1.3 – Street Address:

Q1.4 - City:

Q1.5 - State:

This form is an addendum to the Hospital application and all applicable areas must be completed. It is recommended that the Hospital Risk Manager take responsibility for coordinating the completion of the form. However, it may be most efficient to send the specific sections (e.g., Infection Prevention and Control, Obstetrics, ED) to the managers most familiar with the area and who probably have the information requested readily available.

This addendum is supplemental to the general application incorporated by reference and with this policy issued in reliance therein.

S2 – Administrative and Patient Safety

Q2.1 - Is your facility "Accredited" by (select one):

- The Joint Commission – Full Accreditation
- HFAP (Healthcare Facilities Accreditation Program) AOA (American Osteopathic Association) – Full Accreditation
- DNV Healthcare/National Integrated Accreditation for Healthcare Organizations (NIAHOSM) – Accreditation Certificate
- None of the above

Q2.2 - Are laboratory services accredited by (select one):

- College of American Pathologists (CAP)
- The Joint Commission
- Neither of the above

Q2.3 - What percent of the current active medical staff is board certified? Do not include board eligible.

- 75 percent or more
- Less than 75 percent

Hospital Addendum

Q2.4 - Is a pharmacist available to review medication orders 24 hours per day/7 days per week?

Guidance:

Pharmacist may be in-house or available remotely via telephone, fax, and/or computer or online system.

- Yes
- No

Q2.5 – Have you implemented rapid response teams?

- Yes
- No

Q2.6 – Is your director of ICU a board-certified physician who is additionally certified in the subspecialty of critical care medicine? If there is no ICU, select not applicable.

- Yes
- No
- Not Applicable

Q2.7 – Has your facility obtained Magnet status from the American Nurses' Credentialing Center (ANCC)? If no, select not applicable.

- Yes
- Not Applicable

S3 – Infection Prevention and Control

S3.1 – Ventilator-Associated Pneumonia (VAP)

Q3.1.1 – Have you implemented the bundle of care as recommended by the Institute for Healthcare Improvement (IHI) for the prevention of VAP?

- Yes (implemented in all units with ventilated patients)
- No (not implemented in any units with ventilated patients)
- Partially implemented (implemented in some units with ventilated patients)
- Partially adopted (do not use all recommendations in the bundle on all ventilated patients)
- Not Applicable (no ventilated patients)

Q3.1.2 – If you answered yes or partially implemented to Q3.1.1, do you routinely monitor compliance with the bundle? Select not applicable only if you answered no, partially adopted or not applicable to Q3.1.1.

- Yes
- No
- Not Applicable

Q3.1.3 – If you answered yes or partially implemented to Q3.1.1, have you had a measurable decrease in ventilator-associated pneumonia? Select not applicable only if you answered no, partially adopted or not applicable to Q3.1.1

Guidance:

A measurable decrease is defined as a decrease in the cumulative incidence of ventilator-associated pneumonia sustained for at least six continuous months in all critical care units. Data should be obtained from Infection Control.

- Yes
- No
- Not Applicable

Hospital Addendum

S3.2 – Central Line-Associated Bloodstream Infection (CLABSI)

Q3.2.1 - Have you implemented the bundle of care as recommended by IHI for the prevention of CLABSI?

- Yes (implemented in all patients with central lines)
- No (not implemented in any patients with central lines)
- Partially implemented (implemented in some patients with central lines)
- Partially adopted (do not use all recommendations in the bundle on all patients with central lines)
- Not Applicable (no patients with central lines)

Q3.2.2 – If you answered yes or partially implemented to Q3.2.1, do you routinely monitor compliance with the bundle? Select not applicable only if you answered no, partially adopted or not applicable to Q3.2.1.

- Yes
- No
- Not Applicable

Q3.2.3 – If you answered yes or partially implemented to Q3.2.1, have you had a measurable decrease in central line-associated bloodstream infections? Select not applicable only if you answered no, partially adopted or not applicable to Q3.2.1.

Guidance:

A measurable decrease is defined as a decrease in the cumulative incidence of central line-associated bloodstream infections sustained for at least six continuous months in all critical care units. Data should be obtained from Infection Control.

- Yes
- No
- Not Applicable

S3.3 – Multi-Drug Resistant Organisms (MDROs)

Q3.3.1 - Do you have a proactive program to identify and manage MDROs which includes the following (select all that apply)?

- Establishing a baseline for the incidence of target MDROs [methicillin-resistant Staphylococcus aureus (MRSA) and vancomycin-resistant enterococci (VRE)].
- Using contact precautions for all patients known to be colonized or infected with MDROs.
- Performing ongoing surveillance of MDROs to identify cross-transmission in hospitalized patients.
- Performing active surveillance cultures in high-risk populations and units, as necessary.
- Incorporating prevention and control practices for MDROs into orientation for all patient care staff.
- Providing annual education and training on prevention and control practices for MDROs.

Q3.3.2 - Data on the incidence of MDROs is provided to the Infection Control Committee or other appropriate committee(s):

- Monthly
- Quarterly
- Semi-annually or annually
- Less frequently than annually

Q3.3.3 - Are updates on MDROs provided to administrative/senior management at least annually?

- Yes
- No

Hospital Addendum

S4 - Obstetrics

Q4.1 - Do you provide obstetrical services?

If you answer no, please go to S5 – Emergency Department.

- Yes
 No

S4.2 - Metrics

In order to calculate several rates related to your obstetric practice, please provide the following information using data from the past 12 months.

- A. Number of live births:
B. Number of neonatal deaths (age < 28 days):
C. Number of maternal deaths:
D. Number of total* cesarean deliveries:
* All cesarean deliveries resulting in a live birth in the past 12 months.
E. Number of primary** cesarean deliveries:
** Total number of primary (first time) cesarean deliveries resulting in a live birth in the past 12 months.
F. Number of live births excluding births from mothers who have ever had a previous cesarean delivery***:
*** This number will be used to calculate your primary cesarean rate; thus the number of live births must be adjusted. Please enter the SUM of the number of primary cesarean deliveries and the number of vaginal births in mothers who have not had a previous cesarean.
G. Number of live births with induction****:
**** Total number of induced deliveries utilizing pharmacologic or nonpharmacologic methods to initiate uterine contractions. Include deliveries using pharmacologic (e.g., prostaglandins or other cervical ripening agents or pitocin) or nonpharmacologic methods (e.g., membrane stripping).

S4.3 - Exclusion or Transfer of Services

Q4.3.1 - If services are limited to Basic Care only, please check the appropriate box *if there is a written policy for exclusion or transfer* of the following patients. If the level of perinatal care services is higher than Basic Care, select not applicable.

Guidance:

To view guidelines describing Basic Care services, please refer to American Academy of Pediatrics, American College of Obstetricians and Gynecologists, Guidelines for Perinatal Care, 6th Ed. Library of Congress Cataloging-in-Publication Data, 2007.

- Gestation less than 35-37 weeks
 High-risk pregnancies with select maternal and/or fetal complications
 Not Applicable – we provide Specialty or Subspecialty Care

S4.4 - VBAC Services

Q4.4.1 - Do you offer VBAC services?

If you answer no, please go to S4.5 – Emergency Cesarean Deliveries.

- Yes
 No

Hospital Addendum

Q4.4.2 - Does your policy for VBAC address the following (select all that apply)?

Guidance:

Immediate availability -

Because of the known potential risk of uterine rupture, the organization should be able to respond with an immediate cesarean delivery if needed. ACOG does not specify what number of minutes constitutes "immediate". However, ACOG's specific recommendation regarding "immediate availability" would indicate that the "within 30 minutes" timeframe suggested for other emergency situations requiring cesarean delivery would not be adequate for this situation.

"Immediate availability" would indicate that there is no delay or wait time for team members once the patient is moved into the OR/DR and prepped. (Note: this definition is provided for the purpose of this assessment and has no formal citation.)

- Informed consent
- Criteria for patient selection
- Immediate availability of the operative team

Q4.4.3 - Are all of the following providers required to remain immediately available during a trial of labor after cesarean (TOLAC) or VBAC delivery?

- Obstetric provider
- Anesthesia provider
- All nursing members of the operative team

Guidance:

See "Guidance" under Q4.4.2 for guidance on immediate availability.

- Yes
- No

Q4.4.4 - Select the choice that describes your organization's ability to provide immediate availability of the operative team for all VBAC attempts/deliveries (select one).

Guidance:

All members of the operative team include:

- Obstetric provider
 - Anesthesia provider
 - Operative nursing staff
 - Dedicated provider privileged to resuscitate newborn
- There have been NO INSTANCES IN THE LAST 12 MONTHS when all members of the operative team were not immediately available for the duration of the VBAC attempt/delivery.
- There have been ONE OR MORE INSTANCES IN THE LAST 12 MONTHS when all members of the operative team were not immediately available for the duration of the VBAC attempt/delivery.
- Immediate availability is not required for all members of the operative team.

S4.5 - Emergency Cesarean Deliveries

Q4.5.1 - Select the choice that describes your organization's ability to provide services for emergency cesarean deliveries (select one).

- There have been NO INSTANCES IN THE LAST 12 MONTHS when an emergency cesarean delivery was not initiated within 30 minutes (decision-to-incision).
- There have been ONE OR MORE INSTANCES IN THE LAST 12 MONTHS when an emergency cesarean delivery was not initiated within 30 minutes (decision-to-incision).
- Decision-to-incision time is NOT monitored.

Hospital Addendum

S4.6 – Elective Cesarean Section or Elective Induction

Q4.6.1 – Has the OB medical staff established a policy for both *elective* cesarean section and *elective* induction by establishing processes to determine a gestational age of at least 39 weeks?

Guidance:

Answer yes only if the policy includes written criteria to determine a gestational age of at least 39 weeks.

- Yes, for both elective cesarean section and elective induction
- Yes, but only for elective cesarean section
- Yes, but only for elective induction
- No, we have not established processes to encourage that the fetus is at least 39 weeks gestation for elective cesarean section or elective induction

Q4.6.2 – Select the choice that describes your organization’s performance determining a gestational age of at least 39 weeks for *elective* cesarean section.

- There have been NO INSTANCES IN THE LAST 12 MONTHS when we have performed an elective cesarean section for a fetus of less than 39 weeks gestation.
- There have been ONE OR MORE INSTANCES IN THE LAST 12 MONTHS when we have performed an elective cesarean section for a fetus of less than 39 weeks gestation.
- Not Applicable (we have not established processes to determine a gestational age of at least 39 weeks for elective cesarean section)

Q4.6.3 – Select the choice that describes your organizations’ performance determining a gestational age of at least 39 weeks for *elective* induction

- There have been NO INSTANCES IN THE LAST 12 MONTHS when we have performed an elective induction for a fetus of less than 39 weeks gestation.
- There have been ONE OR MORE INSTANCES IN THE LAST 12 MONTHS when we have performed an elective induction for a fetus of less than 39 weeks gestation.
- Not Applicable (we have not established processes to determine a gestational age of at least 39 weeks for elective induction)

S4.7 – OB Board Certification

Q4.7.1 – What percent of the OB medical staff is board certified in obstetrics?

- 75 percent or more
- 50 to 74 percent
- Less than 50 percent
- Unknown

S4.8 – Family Practitioners

Q4.8.1 – Do Family Practitioners have the following obstetric privileges (select all that apply)?

- Obstetric privileges
- Cesarean delivery privileges
- VBAC privileges
- Family Practitioners are not granted obstetric privileges

Q4.8.2 – Does the medical staff have written requirements for education, training, and experience for Family Practitioners providing obstetric care, including cesarean deliveries, as part of the privileging and credentialing process? If Family Practitioners do not provide obstetric care, select not applicable.

- Yes
- No
- Not Applicable

Hospital Addendum

S4.9 - Peer Review

Q4.9.1 - Which of the following provider-specific performance indicators are used for peer review in obstetrics (select all that apply)?

- Rate of primary cesarean delivery
- Rate of all cesarean deliveries
- Rate of births with induction
- Review of any *elective* cesarean section for fetus less than 39 weeks gestation
- Review of any *elective* induction for fetus less than 39 weeks gestation
- Review of all births with injuries or adverse outcomes
- Review of all unattended births
- 3 or 4 degree perineal tear
- Uterine rupture
- Readmission (mother or baby)
- Maternal admission to ICU
- Blood transfusion
- Return to OR / labor and delivery (mother)
- Review of any instance of sequential use of either forceps then vacuum, or vacuum then forceps

Q4.9.2 - Is rate of VBAC delivery used for peer review? If VBAC services are not offered, select not applicable.

- Yes
- No
- Not Applicable

Q4.9.3 - Is rate of births using forceps or vacuum extraction used for peer review? If mechanical devices are not used, select not applicable.

- Yes
- No
- Not Applicable

Q4.9.4 - Is compliance with criteria for performance of cesarean delivery used for peer review? If no written criteria, select no.

- Yes
- No

Q4.9.5 - Is compliance with criteria for performance of VBAC delivery used for peer review? If no written criteria, select no. If VBAC services are not offered, select not applicable.

- Yes
- No
- Not Applicable

Q4.9.6 - Is compliance with criteria for induction of labor used for peer review? If no written criteria, select no.

- Yes
- No

Q4.9.7 - Is compliance with criteria for augmentation/stimulation of labor using pitocin used for peer review? If no written criteria, select no.

- Yes
- No

Hospital Addendum

Q4.9.8 - Is compliance with criteria for use of mechanical devices used for peer review? If no written criteria, select no. If mechanical devices are not used, select not applicable.

- Yes
- No
- Not Applicable

S4.10 - Electronic Fetal Monitoring

Q4.10.1 - Do you require Labor and Delivery nursing staff to successfully complete an initial training course such as the AWHONN EFM course, or an equivalent course?

- Yes
- No

Q4.10.2 - Select the choice that describes your organization's ongoing competency training in EFM (select one).

- No program for ongoing training with competency
- Training and competency less than annually
- Training and competency annually
- Training and competency more frequently than annually

S4.11 - Obstetric Drills

Q4.11.1 - Please check if emergency mock/practice drills are completed *at least annually* for the following obstetrical emergencies (select all that apply).

- Shoulder dystocia
- Emergency cesarean delivery
- Neonatal resuscitation
- Maternal resuscitation
- Infant abduction
- Maternal hemorrhage

Remainder of page intentionally left blank

Hospital Addendum

S5 - Emergency Department

Q5.1 - Which of the following performance measures do you routinely monitor and review within the ED (select all that apply)?

- Number of unexpected deaths within 72 hours of an ED visit
- Percent of patients leaving without being seen/against medical advice
- Discrepancies in x-ray interpretations
- Discrepancies in EKG interpretations
- Worked hours per patient visit (include ED nursing staff/management/ED tech or nursing assistants/clerical staff)
- Median time from ED arrival to ED departure for admitted patients
- Time patient presents to time seen by practitioner
- Response time of specialists
- Ancillary service delays
- Documentation
- Complaints

Q5.2 - What is the median time from ED arrival to ED departure for admitted patients (select one)?

- Less than 2 hours
- 2 to 4 hours
- 4 to 6 hours
- More than 6 hours
- Unknown

Q5.3 - What is the median time from ED arrival to ED departure for discharged ED patients (select one)?

- Less than 2 hours
- 2 to 4 hours
- 4 to 6 hours
- More than 6 hours
- Unknown

Q5.4 - Which of the following clinical practice guidelines do you use (select all that apply)?

- Trauma
- Children with fever
- Chest pain
- Abdominal pain
- Headache
- Head trauma
- Intoxicated or impaired mental status
- Spinal injury
- Stroke

Hospital Addendum

Q5.5 - Which of the following provider-specific performance indicators are used for peer review in the ED (select all that apply)?

- Unanticipated return to the ED within 72 hours
- Returns within 72 hours resulting in admission
- Unexpected death within 72 hours of an ED visit
- X-ray discrepancies requiring a change in patient management
- EKG discrepancies requiring a change in patient management
- Response time of specialists
- Compliance with evidence-based clinical practice guidelines (if used)

Q5.6 - Are on-call responsibilities defined in the medical staff bylaws that address the following (select all that apply)?

- On-call specialists are required to respond to assist in the care of emergency patients within reasonable established time limits
- Response time defined in minutes
- Arrangement of follow-up care for all patients who require such care

Q5.7 – Are RNs required to be certified in the following within an established timeframe (select all that apply)?

- ACLS
- PALS

Q5.8 – Do nurses receive competency-based training for the following high-risk clinical protocols (select all that apply)?

- Trauma
- Children with fever
- Chest pain
- Abdominal pain
- Headache
- Head trauma
- Intoxicated or impaired mental status
- Spinal injury
- Stroke

Q5.9 – Which of the following do you use to determine the correct dosage and equipment for pediatric patients (select all that apply)?

- Color-coded tape for dosing pediatric medications and infusions
- Color-coded “crash cart” that includes pediatric equipment sizes
- Neither of the above

Q5.10 – Are all patients who present with behavioral emergencies evaluated by a qualified mental health worker prior to final disposition?

Guidance:

Examples of behavioral emergencies may include, but are not limited to, acute psychotic disturbances, manic episodes, major depression, bipolar disorder and substance abuse.

- Yes
- No

Q5.11 – Are nursing staff and security personnel trained in violence prevention/de-escalation techniques?

- Yes
- No

Hospital Addendum

S6 - Surgery and Anesthesia

Q6.1 - Which of the following performance measures do you routinely monitor and review within surgery and anesthesia (select all that apply)?

- Compliance with The Joint Commission Universal Protocol for preventing wrong site/wrong procedure/wrong person surgery.
- Wrong implant precautions included in the time-out.
- Preventive maintenance of electrosurgical units and other OR equipment based on manufacturer specifications.
- Near misses for wrong site/wrong patient/wrong procedure surgery.
- Labeling of all medications - medication containers (e.g. syringes/medicine cups/basins) - other solutions on and off the sterile field in perioperative and other procedural settings to include anesthesia medications.

Q6.2 - Which of the following unexpected occurrences do you routinely monitor and review within surgery and anesthesia (select all that apply)?

- Unscheduled admissions following ambulatory surgery
- Readmission within 30 days of surgery
- Unscheduled returns to the OR
- OR/PACU deaths
- Deaths within 24 hours of anesthesia
- Cardiac arrests in OR or PACU
- Occurrences of wrong site/wrong patient/wrong procedure surgery
- Number of occurrences of unintentionally retained foreign body (e.g. instrument/sharps/sponges)
- Injuries from OR or anesthesia
- Injuries from equipment (e.g. burns/pressure ulcers)
- Change in procedure from planned procedure
- Pathology report normal or unrelated to diagnosis

Q6.3 - Are unplanned ICU admissions from the OR routinely monitored and reviewed within surgery and anesthesia? If there is no ICU, select not applicable.

- Yes
- No
- Not Applicable

Q6.4 - Which of the following provider-specific performance indicators are used for peer review in surgery and anesthesia (select all that apply)?

- Surgical complication rate
- Surgical deaths
- Surgical site infection rate
- Unscheduled return to the OR
- Pre and post-operative tissue diagnosis
- Anesthesia complications or injuries
- Anesthesia deaths

Q6.5 - Are patients screened for potential obstructive sleep apnea using ASA Guidelines?

- Yes
- No

Hospital Addendum

Q6.6 - Please check if formal simulation training or drills are completed *at least annually* for the following (select all that apply).

- Malignant hyperthermia
- Adult cardiac resuscitation
- Pediatric cardiac resuscitation
- Fire
- Evacuation

Q6.7 - With respect to compliance with surgical fire prevention methods, which of the following do you routinely monitor (select all that apply)?

- Delay draping patients until all flammable preps have fully dried.
- Questioning the need for 100% O2 for open delivery to the face (e.g. when using a nasal cannula)-- use air or +/- 30% O2 for open delivery consistent with patient needs.

Q6.8 - During oropharyngeal surgery, is compliance monitored with the following surgical fire prevention method:

Wet any gauze or sponges used with uncuffed tracheal tubes to minimize leakage of gases into the oropharynx, and keep them wet.

If oropharyngeal surgical services are not offered, select not applicable.

- Yes
- No
- Not Applicable

Q6.9 - During electrosurgery, is compliance monitored with the following surgical fire prevention method:

Place the electrosurgical pencil in a holster when it is not in active use.

If electrosurgical services are not offered, select not applicable.

- Yes
- No
- Not Applicable

Q6.10 - During laser surgery, is compliance monitored with the following surgical fire prevention method:

Place the laser in standby mode whenever it is not in active use.

If laser surgical services are not offered, select not applicable.

- Yes
- No
- Not Applicable

Q6.11 – Which of the following are included in special training (select all that apply)?

- Proper use of fire-fighting equipment
- Proper methods for rescue and escape
- Identification and location of medical gas/ventilation/electrical systems and controls including when/where/how to shut off these systems
- Use of the hospital alarm system and system for contacting the local fire department

Information provided by:

Signature

Title

Date

Hospital Bariatric Surgery Addendum

This addendum is supplemental to the general application incorporated by reference and with this policy issued in reliance therein.

S1 - Demographic Information

Q1.1 - Facility Name:

Q1.2 - Corporate Name:

Not Applicable

Q1.3 - City:

Q1.4 - State:

S2 - ACS BSCN Accreditation Program

American College of Surgeons (ACS) Bariatric Surgery Center Network (BSCN) accreditation program.

Q2.1 - Has your bariatric surgery center applied for and its application been approved by ACS?

Guidance:

To improve the quality and facilitate access to care for morbidly obese patients, the ACS will acknowledge as Bariatric Centers, facilities which implement and maintain certain physical resources, human resources, standards of practice, and documentation of outcomes of care. Hospitals wishing to participate in the ACS Bariatric Surgery Center Network accreditation program undergo a verification process, which includes review of initial application. Information is available at <http://www.facs.org/cqi/bscn/index.html>.

If you answer no, please go to S3 – Volume and Types of Procedures.

Yes

No

Hospital Bariatric Surgery Addendum

Q2.2 - Select the ACS BSCN accreditation approval status for your hospital's bariatric surgery center.

Guidance:

To obtain **"full approval"** as an ACS accredited bariatric surgery center, a center must first complete and submit the Pre-Site Review Questionnaire and schedule a site visit within six months of provisional approval. After the completion of the site visit review by an ACS Site Visitor, the Final Site Visitor Report must be reviewed and approved by the Bariatric Advisory Committee. Once the final report is approved, the center will receive a letter granting "full approval" along with an ACS BSCN Certificate of Accreditation.

To obtain **"provisional approval"** as an ACS accredited bariatric surgery center, the submitted application and letter of support from the CEO must first be reviewed and approved by the Bariatric Advisory Committee. Once the application is approved, the center will receive a Participation Agreement and a Business Associate Agreement. When the agreements are fully executed and the program fee is received, the center will receive a letter granting "provisional approval" along with a site visit packet including a Pre-Site Questionnaire in preparation for the site visit review.

- Full approval
- Provisional approval
- Application approved - provisional approval pending execution of participation and business agreements and program fee
- Full approval denied - appeal may be pending

Q2.3 - Select the ACS designation level for your bariatric surgery center.

Guidance:

Hospitals recognized as level 1a and 1b bariatric centers will provide complete tertiary care, physical and human resources devoted to bariatric surgery. Level 1a and 1b centers can manage the most complex patients with optimal opportunity for safe and effective outcome. Level 1a and 1b centers will have high volume practices. Level 2a and 2b centers will provide high quality care to a lower volume of patients having lesser obesity and lesser comorbidities.

- 1a
- 1b
- 2a
- 2b
- Do not know

S3 - Volume and Types of Procedures

Q3.1 - Please provide the number of weight loss operations performed at your center during the past 12 months.

Q3.2 - Please provide the number of active bariatric surgeons on staff.

Hospital Bariatric Surgery Addendum

Q3.3 - Please check the box next to the types of weight loss operations performed during the past 2 years (select all that apply).

- Gastric Bypass - Open
- Gastric Bypass - Laparoscopic
- Vertical Banded Gastroplasty
- Gastric Band
- Duodenal Switch
- Other

Other (please list):

S4 - Verification of Standards

Q4.1 – Reserved for AIG Healthcare to verify full approval status from ACS. If full approval status is indicated in Q2.2 and verified, this is the end of the assessment.

If you have not applied for accreditation status with ACS, or have applied but have not received full approval status, please go to **S4.2 – High Volume/High Complex Centers.**

S4.2 - High Volume/High Complex Centers

Q4.2.1 - Does your bariatric surgery center perform at least 125 weight loss operations annually?

If you answer no, please go to S4.3 – Lower Volume/Lesser Complex Centers.

- Yes
- No

Q4.2.2 - Does your bariatric surgery center have at least two bariatric surgeons performing at least 50 primary weight loss operations each annually?

- Yes
- No

Q4.2.3 - Does your bariatric surgery center use criteria to exclude patients?

Guidance:

Exclusion criteria may include patients over the age of 60 years with cardiac or pulmonary comorbidities, BMI greater than or equal to 55 for males or 60 for females, or patients who are medically disabled.

- Yes
- No

Hospital Bariatric Surgery Addendum

Q4.2.4 - Does your hospital provide the following multispecialty services?

Guidance:

For bariatric surgery centers who accept complex, high risk cases, hospital active staff **must** include all of the following:

- Pulmonology
- Cardiology
- Intensivists
- Infectious disease
- Nephrology
- Psychiatry/psychology
- Gastroenterology
- Thoracic surgery
- Otorhinolaryngology
- Orthopedics

Centers accepting selected cases based on written exclusion criteria may provide selected multispecialty services.

- Yes
- No
- Do not have all of the above but we exclude high-risk complex cases.

Q4.2.5 - Does anesthesiology provide full coverage of perioperative and postoperative pain control services, including drug management, patient controlled analgesia, and epidural techniques?

- Yes
- No

Q4.2.6 - Does your hospital have a full-service, full-time emergency room staffed with emergency room physicians?

- Yes
- No

Q4.2.7 - Does your hospital have a critical care unit with physician/surgeon staffing 24 hours per day/7 days per week with a trained critical care nursing staff?

- Yes
- No

Q4.2.8 - Is your critical care unit equipped for obese patients?

- Yes
- No
- Do not have a critical care unit

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S4.3 - Lower Volume/Lesser Complex Centers

Q4.3.1 - If your bariatric surgery center performs LESS THAN 125 weight loss operations annually, please select yes. If your center performs at least 125 weight loss operations annually, please select no.

Guidance:

If your center performs 125 or more weight loss operations annually and you select no to this question, you should have selected yes for Q4.2.1 and completed Q4.2.2 through Q4.2.8.

If you answer no, please go to S4.4 – All Centers.

- Yes
- No

Q4.3.2 - Does your bariatric surgery center have at least one bariatric surgeon performing at least 25 primary weight loss operations annually?

- Yes
- No

Q4.3.3 - Does your bariatric surgery center exclude the following patients:

- Patients over the age of 60 years with existing cardiac or pulmonary comorbidities
- Males with a BMI greater than or equal to 55
- Females with a BMI greater than or equal to 60
- Patients who are medically disabled

If your center accepts any of the above patients, please select no.

- Yes
- No

Q4.3.4 - Does your hospital provide any of the following multispecialty services?

- Pulmonology
- Cardiology
- Intensivists
- Infectious disease
- Nephrology
- Psychiatry/psychology
- Gastroenterology
- Thoracic surgery
- Otorhinolaryngology
- Orthopedics

- Yes
- No

Please indicate which services are available:

Q4.3.5 - Does your hospital maintain a staffed emergency room 24 hours per day/7 days per week?

- Yes
- No

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Q4.3.6 - Does your hospital provide critical care services with physician staffing, a trained critical care nursing staff, and physician critical care coverage available during evening and night shifts?

- Yes
- No

Q4.3.7 - Is your critical care unit equipped for obese patients?

- Yes
- No
- Do not have a critical care unit

S4.4 - All Centers

Q4.4.1 - Hospital accreditation:

Guidance:

"Accredited" by Joint Commission means the organization is in compliance with all standards at the time of the on-site survey or has successfully addressed requirements for improvement in an Evidence of Standards Compliance (ESC) within 45 days following the survey.

- Joint Commission
- American Osteopathic Association (AOA) – Healthcare Facilities Accreditation Program
- Other
- Not accredited

Q4.4.2 - Has your bariatric surgery center performed weight loss operations for the past 24 months?

- Yes
- No

Q4.4.3 - Does your hospital's bariatric surgery center have a Director of Bariatric Surgery?

- Yes
- No

Q4.4.4 - Is the Director of Bariatric Surgery certified or recertified by the American Board of Surgery (ABS)? If there is no Director, select not applicable.

- Yes
- No
- Not Applicable

Q4.4.5 - Does your bariatric surgery center have a coordinator for bariatric surgery?

Guidance:

A Bariatric Surgery Program Coordinator (a nurse or a physician assistant) will report to the Director of Bariatric Surgery.

- Yes
- No

Hospital Bariatric Surgery Addendum

Q4.4.6 - Indicate the percentage of your active bariatric surgeons certified or recertified by ABS.

- 100 percent
- Less than 100 percent

Q4.4.7 - Are anesthesia services provided by board certified anesthesiologists with special competence in managing obese patients and complex airway problems?

- Yes
- No

Q4.4.8 - Does your bariatric surgery center have a fully staffed and medically equipped operating room for morbidly obese patients?

Guidance:

Fully staffed shall mean nursing staff trained in performance of bariatric surgical procedures. Centers performing high volume of procedures annually, including complex cases, shall have a dedicated nursing team with special training and interest in bariatric surgery and minimally invasive surgery. Medically equipped shall mean special operating room tables and equipment to accommodate morbidly obese patients, retractors suitable for bariatric surgical procedures, specifically designed stapling instruments, appropriately long surgical instruments, and other special supplies unique to the procedure.

- Yes
- No

Q4.4.9 - Does your bariatric surgery center have a fully staffed and medically equipped recovery room for morbidly obese patients?

Guidance:

Fully staffed shall mean a recovery room nursing staff experienced in managing obese patients. Fully equipped shall mean stretchers, lifting devices, and other equipment for managing obese patients.

- Yes
- No

Q4.4.10 - Does your hospital have facilities for upper GI endoscopy and bronchoscopy equipped for obese patients?

Guidance:

The bariatric surgery center's patients should have access to comprehensive endoscopy services 24 hours per day/7 days per week.

- Yes
- No

Q4.4.11 - Does your bariatric surgery center have a dedicated nursing team utilized in minimally invasive surgery of the GI tract, biliary system, and abdominal organs including anastomotic procedures?

Guidance:

The bariatric surgery center should have a dedicated nursing team with training, experience and interest in bariatric surgery and minimally invasive surgery.

- Yes
- No

Hospital Bariatric Surgery Addendum

Q4.4.12 - Is the hospital's radiology unit equipped with oversized CT and MR equipment adequate for patients undergoing bariatric surgery?

- Yes
- No

Q4.4.13 - Does your bariatric surgery center provide adequate accommodations for morbidly obese patients?

Guidance:

The bariatric surgery center's patient care units should include shower rooms large enough to accommodate their heaviest patients. Furniture, beds, scales, wheelchairs, litters, floor mounted toilets, doorways, blood pressure cuffs, abdominal binders, gowns, walkers, SCD boots, and patient movement and transport systems should be available for morbidly obese patients.

- Yes
- No

Q4.4.14 - Does your bariatric surgery center employ clinical practice guidelines?

- Yes
- No

Q4.4.15 - Does your bariatric surgery center report outcomes data to an external repository database used for collecting, benchmarking and reporting of weight loss surgery outcomes?

Guidance:

Patient outcomes from weight loss surgery should be collected and reported to an external database. The center should receive reports comparing its results with other contributors. The database should include preoperative, intraoperative, and 30-day postoperative data. One-year follow-up outcome data may be included as well. Standards for rigorous analysis require logistic regressions to identify significant risk factors for morbidity and mortality for predicting expected outcomes. Expected outcomes are then compared to observed outcomes (odds ratio) to quantify quality and provide a valid comparison of outcomes between hospitals. Centers performing lower volume of weight loss operations, including less complex cases, may report to an external repository who may report non risk-adjusted outcome data.

Two examples of risk-adjusted external bariatric outcomes data repositories are ACS' National Surgical Quality Improvement Program (NSQIP) and the International Bariatric Surgery Registry (IBSR) at the University of Iowa Hospitals and Clinics, Department of Surgery, College of Medicine. An example of a non risk-adjusted data repository is ACS' Bariatric Center Network Database Participants.

- Yes
- No

Q4.4.16 - Does your bariatric surgery center review outcomes on all patients undergoing weight loss surgery as part of the surgeon credentialing process?

- Yes
- No

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Q4.4.17 - Does your bariatric surgery center have a quality improvement program including establishing best practices and monitoring their implementation?

Guidance:

Essential to an effective quality improvement program is the reporting and tracking of outcomes data associated with weight loss surgery. Use of best practices should be promoted and documented. Outcomes should be measurable.

- Yes
- No

Q4.4.18 - Does the credentialing process for surgeons performing weight loss surgery include written documentation of primary source verification of procedure specific criteria?

Guidance:

Credentialing criteria should be procedure specific. For example, laparoscopic does not qualify for open, open does not qualify for laparoscopic, band does not qualify for gastric bypass, and gastric bypass does not qualify for band. Newly trained surgeons should have completed a General Surgery Residency and performed a minimum number of laparoscopic and/or open bariatric operations during residency. General Surgery Residency may be followed by Bariatric Surgery Fellowship or a Minimally Invasive Surgery Fellowship. Established surgeons should complete a didactic course on bariatric surgery followed by successful completion of a minimum number of laparoscopic and/or open bariatric operations under proctorship.

- Yes
- No

Q4.4.19 - Does the recredentialing of bariatric surgeons include the following (select all that apply)?

- ABS certification maintained
- 50 primary weight loss operations performed during previous 2 years
- Documented long-term patient follow-up
- No substantial deviation of weight loss surgery outcomes from accepted norms or benchmarks. Substantial deviation may be represented by outlier as defined using a percentile or factor of standard deviation.
- Minimum of 12 weight loss surgery CME credits every 2 years

Q4.4.20 - Does your bariatric surgery center use a multidisciplinary group of clinicians to review bariatric surgery candidates?

Guidance:

Bariatric surgery centers should establish a multidisciplinary group of clinicians that will review bariatric surgery candidates to evaluate indications for surgery, contraindications for surgery, comorbidities, and operative risks.

- Yes
- No

Hospital Bariatric Surgery Addendum

Q4.4.21 - With respect to your informed consent and informed assent process for bariatric surgery patients, select all that apply.

- Informed consent includes communication with the patient providing description of the procedure and its risks and benefits.
- Patient understands what to expect during early postoperative period as well as during long term.
- Long-term follow-up discussion includes reviewing quality of life and lifestyle issues as well as what late complications can occur.
- Educational materials used to inform the patient are documented.
- Patient is aware of signs and symptoms of complications common to the procedure as well as signs and symptoms that require emergency attention.
- Informed consent includes explanation of alternative procedures including an alternative of no operation.

Q4.4.22 - Is there a protocol in place for the bariatric patient to receive discharge instructions that address activity, diet, wound care, and symptoms of complications?

- Yes
- No

Q4.4.23 - Do your bariatric surgery center or surgeons have a protocol in place for follow-up visits at 2 weeks postoperatively, several weeks later as indicated, 3 months, 6 months, 1 year, then annually?

- Yes
- No

Q4.4.24 - Does your bariatric surgery center's protocol for postoperative rehabilitation and follow-up include the following (select all that apply)?

- Dietary counseling
- Exercise counseling
- Psychological counseling
- Plastic Surgery counseling

Q4.4.25 - Does your bariatric surgery center document at least one year of personal contact or contact effort with patients?

Guidance:

Bariatric surgery centers should document at least one year of personal contact or contact effort with patients. An attempt to contact a patient should include 2 letters to the patient, one of which is certified, along with a phone call to the patient and a letter to the patient's physician.

- Yes
- No

S4.5 - Adolescents

Q4.5.1 - Does your bariatric surgery center perform weight loss operations on adolescents (patients under the age of 18 years)?

If you answer no, this is the end of the assessment.

- Yes
- No

Hospital Bariatric Surgery Addendum

Q4.5.2 - Is your hospital a pediatric specialty hospital or major teaching institution with a pediatric/adolescent surgery program?

- Yes
 No

Q4.5.3 - Does your bariatric surgery center use a multi-disciplinary approach inclusive of pediatric/adolescent subspecialty (board certified physicians) in surgery, medicine, endocrinology, psychiatry, pulmonology, gastroenterology, cardiology, and orthopedics?

- Yes
 No

Q4.5.4 - Does your bariatric surgery center use a preoperative psychosocial evaluation of both the adolescent and the parent(s) to assess if the adolescent is an appropriate candidate for weight loss surgery, and whether the family will be able to provide appropriate support to the adolescent undergoing weight loss surgery?

- Yes
 No

Q4.5.5 - Does your bariatric surgery center have formal, written criteria for patient selection and exclusion in place for the adolescent bariatric surgery program consistent with guidelines and/or recommendations from the National Institutes of Health?

- Yes
 No

Information provided by:

Signature

Title

Date