2024 Annual Survey of Hospitals

25-11006 **FID Number:** _____

Hospital Name

Address

City **County** **Zip**

Texas Dept of State Health Services
Center for Health Statistics
Hospital Survey Unit
1100 West 49th Street
PO Box 149347
Austin, Texas 78714-9347

Phone (512) 776-7261

The 2024 Cooperative Annual Survey is enclosed. This survey represents the thirty-eighth year of cooperation between the Department of State Health Services (DSHS), the American Hospital Association (AHA), and the Texas Hospital Association (THA). In an effort to reduce the reporting burden on Texas hospitals, DSHS and AHA have combined their annual survey into a single questionnaire.

The 2024 DSHS/AHA/THA Annual Survey of Hospitals is available online! We recommend that you use this web-based tool **(click on www.ahasurvey.org or Hospital Survey Unit | Texas DSHS)** as it will enable you to submit your data online more easily and efficiently.

State laws (Health and Safety Code, Chapters 104 and 311) require DSHS to collect aggregate financial, utilization, and other data from all licensed hospitals. Therefore, it is extremely important that all sections of the survey be completed fully and accurately.

This survey provides the state's only comprehensive source of information on issues such as uncompensated care and hospital utilization trends. The survey findings are used by legislators, state agencies, and research institutions to support the development of health policy and accompanying programs. The survey also provides data for AHA and THA to assess the current status of the hospital industry and to enable them to provide effective representation and advocacy.

ALL HOSPITALS ARE REQUIRED TO SUBMIT THE SURVEY DATA WITHIN 60 DAYS OF RECEIPT OF THIS SURVEY FORM. Your **timely** completion of this Annual Survey will fulfill your reporting obligation under Texas statutes. It will also ensure the inclusion of your facility's utilization data in **The AHA Guide** for 2024.

Please read the instructions for completion carefully. If you have any questions, please contact the Department of State Health Services, Center for Health Statistics, Hospital Survey Unit at HSU@dshs.texas.gov. Thank you for your cooperation.

Dr. Jennifer A. Shuford
Commissioner
Department of State Health Services

John Hawkins
President/Chief Executive Officer
Texas Hospital Association

General instructions for completing the online screening tool.

A copy of the completed survey form should be retained in your files for your reference. In addition, if there are any questions about your responses, this file copy may be of assistance to you in the follow-up and editing process.

Please report utilization and financial information for a full 12-month period, preferably using your fiscal year as the reporting period.

Use the following guidelines when completing the survey:

1. Make an entry for **EVERY ITEM** on the survey.

2. For items that are not applicable to your hospital or for which no services were provided enter **"0"** (zero).

3. **DO NOT USE "N/A" or "NA"** in any of your responses on the survey form. Enter **"NAV"** for an item which is applicable to your hospital, but data are not available from your hospital records in the detail required to complete the item.

4. For items which are combined with another variable, mark as **"NAV"** and indicate which variables are combined.

If you have any questions, please contact Dwayne Collins at the Department of State Health Services by email at dwayne.collins@dshs.texas.gov.

Please Note: ALL OF THE INFORMATION REPORTED IN THIS SURVEY WILL BE AVAILABLE TO THE PUBLIC EXCEPT AS OTHERWISE SPECIFIED. As of September 1, 1993, the confidentiality restriction on hospital specific financial data was removed for information reported since September 1, 1987. This change resulted from amendments made to the Health and Safety Code, Chapter 311.

A. REPORTING PERIOD (please refer to the instructions and definitions on page 24)

Report data for a full 12-month period, preferably your last completed fiscal year (365 days). (Be consistent in using the same reporting period for responses throughout various sections of this survey.)

1. Reporting Period used (beginning and ending date) ..... _____ to _____
   Month/Day/Year Month/Day/Year
2. a. Were you in operation 12 full months at the end of your reporting period? ..... YES ☐ NO ☐
   b. Number of days open during reporting period. ... _____
3. Indicate the beginning of your current fiscal year .....
   Month/Day/Year

B. ORGANIZATIONAL STRUCTURE

1. CONTROL

Indicate the type of organization that is responsible for establishing policy for overall operation of your hospital. CHECK ONLY ONE:

Government, nonfederal
- ☐ 12 State
- ☐ 13 County
- ☐ 14 City
- ☐ 15 City-County
- ☐ 16 Hospital district or authority

Non-government, not-for profit (NFP)
- ☐ 21 Church-operated
- ☐ 23 Other not-for-profit (including NFP Corporation)

Investor-owned, for-profit
- ☐ 31 Individual
- ☐ 32 Partnership
- ☐ 33 Corporation

Government, federal
- ☐ 40 Department of Defense
- ☐ 44 Public Health Service
- ☐ 45 Veterans' Affairs
- ☐ 46 Federal other than 41-45 or 47-48
- ☐ 47 PHS Indian Service
- ☐ 48 Department of Justice

2. SERVICE

a. Indicate the ONE category that BEST describes your hospital or the type of service it provides to the MAJORITY of patients:

- ☐ 10 General medical and surgical
- ☐ 11 Hospital unit of an institution (prison hospital, college infirmary)
- ☐ 12 Hospital unit within a facility for persons with intellectual disabilities
- ☐ 13 Surgical
- ☐ 18 REH (Rural Emergency Hospital)
- ☐ 22 Psychiatric
- ☐ 33 Tuberculosis and other respiratory diseases
- ☐ 41 Cancer
- ☐ 42 Heart
- ☐ 44 Obstetrics and gynecology
- ☐ 45 Eye, ear, nose, and throat
- ☐ 46 Rehabilitation
- ☐ 47 Orthopedic
- ☐ 48 Chronic diseases
- ☐ 62 Intellectual Disabilities
- ☐ 80 Acute long-term care hospital
- ☐ 82 Substance use disorder
- ☐ 49 Other-specify treatment area: _____

b. If 18 REH was selected, please indicate the date when your hospital converted to REH designation:
__ __ / __ __ / __ __ __ __

3. OTHER

a. Are you primarily a Children's Hospital? ..... YES ☐ NO ☐

b. Is your hospital owned in whole or in part by physicians or a physician group?..... YES ☐ NO ☐

c. If you checked 80 Acute long-term care hospital (LTCH) in the Section B2 (Service), please indicate if you are a freestanding LTCH or a LTCH arranged within a general acute care hospital.
☐ Freestanding LTCH ☐ LTCH arranged within a general acute care hospital
If you are arranged in a general acute care hospital, what is your host hospital's name?
Name: _____ City: _____ State

d. Are other types of hospitals co-located in your hospital? YES ☐ NO ☐

e. If you checked yes for 3d, what type of hospital is co-located? (Check all that apply)
1. ☐ Cancer
2. ☐ Cardiac
3. ☐ Orthopedic
4. ☐ Pediatric/Children's
5. ☐ Psychiatric
6. ☐ Surgical
7. ☐ Rehabilitation
8. ☐ Long-term Acute Care
9. ☐ Other _____

B. ORGANIZATIONAL STRUCTURE (continued)

f. Does the hospital participate in a group purchasing arrangement? YES ☐ NO ☐

If yes, please provide the name, city and state of your primary group puchasing organization.

Name: _____ City:_____ State:_____

g. Does the hospital purchase medical/surgical supplies directly through a distributor? YES ☐ NO ☐

If yes, please provide the name of your primary distributor.

Name:_____

C. FACILITIES AND SERVICES

For each service or facility listed below, please check all the categories that describe how each item is provided **as of the last day of the reporting period**. Check all categories that apply for an item. If you checked column (1) for C1-20, please include the number of beds. **The sum of the beds reported in 1-20 should equal E(2b), beds set up and staffed.**

Please report # Beds that were provided within your hospital and were set up and staffed for use at the end of the reporting period

	(1) Owned or provided by my hospital or its subsidiary		(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
A. Inpatient Care Services					
1. General medical-surgical care	☐	(#Beds: _____)	☐	☐	☐
2. Pediatric medical-surgical care	☐	(#Beds: _____)	☐	☐	☐
3. Obstetrics [Hospital level of unit (1-4):(_____)]	☐	(#Beds: _____)	☐	☐	☐
4. Medical surgical intensive care	☐	(#Beds: _____)	☐	☐	☐
5. Cardiac intensive care	☐	(#Beds: _____)	☐	☐	☐
6. Neonatal Intensive Care Highest Level (1-4)(__)	☐	(#Total Beds: _____)	☐	☐	☐
7. Neonatal intermediate care	☐	(#Beds: _____)	☐	☐	☐
8. Pediatric intensive care	☐	(#Beds: _____)	☐	☐	☐
9. Burn care	☐	(#Beds: _____)	☐	☐	☐
10. Other special care (specify: _____)	☐	(#Beds: _____)	☐	☐	☐
11. Other intensive care (specify: _____)	☐	(#Beds: _____)	☐	☐	☐
B. Rehabilitation and Long-Term Care					
12. Physical rehabilitation	☐	(#Beds: _____)	☐	☐	☐
13. Inpatient Substance use disorder care	☐	(#Beds: _____)	☐	☐	☐
14. Inpatient Psychiatric care	☐	(#Beds: _____)	☐	☐	☐
15. Skilled nursing care	☐	(#Beds: _____)	☐	☐	☐
16. Intermediate nursing care	☐	(#Beds: _____)	☐	☐	☐
17. Acute long-term care	☐	(#Beds: _____)	☐	☐	☐
18. Other long-term care	☐	(#Beds: _____)	☐	☐	☐
19. Biocontainment patient care unit	☐	(#Beds: _____)	☐	☐	☐
20. Other care (specify: _____)	☐	(#Beds: _____)	☐	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
C. Outpatient and Ambulatory Services				
21. Adult day care program	☐	☐	☐	☐
22. Ambulance surgery center	☐	☐	☐	☐
23. Ambulance services	☐	☐	☐	☐
24. Air Ambulance services	☐	☐	☐	☐
25. Freestanding outpatient care center	☐	☐	☐	☐
26. Home health services	☐	☐	☐	☐
27. Hospice program	☐	☐	☐	☐
28. Hospital-based outpatient care center services	☐	☐	☐	☐
29. Hospital at Home Program	☐	☐	☐	☐
30. Outpatient Surgery	☐	☐	☐	☐
31. Indigent care clinic	☐	☐	☐	☐
32. Rural health clinic	☐	☐	☐	☐
D. Specialized Medical Services				
33. Airborne infection isolation room (#Rooms_____)	☐	☐	☐	☐
34. Cardiology and cardiac surgery services				
34a. Adult cardiology services	☐	☐	☐	☐
34b. Pediatric cardiology services	☐	☐	☐	☐
34c. Adult diagnostic catheterization	☐	☐	☐	☐
34d. Pediatric diagnostic catheterization	☐	☐	☐	☐
34e. Adult interventional cardiac catheterization	☐	☐	☐	☐
34f. Pediatric interventional cardiac catheterization	☐	☐	☐	☐
34g. Adult cardiac surgery	☐	☐	☐	☐
34h. Pediatric cardiac surgery	☐	☐	☐	☐
34i. Adult cardiac electrophysiology	☐	☐	☐	☐
34j. Pediatric cardiac electrophysiology	☐	☐	☐	☐
34k. Cardiac rehabilitation	☐	☐	☐	☐
35. Chemotherapy	☐	☐	☐	☐
36. Hemodialysis	☐	☐	☐	☐
37. Oncology services	☐	☐	☐	☐
38. Neurological services	☐	☐	☐	☐
39. Orthopedic services	☐	☐	☐	☐
40. Pain management program	☐	☐	☐	☐
41. Palliative care program	☐	☐	☐	☐
42. Palliative care inpatient unit	☐	☐	☐	☐
43. Radiology, diagnostic				
43a. CT Scanner	☐	☐	☐	☐
43b. Diagnostic radioisotope facility	☐	☐	☐	☐
43c. Electron beam computed tomography (EBCT)	☐	☐	☐	☐
43d. Full-field digital mammography (FFDM)	☐	☐	☐	☐
43e. Magnetic resonance imaging (MRI)	☐	☐	☐	☐
43f. Intraoperative magnetic resonance imaging	☐	☐	☐	☐
43g. Magnetoencephalography (MEG)	☐	☐	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
43h. Multi-slice spiral computed tomography (<64+ slice CT)	☐	☐	☐	☐
43i. Multi-slice spiral computed tomography (64+ slice CT))	☐	☐	☐	☐
43j. Positron emission tomography (PET)	☐	☐	☐	☐
43k. Positron emission tomography/CT (PET/CT)	☐	☐	☐	☐
43l. Single photon emission computerized tomography (SPECT)	☐	☐	☐	☐
43m. Ultrasound	☐	☐	☐	☐
44. Radiology therapeutic:				
44a. Image-guided radiation therapy (IGRT)	☐	☐	☐	☐
44b. Intensity-modulated radiation therapy (IMRT)	☐	☐	☐	☐
44c. Stereotactic radiosurgery	☐	☐	☐	☐
44d. Proton beam therapy	☐	☐	☐	☐
44e. Shaped beam radiation system	☐	☐	☐	☐
44f. Basic interventional radiology	☐	☐	☐	☐
45. Physical rehabilitation services				
45a. Assistive technology center	☐	☐	☐	☐
45b. Electrodiagnostic services	☐	☐	☐	☐
45c. Physical rehabilitation outpatient services	☐	☐	☐	☐
45d. Prosthetic and orthotic services	☐	☐	☐	☐
45e. Robot-assisted walking therapy	☐	☐	☐	☐
45f. Simulated rehabilitation environment	☐	☐	☐	☐
46. Transplant services				
46a. Bone marrow	☐	☐	☐	☐
46b. Heart	☐	☐	☐	☐
46c. Kidney	☐	☐	☐	☐
46d. Liver	☐	☐	☐	☐
46e. Lung	☐	☐	☐	☐
46f. Tissue	☐	☐	☐	☐
46g. Other:_____	☐	☐	☐	☐
47. Bariatric/weight control services	☐	☐	☐	☐
48. Birthing room/LDR room/LDRP room	☐	☐	☐	☐
49. Chiropractic services	☐	☐	☐	☐
50. Complementary and alternative medicine services	☐	☐	☐	☐
51. Computer assisted orthopedic surgery (CAOS)	☐	☐	☐	☐
52. Dental services	☐	☐	☐	☐
53. Endoscopic services	☐	☐	☐	☐
53a. Optical colonoscopy	☐	☐	☐	☐
53b. Endoscopic ultrasound	☐	☐	☐	☐
53c. Ablation of Barrett's esophagus	☐	☐	☐	☐
53d. Esophageal impedance study	☐	☐	☐	☐
53e. Endoscopic retrograde cholangiopancreatography (ERCP)	☐	☐	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
54. Extracorporeal shock wave lithotripter (ESWL)	☐	☐	☐	☐
55. Fertility clinic	☐	☐	☐	☐
56. Geriatric services	☐	☐	☐	☐
57. Health research	☐	☐	☐	☐
58. HIV/AIDS services	☐	☐	☐	☐
59. Occupational health services	☐	☐	☐	☐
60. Patient controlled analgesia (PCA)	☐	☐	☐	☐
61. Primary care department	☐	☐	☐	☐
62. Robotic surgery	☐	☐	☐	☐
63. Sleep Center	☐	☐	☐	☐
64. Sports Medicine	☐	☐	☐	☐
65. Stroke care	☐	☐	☐	☐
66. Swing bed services	☐	☐	☐	☐
67. Women's health center/services (not related to pregnancy or postpartum care)	☐	☐	☐	☐
68. Wound management services	☐	☐	☐	☐
E. Support Services				
69. Case management	☐	☐	☐	☐
70. Chaplaincy/pastoral care services	☐	☐	☐	☐
71. Community outreach	☐	☐	☐	☐
72. Support groups	☐	☐	☐	☐
73. Social work services	☐	☐	☐	☐
74. Transportation to health services (non-emergency)	☐	☐	☐	☐
75. Volunteer services department	☐	☐	☐	☐
76. Volunteer Community Organization	☐	☐	☐	☐
77. Enrollment (insurance) assistance services	☐	☐	☐	☐
78. Employment support services	☐	☐	☐	☐
79. Hosting services	☐	☐	☐	☐
79a. Assisted living	☐	☐	☐	☐
79b. Retirement housing	☐	☐	☐	☐
79c. Supportive housing services	☐	☐	☐	☐
80. Linguistic/translation services	☐	☐	☐	☐
81. Meal delivery services	☐	☐	☐	☐
82. Mobile health services	☐	☐	☐	☐
83. Patient education center	☐	☐	☐	☐
84. Patient representative services	☐	☐	☐	☐
85. Prenatal and Postpartum services	☐	☐	☐	☐
86. Teen outreach services	☐	☐	☐	☐
F. Emergency and Urgent Care Services				
87. On-campus emergency department	☐	☐	☐	☐
88. Off-campus emergency department	☐	☐	☐	☐
89. Pediatric emergency department	☐	☐	☐	☐
90. Trauma center (designated) [ATS Level (1-4) _____]	☐	☐	☐	☐
90a. If column(1) is checked for 90 (Trauma center), does your hospital own the trauma certification?		Yes ☐ No ☐		
91. Urgent care center	☐	☐	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
G. Preventative and Wellness Programs				
92. Alzheimer center	☐	☐	☐	☐
93. Arthritis treatment center	☐	☐	☐	☐
94. Blood donor center	☐	☐	☐	☐
95. Breast cancer screening/mammograms	☐	☐	☐	☐
96. Diabetes prevention program	☐	☐	☐	☐
97. Fitness Center	☐	☐	☐	☐
98. Community health education	☐	☐	☐	☐
99. Genetic testing/counseling	☐	☐	☐	☐
100. Health screenings	☐	☐	☐	☐
101. Tobacco treatment/cessation program	☐	☐	☐	☐
102. Children's wellness program	☐	☐	☐	☐
103. Early Intervention Treatment	☐	☐	☐	☐
104. Immunization program	☐	☐	☐	☐
105. Nutrition program	☐	☐	☐	☐
106. Violence prevention programs				
106a. For the workplace	☐	☐	☐	☐
106b. For the community	☐	☐	☐	☐
H. Telehealth Services				
107. Consultation and office visits	☐	☐	☐	☐
108. eICU	☐	☐	☐	☐
109. Telehealth Stroke care	☐	☐	☐	☐
110. Psychiatric Treatment	☐	☐	☐	☐
111. Substance Use Disorder Treatment	☐	☐	☐	☐
112. Remote patient monitoring	☐	☐	☐	☐
112a. Post-discharge	☐	☐	☐	☐
112b. Ongoing chronic care management	☐	☐	☐	☐
112c. Other remote patient monitoring	☐	☐	☐	☐
113. Virtual colonoscopy	☐	☐	☐	☐
114. Other telehealth:_____	☐	☐	☐	☐
I. Behavioral Health Services				
115. Psychiatric services:				
115a. Psychiatric consultation-liaison services	☐	☐	☐	☐
115b. Psychiatric pediatric care……(#Staffed Beds _____)	☐	☐	☐	☐
115c. Psychiatric geriatric care…….(#Staffed Beds _____)	☐	☐	☐	☐
115d. Psychiatric education services	☐	☐	☐	☐
115e. Psychiatric emergency services	☐	☐	☐	☐
115f. Psychiatric outpatient services	☐	☐	☐	☐
115g. Psychiatric intensive outpatient services	☐	☐	☐	☐
115h. Social and community psychiatric services	☐	☐	☐	☐
115i. Forensic psychiatric services	☐	☐	☐	☐
115j. Prenatal and postpartum psychiatric services	☐	☐	☐	☐
115k. Psychiatric partial hospitalization services–adult	☐	☐	☐	☐
115l. Psychiatric partial hospitalization services–pediatric	☐	☐	☐	☐
115m. Psychiatric residential treatment – adult	☐	☐	☐	☐

C. FACILITIES AND SERVICES (continued)

	(1) Owned or provided by my hospital or its subsidiary	(2) Provided by my Health System (in my local community)	(3) Provided through a formal contractual arrangement or joint venture with another provider that is not in my health system (in my local community)	(4) Not Provided
115n. Psychiatric residential treatment – pediatric	☐	☐	☐	☐
115o. Suicide prevention services	☐	☐	☐	☐
116. Substance use disorder services				
116a. Substance use disorder pediatric services (#Staffed Beds_____)	☐	☐	☐	☐
116b. Substance use disorder outpatient services	☐	☐	☐	☐
116c. Substance use disorder partial hospitalization services	☐	☐	☐	☐
116d. Medication assisted treatment for Opioid Use Disorder	☐	☐	☐	☐
116e. Medication assisted treatment for other substance use disorders	☐	☐	☐	☐

117. Does your organization routinely integrate behavioral health services in the following care areas?

a. Emergency services YES ☐ NO ☐
b. Primary care services YES ☐ NO ☐
c. Acute inpatient care YES ☐ NO ☐
d. Extended care YES ☐ NO ☐

Integration ranges from co-located physical and behavioral health providers, with some screening and treatment planning, to fully integrated care where behavioral and physical health providers function as a true team in a shared practice.

118. Does your organization routinely offer **psychiatric consultation & liaison services** in the following care areas? Consultation-liaison Psychiatrists, medical physicians, or advanced practice providers (APPs) work to help people suffering from a combination of mental and physical illness by consulting with them and liaising with other members of their care team.

a. Emergency services YES ☐ NO ☐
b. Primary care services YES ☐ NO ☐
c. Acute inpatient care YES ☐ NO ☐
d. Extended care YES ☐ NO ☐

119. Does your organization routinely offer **addiction/substance use disorder consultation & liaison services** in the following care areas?

a. Emergency services YES ☐ NO ☐
b. Primary care services YES ☐ NO ☐
c. Acute inpatient care YES ☐ NO ☐
d. Extended care YES ☐ NO ☐

120. Does your organization routinely screen for **psychiatric disorders** in the following care areas?
Screens can include but are not limited to the PHQ-2 and PHQ9 depression screen, the Columbia DISC Depression Scale, and/or the GAD-2 and GAD-7 for anxiety disorders.

a. Emergency services YES ☐ NO ☐
b. Primary care services YES ☐ NO ☐
c. Acute inpatient care YES ☐ NO ☐
d. Extended care YES ☐ NO ☐

121. Does your organization routinely screen for **substance use disorders** in the following care areas?
Screens can include but are not limited to the CAGE Substance Abuse Screening Tool; NIDA's drug screening tool; and/or TAPS: Tobacco, Alcohol, Prescription medication, and other Substance use Tool

a. Emergency services YES ☐ NO ☐
b. Primary care services YES ☐ NO ☐
c. Acute inpatient care YES ☐ NO ☐
d. Extended care YES ☐ NO ☐

C. FACILITIES AND SERVICES (continued)

122. **PHYSICIAN ARRANGEMENTS**

122a. Please indicate the numer of physicians on your hospital's medical staff whose practices are organized in the following ways:

	(a) Number of Involved Physicians in My Hospital	(b) Number of Involved Physicians in My Health System	(c) Not Provided
1. Employed Model OR Group owned/operated by the hospital/health system:	_____	_____	☐
2. Foundation Model:	_____	_____	☐
3. Independent Practice Association (IPA):	_____	_____	☐
4.Independent Group owned/operated by its partners:	_____	_____	☐
5. Independent Group owned/operated by a third party separate from the hospital/health system (e.g., private equity, insurance company, etc):	_____	_____	☐
6. Independent Solo Practice:	_____	_____	☐
7. Other (please specify) _____	_____	_____	☐

122b. Please indicate the number physicians in each of the following relationships with your hospital:

	Number of Involved Physicians
1. Employed:	_____
2. Contract Group:	_____
3. Privileges Only	_____
4. Other (please specify)	_____

122c.Please indicate the number of physicians affiliated with your hospital that belong to each type of physician specialty arrangement:

	Number of Involved Physicians
1. Single Specialty:	_____
2. Multispecialty:	_____
3. Other (please specify) _____	_____

122d. Of the physician practices owned by the hospital, what percentage are primary care? ____%

122e. Of the physician practices owned by the hospital, what percentage are specialty care? ____%

123a. Does your hospital participate in any joint venture arrangements with physicians or physician groups? ☐ YES ☐ NO

123b. If your hospital participates in any joint ventures with physicians or physician groups, please indicate which types of services are involved in those joint ventures. (Check all that apply)

1. ☐ Limited service hospital
2. ☐ Ambulatory surgical centers
3. ☐ Imaging Centers
4. ☐ Other _____

123c. If you selected '1. Limited Service Hospital', please tell us what type(s) of services are provided. (Check all that apply)

1. ☐ Cardiac
2. ☐ Orthopedic
3. ☐ Surgical
4. ☐ Other _____

123d. Does your hospital participate in joint venture arrangements with organizations other than physician groups? ☐ YES ☐ NO

124. **Does your hospital have a partnership with a Community Mental Health Center or a Certified Community Behavioral Health Center?**

a. Community Mental Health Center ☐ Yes ☐ No

b. Certified Community Behavioral Health Center ☐ Yes ☐ No

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D. INSURANCE AND ALTERNATIVE PAYMENT MODELS

INSURANCE

1. Does your hospital own or jointly own a health plan? YES ☐ NO ☐
   a. If yes, in what states? States: _____

2. Does your hospital/system have a significant partnership with an insurer on an insurance company/health plan? (eg, a joint venture) YES ☐ NO ☐ N/A ☐
   a. If yes, in what states? States: _____

3. If yes to 1, 2, and/or 3 above, please indicate the insurance products and the total medical enrollment (Check all that apply)

Insurance Products	Hospital	System	JV	No	Do not know
a. Medicare Advantage	☐	☐	☐	☐	☐
b. Medicaid Managed Care	☐	☐	☐	☐	☐
c. Health Insurance Marketplace ("exchange")	☐	☐	☐	☐	☐
d. Small Group	☐	☐	☐	☐	☐
e. Large Group	☐	☐	☐	☐	☐
f. Other_____	☐	☐	☐	☐	☐

If you have answered 'no' to all parts of questions 1, 2, and 3, please skip to question 8.

4. Does your **health plan** make capitated payments to physicians either within or outside of your network for specific groups or enrollees?
   a. Physicians within your network Yes ☐ No ☐ Do not know ☐
   b. Physicians outside your network Yes ☐ No ☐ Do not know ☐
   c. If yes, which specialties? _____

5. Does your **health plan** make bundled payments to providers in your network or to outside providers?
   a. Physicians within your network Yes ☐ No ☐ Do not know ☐
   b. Physicians outside your network Yes ☐ No ☐ Do not know ☐
   c. If yes, which specialties? _____

6. Does your **health plan** offer shared risk contracts to either providers in your network or to outside providers? (i.e., other than capitation or bundled payment.)
   a. Physicians within your network Yes ☐ No ☐ Do not know ☐
   b. Physicians outside your network Yes ☐ No ☐ Do not know ☐
   c. If yes, which specialties? _____

7. Does your hospital or system fund the health benefits for your employees? Yes ☐ No ☐
   a. If yes, does the hospital or health system also administer the benefits (as opposed to contracting with a third party administrator)? Yes ☐ No ☐

8. What percentage of your **hospital's** patient revenue is paid on a capitated basis? ☐%

   a. In total, how many patients do you serve under capitated contracts? Total patients: _____

9. Does your **hospital** participate in any bundled payment arrangements? Yes ☐ No ☐ (if no, skip to 11)

9a. If yes, for which of the following payers and medical/surgical conditions does your **hospital** have a bundled payment arrangement? (Check all that apply)

	(a) Traditional Medicare	(b) Medicare Advantage Plan	(c) Commercial Insurance Plan (including ACA participants, individual, group or employer markets)	(d) Medicaid
1. Cardiovascular	☐	☐	☐	☐
2. Orthopedic	☐	☐	☐	☐
3. Oncologic	☐	☐	☐	☐
4. Neurology	☐	☐	☐	☐
5. Hematology	☐	☐	☐	☐
6. Gastrointestinal	☐	☐	☐	☐
7. Pulmonary	☐	☐	☐	☐
8. Infectious Disease	☐	☐	☐	☐
9. Hospitalist	☐	☐	☐	☐
10. Nephrology	☐	☐	☐	☐
11. Obstetrics	☐	☐	☐	☐
12. Endocrinology	☐	☐	☐	☐
13. Psychiatric Disorders	☐	☐	☐	☐
14. Substance Use Disorders	☐	☐	☐	☐
15. Other:_____	☐	☐	☐	☐

D. INSURANCE AND ALTERNATIVE PAYMENT MODELS (continued)

9b. What percentage of the **hospital's** patient revenue is paid through bundled payment arrangements? _____**%**

10. Does your **hospital** participate in a bundled payment program involving care settings outside of the hospital (e.g., physician, outpatient, post-acute)? YES ☐ NO ☐
    a. If, yes, does your hospital share upside or downside risk for any of those outside providers? YES ☐ NO ☐

11. What percentage of your **hospital's** patient revenue is paid on a shared risk basis (other than capitated or bundled payment)? ____**%**

12. Does your **hospital** contract directly with employers or a coalition of employers to provide care on a capitated, predetermined, or shared risk basis? YES ☐ NO ☐

13. Does your **hospital** have contracts with commercial payers where payment is tied to performance on quality/safety metrics? YES ☐ NO ☐

14a. Has your **hospital** or **health care system** established an accountable care organization (ACO)?
1. ☐ My hospital currently leads an ACO **(Skip to 14b)**
2. ☐ My hospital currently participates in an ACO (but is not its leader) **(Skip to 15)**
3. ☐ My hospital previously led or participated in an ACO but is no longer doing so **(Skip to 15)**
4. ☐ My hospital has never participated or led an ACO **(Skip to 15)**

14b. With which of the following types of payers does your hospital have an accountable care contact? (Select all that apply)
1. ☐ Traditional Medicare (MSSP and NextGen) **(Skip to 14c)**
2. ☐ A Medicare Advantage plan **(Skip to 14d)**
3. ☐ A commercial insurance plan (including ACA participants, individual, group, and employer markets) (**Skip to 14d**)
4. ☐ Medicaid **(Skip to 14d)**

14c. If you selected Traditional Medicare, in which of the following Medicare programs is your hospital/system participating? (Check all that apply)

1. ☐ MSSP BASIC Track, Level A
2. ☐ MSSP BASIC Track, Level B
3. ☐ MSSP BASIC Track, Level C
4. ☐ MSSP BASIC Track, Level D
5. ☐ MSSP BASIC Track, Level E
6. ☐ MSSP ENHANCED Track
7. ☐ Original MSSP program, Tracks 1, 1+, 2 or 3
8. ☐ Comprehensive ESRD Care

14d. What percentage of your hospital's/system's patients are covered by accountable care contracts? ____**%**

14e. What percentage of your hospital's/system's patient revenue came from ACO contracts in 2024? ____**%**

15. Does your hospital/system have an established medical home program?

a. Hospital YES ☐ NO ☐ b. System YES ☐ NO ☐

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E. TOTAL FACILITY BEDS AND UTILIZATION

Please report beds and utilization data for the 12-month period that is consistent with the period reported on page 3. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate.

Fill out column (2) if hospital owns and operates a nursing home type unit/facility. Column (1) should be the combined total of hospital plus Nursing Home Unit/Facility.

1 Does your hospital own and operate a nursing home type unit/facility? Yes ☐ No ☐

	(1) Total Facility	(2) Nursing Home Unit/Facility
2. BEDS AND UTILIZATION		
a. Total licensed beds	_____	_____
b. Beds set up and staffed for use at the end of the reporting period (Do not report licensed beds; should match Total # Beds on page 4)	_____	_____
c. Bassinets set up and staffed for use at the end of the reporting period	_____	
d. Births (exclude fetal deaths)	_____	
e. Admissions (exclude newborns; include neonatal & swing admissions)	_____	_____
f. Discharges (exclude newborns; include neonatal & swing discharges)	_____	_____
g. Inpatient days (exclude newborns; include neonatal & swing days)	_____	_____
h. Emergency department visits	_____	
i. Total outpatient visits (include emergency visits & outpatient surgeries)	_____	
j. Inpatient surgical operations	_____	
k. Number of operating rooms	_____	
l. Outpatient surgical operations	_____	

3. UTILIZATION BY PAYER

Inpatient days and total discharges should equal inpatient days and discharge totals reported in Admissions (E2e) and Discharges (E2f)

a1. Total Medicare (Title XVIII) inpatient discharges (including Medicare Managed Care)	_____	_____
a2. How many Medicare inpatient discharges were Medicare Managed Care	_____	_____
b1. Total Medicare (Title XVIII) inpatient days (including Medicare Managed Care)	_____	_____
b2. How many Medicare inpatient days were Medicare Managed Care	_____	_____
c1. Total Medicaid (Title XIX) inpatient discharges (including Medicaid Managed Care)	_____	_____
c2. How many Medicaid inpatient discharges were Medicaid Managed Care	_____	_____
d1. Total Medicaid (Title XIX) inpatient days (including Medicaid Managed Care)	_____	_____
d2. How many Medicaid inpatient days were Medicaid Managed Care	_____	_____
e1. Total self-pay discharges	_____	_____
e2. Total self-pay inpatient days	_____	_____
f1. Total Commercial (non-Medicare, non-Medicaid) discharges	_____	_____
f2. Total Commercial (non-Medicare, non-Medicaid) inpatient days	_____	_____
g1. Other payer (government and non-government) inpatient discharges	_____	_____
g2. Other payer (government and non-government) inpatient days	_____	_____

E. TOTAL FACILITY BEDS AND UTILIZATION (continued)

4. UTILIZATION OF TELEHEALTH/VIRTUAL CARE

The definitions used herein represent one approach in understanding telehealth/virtual care. The AHA is aware that different organizations use different definitions for these terms and that Medicare defines them in a more narrow way than they are used in the field. The definitions we chose are meant to balance the statutory and regulatory use of the terms with the way they are understood by providers on the groud.

a. Number of video visits: Sychronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication. _____

b. Number of audio visits: synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication. _____

c. Number of patients being monitored through remote patient monitoring (RPM): Use of medical devices to collect and transmit physiologic data to providers. Services include medical device set up, patient education, transmission of data, and interpretation and analysis of results. _____

d. Number of patients being monitored thourgh remote therapeutic monitoring (RTM): Collection and transmission of non-physiologic data to providers. Services include medical device set up, patient education, transmission of data, and interpretation and analysis of results. _____

e. Number of patients receiving other virtual services: All other synchronous or asynchronous interactions between a provider and patient or provider delivered remotely, including messages, eConsults, and virtual check-ins. _____

f. Number of eVisits: Non-face-to-face patient -initiated communication through an online patient portal. _____

g. Number of eConsults: Synchronous or asynchronous two-way communication technology between primary care clinicians and specialists. _____

h. Number of Virtual Check-ins: Brief communication technology-based service (including synchronous audio or asynchronous exchange of video or images). _____

F. Total Facility Finances

Please report financial data for the 12-month period that is consistent with the period reported on page 3. Report financial data for reporting period only. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate. Round to the nearest dollar.

1. FINANCIAL	**(1) Total Facility**	**(2) Nursing Home Unit/Facility**
a. Net patient revenue **(treat bad debt as a deduction from revenue) (must equal F4c2, column 2, Total net revenue)**	_____.00	_____.00
b. Tax appropriations	_____.00	
c. Other operating revenue	_____.00	
d. Non-operating revenue	_____.00	
e. TOTAL REVENUE (add 1a thru 1d)	_____.00	_____.00
f. Payroll Expenses (only)	_____.00	_____.00
g. Employee benefits	_____.00	_____.00
h. Depreciation expense (for reporting period only)	_____.00	
i. Interest expense	_____.00	
j. Pharmacy expenses	_____.00	
k. Supply expense (other than pharmacy)	_____.00	
l. All other expenses	_____.00	
m. TOTAL EXPENSES (add 1f thru 1l. Exclude bad debt	_____.00	_____.00
n. Do your total expenses (F1m) reflect full allocation from your corporate office?	Yes ☐ No ☐	
o. Does your hospital monitor the expenses related to collecting payments from insurers?	Yes ☐ No ☐	
1 if yes, what percent of your hospital's revenue was spent on collecting reimbursement from insurers?	_____	

F. Total Facility Finances (continued)

2. REVENUE BY TYPE

a. Total gross inpatient revenue ..... _____.00
b. Total gross outpatient revenue ..... _____.00
c. Total gross patient revenue (must equal F4c, column 1) ..... _____.00

3. UNCOMPENSATED CARE AND PROVIDER TAXES

a. Bad debt (revenue forgone at full established rates. Include in gross revenue.) _____.00
1. Are you able to distinguish bad debt derived from patients with or without insurance? ..... Yes ☐ No ☐
2. If yes, how much is from patients with insurance? ..... _____.00
b. Financial Assistance (Includes charity care) (Revenue forgone at full established rates. Include gross revenue.) ..... _____.00
c. Is your bad debt (F3a) reported on the basis of full charges? ..... Yes ☐ No ☐
d. Does your state have a provider Medicaid tax/assessment program? ..... Yes ☐ No ☐
e. If yes, please report the total gross amount paid into the program ..... _____.00
f. Due to different accounting standards please indicate whether the provider tax/assessment is included in:
1. Total expenses ..... Yes ☐ No ☐
2. Deductions from net patient revenue ..... Yes ☐ No ☐

4. REVENUE BY PAYER (report total facility gross and net figures)

	(1) Gross	(2) Net
a. GOVERNMENT		
(1) Medicare:		
a) Fee for service patient revenue	_____.00	_____.00
b) Managed care revenue	_____.00	_____.00
c) Total (a+b)	_____.00	_____.00
(2) Medicaid:		
a) Fee for service patient revenue	_____.00	_____.00
b) Managed care revenue	_____.00	_____.00
c) Medicaid Graduate Medical Education (GME) payments		_____.00
d) Medicaid Disproportionate Share Hospital Payments (DSH)		_____.00
e) Medicaid State Directed Payments		_____.00
f) Other Medicaid Supplemental Payments (not including Medicaid DSH Payments or Medicaid State Directed Payments		_____.00
g) Other Medicaid)		_____.00
h) Total (a thru g)	_____.00	_____.00
(3) Other Government	_____.00	_____.00
b. NONGOVERNMENT		
(1) Self-pay	_____.00	_____.00
(2) Commercial payers:		
a) Managed care (includes HMO and PPO)	_____.00	_____.00
b) Other Commercial payers	_____.00	_____.00
c) Total Commercial payers (a+b)	_____.00	_____.00
(3) All other nongovernment	_____.00	_____.00
c. TOTAL	**_____.00**	**_____.00**

(Total gross should equal F2c. Total net should equal F1a.)

F. Total Facility Finances (continued)

	Inpatient (1)	Outpatient (2)
d. If you report Medicaid Supplemental Payments on line F4a(2)f, please break the payment total into inpatient and outpatient care.	.00	.00
e. If you are a government owned facility (control codes 12-16), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditures program?.....	Yes ☐	No ☐
	(1) Gross	**(2) Net**
f. If yes, please report gross and net revenue:	.00	.00

5. FINANCIAL PERFORMANCE – MARGIN (Please report each margin as a percentage (%), not as a dollar amount.)

a. Total Margin ____ %

b. Operating Margin ____ %

c. EBITDA Margin ____ %

d. Medicare Margin ____ %

e. Medicaid Margin ____ %

6. FIXED ASSETS

a. Property, plant and equipment at cost..... .00

b. Accumulated depreciation..... .00

c. Net property, plant and equipment (a-b)..... .00

d. Total gross square feet of your physical plant used for or in support of your healthcare activities..... ____

7. TOTAL CAPITAL EXPENSES

Include all expenses used to acquire assets, including buildings, remodeling projects, equipment or property .00

a. * Are the financial data responses in section F: Total Facility Finances primarily sourced from your audited financial statement?
Yes ☐ No ☐

b. IS THERE ANY REASON WHY YOU CANNOT ENTER REVENUE BY PAYER? Yes ☐ No ☐

G. INFORMATION TECHNOLOGY AND CYBERSECURITY

1. INFORMATION TECHNOLOGY AND CYBERSECURITY

If you are part of a larger health system, report the overall system cyber budget and related numbers, unless each hospital in the system has their own independent cyber budget.

a. Overall IT Budget .00

b. Number of internal IT staff (in FTEs) ____

c. What percent of your IT budget is spent on cybersecurity? ____ %

d. Number of internal staff devoted to cybersecurity (in FTEs) ____

e. Number of outsourced staff for cybersecurity (in FTEs) ____

f. What position does your cybersecurity lead report to? ____

☐ Chief Executive Officer ☐ Chief Information Officer ☐ Chief Financial Officer ☐ Chief Operating Officer ☐ Chief/Legal Compliance Officer ☐ Chief Risk Officer ☐ Other, please specify ____

g. Does your hospital have an enterprise risk management system? ☐ Yes ☐ No

1. If yes, what priority an enterprise risk management system? ____

2. If no, is cybersecurity considered an enterprise risk issue? ☐ Yes ☐ No

h. How often is the board briefed on cybersecurity?
☐ Quarterly ☐ Semi-annually ☐ Yearly ☐ Never ☐ Other _____

i. What do you view as your biggest cybersecurity threat? (Please rank the choices 1-10, with 1 being the biggest threat)
(Please do not duplicate your rankings)

1. Ransomware which may disrupt and delay patient care delivery ____

G. INFORMATION TECHNOLOGY AND CYBERSECURITY (continued)

2. Ransomware which may disrupt business operations _____
3. Theft of sensitive patient data such as Protected Health Information (PHI) or Personally identifiable Information (PII) _____
4. Theft of medical research or intellectual property _____
5. Cyber risk exposure through third parties or business associates. (For example, third parties or business associate as conduit for cyber attacks or theft of your data stored by third parties. _____
6. Technology and supply chain cyber risk _____
7. Other supply chain risk (e.g. blood supply, medical supplies) _____
8. Medical device cyber risk _____
9. Phishing emails or other social engineering attacks which may result in the delivery of malware or ransomware into the organization. _____
10. Phishing emails or other social engineering attacks which may result in the theft of funds _____

j. What do you feel your largest cybersecurity challenges are in defending against threats in i1?

1. Recruitment and retention of cybersecurity professionals ☐
2. Funding ☐
3. Technology ☐
4. Leadership support ☐
5. Staff support ☐
6. Government support (explain in other option below) ☐
7. Lack of cyber threat information sharing ☐
8. Other _____ ☐

k. Does your organization use any of the following cybersecurity techniques?

1. Enterprise wide multi-factor authentication for all remote access to networks, data, and applications	☐ Yes	☐ No
2. Network segmentation	☐ Yes	☐ No
3. Offline, network segmented, redundant network and data back ups	☐ Yes	☐ No
4. Immutable backups	☐ Yes	☐ No
5. Intrusion detection systems	☐ Yes	☐ No
6. Employee cybersecurity education including phishing email simulations	☐ Yes	☐ No
7. 24/7 Security Operations Center (SOC) monitoring all cyber incidents and events	☐ Yes	☐ No
8. Highly efficient and effective patch management program	☐ Yes	☐ No
9. Forced password change every 90 days or less	☐ Yes	☐ No
10. Integration of cyber incident response plans with emergency management plans	☐ Yes	☐ No
11. Cross function cyber incident response exercise for all leaders	☐ Yes	☐ No
12. Relationship with local FBI and CIA offices	☐ Yes	☐ No
13. Third Party Risk Management Program which assesses business associate access to networks and bulk sensitive data; mission criticality and life criticality of third party	☐ Yes	☐ No

l. How confident are you in the organization's ability to sustain care delivery through manual downtime procedures for up to four (4) weeks, without the benefit of network and internet connected technology?

☐ Confident ☐ Somewhat confident ☐ Uncertain ☐ Somewhat not confident ☐ Not confident

m. What do you view as your biggest challenges in improving your organization's cybersecurity posture? (Please rank the choices 1-6, with 1 being the biggest challenge) **(Please do not duplicate your rankings)**

1. Funding _____
2. Staffing _____
3. Legacy insecure technology _____
4. Leadership support _____
5. Organizational culture _____
6. Non-compliant third parties/business associates _____

2. ARTIFICIAL INTELLIGENCE

Artificial Intelligence (AI) encompasses a broad range of technologies that enable machines to simulate human intelligence and perform tasks that typically require human cognitive abilities. For the purposes of the following survey questions, please consider AI to include any of the technologies below when answering the questions.

- **Artificial Intelligence (AI):** The use of computer systems to perform tasks that typically require human intelligence, such as decision-making, pattern recognition, and learning.
- **Generative AI (gen-AI):** AI systems that generate new content, such as text, images, or data, based on learned patterns.
- **Machine Learning (ML):** A subset of AI where computer systems improve their performance over time through experience (data) without explicit programming.
- **Robotic Process Automation (RPA):** The automation of repetitive tasks using software robots, often in administrative functions.
- **Natural Language Processing (NLP):** A branch of AI focused on enabling machines to understand and respond to human language, applied in areas such as text analysis, medical documentation, and chatbots.
- **Computer Vision:** A branch of AI that enables machines to interpret and make decisions based on visual inputs like medical images, used in diagnostics and imaging.

a. How would you describe your hospital's current level of AI implementation in the following clinical areas?

	(1) Not Implementing	(2) Exploring	(3) Piloting/Testing	(4) Expanding	(5) Fully Integrated	(0) Don't Know
1. AI-assisted diagnostics (including imaging & early detection)	☐	☐	☐	☐	☐	☐
2. Predictive analytics for patient care (including outcomes & deterioration)	☐	☐	☐	☐	☐	☐
3. Clinical decision support tools	☐	☐	☐	☐	☐	☐
4. AI-assisted surgery	☐	☐	☐	☐	☐	☐
5. AI-powered patient communication and education	☐	☐	☐	☐	☐	☐
6. AI-driven population health management	☐	☐	☐	☐	☐	☐
7. Predictive models for resource allocation during emergencies	☐	☐	☐	☐	☐	☐
8. Other, please specify: _____	☐	☐	☐	☐	☐	☐

b. How would you describe your hospital's current level of AI implementation in the following operational areas?

	(1) Not Implementing	(2) Exploring	(3) Piloting/Testing	(4) Expanding	(5) Fully Integrated	(0) Don't Know
1. Revenue cycle management (e.g., billing, claims processing)	☐	☐	☐	☐	☐	☐
2. Supply chain optimization	☐	☐	☐	☐	☐	☐
3. Staff scheduling and workforce management	☐	☐	☐	☐	☐	☐
4. Patient flow and demand forecasting	☐	☐	☐	☐	☐	☐
5. Optimizing operational efficiency	☐	☐	☐	☐	☐	☐
6. Other, please specify: _____	☐	☐	☐	☐	☐	☐

c. Has your hospital encountered the following challenges in implementing AI in clinical or operational areas?

	(1) Yes	(2) No
1. Cost and resource requirements	☐	☐
2. Staff training and upskilling	☐	☐
3. Data integration and interoperability	☐	☐

2. ARTIFICIAL INTELLIGENCE (continued)

4.	Regulatory compliance and safety concerns	☐	☐
5.	Patient trust and acceptance	☐	☐
6.	Other, please specify: _____	☐	☐

H. Total Facility Staffing

1. STAFFING

Report full-time (35 hours or more) and part-time (less than 35 hours) personnel who were on the hospital/facility **payroll at the end of your reporting period.** Include members of religious orders for whom dollar equivalents were reported. Exclude private-duty nurses, volunteers, and all personnel whose salary is financed entirely by outside research grants. Exclude physicians and dentists who are paid on a fee basis.

- **FTE** is the total number of hours **worked** (excluding non-worked hours such as PTO, etc.) by all employees over the full (12 month) reporting period divided by the normal number of hours worked by a full-time employee for that same time period.
  - For example, if your hospital considers a normal workweek for a full-time employee to be 40 hours, a total of 2,080 would be worked over a full year (52 weeks). If the total number of hours worked by all employees on the payroll is 208,000, then the number of Full-Time Equivalents (FTE) is 100 (employees).
  - The FTE calculation for a specific occupational category should be based on the number of hours worked by staff employed in that specific category.

For each occupational category, please report the number of staff vacancies as of the last day of your reporting period.

A vacancy is defined as a budgeted staff position which is unfilled as of the last day of the reporting period and for which the hospital is actively seeking either a full-time or part-time permanent replacement. Personnel who work in more than one area should be included only in the category of their **primary responsibility and should be counted only once**.

	(1) Full-Time (35 hr/wk or more) On payroll (Headcount)	(2) Part-Time (less than 35 hr/wk) On Payroll (Headcount)	(3) FTE	(4) Vacancies (Headcount)
a. Physicians	_____	_____	_____	_____
b. Dentists	_____	_____	_____	_____
c. Medical Residents/Interns	_____	_____	_____	_____
d. Dental Residents/Interns	_____	_____	_____	_____
e. Other Trainees	_____	_____	_____	_____
f. Registered Nurses	_____	_____	_____	_____
g. Licensed Practical (Vocational) Nurses	_____	_____	_____	_____
h. Nursing Assistive Personnel	_____	_____	_____	_____
i. Radiology Technicians	_____	_____	_____	_____
j. Laboratory Technicians	_____	_____	_____	_____
k. Pharmacists, Licensed	_____	_____	_____	_____
l. Pharmacy Technicians	_____	_____	_____	_____
m. Respiratory Therapists	_____	_____	_____	_____
n. All Other Personnel	_____	_____	_____	_____
o. Total facility personnel (add 1a through 1n) *(Total facility personnel should include hospital and nursing home type unit/facility personnel, if applicable. Nursing home type unit/facility personnel should be reported in 1p and 1q.)*	_____	_____	_____	_____
p. Nursing home type unit/facility Registered Nurses	_____	_____	_____	_____
q. Total nursing home type unit/facility personnel	_____	_____	_____	_____

H. Total Facility Staffing (continued)

r. Please break out the FTE's for the following staffing below. Staffing included below should be on the HOSPITAL's payroll.

	FTE
1. Therapy Roles (OT/PT/Speech)	_____
2. Virtual nurses	_____
3. Psychiatrists	_____
4. Psychologists	_____
5. Social Workers	_____
6. Counselors	_____
7. Case Managers	_____
8. Community Health Workers	_____
9. Peer Support Specialists	_____
10. Tech Roles	_____
11. Administrative and Billing Support Staff	_____
12. Certified Registered Nurse Anesthetists	_____
13. Clinical Nurse Specialists	_____
14. Physician Assistants	_____
15. Nurse Practitioners	_____
16. Certified Nurse-Midwives	_____
17. Clinical Pharmacist Practitioner	_____

s. How much clinician time is being spent on administrative tasks, i.e. billing/prior auth/RCM? _____
(Please report in FTEs)

t. For your medical residents/interns reported above (H.1c.column 1) please indicate the number of full time personnel on payroll by specialty.

	Full-Time (35 hr/wk or more) On Payroll (Headcount)
1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics)	_____
2. Other specialties	_____

2. ADVANCED PRACTICE PROVIDERS

a. Do Advanced Practice Providers provide care for patients in your hospital? (If no, please skip to 3) ☐ Yes ☐ No

b. If yes, please report the number of FTEs for Advanced Practice Nurses and Physician Assistants (PAs) who provide care for patients in your hospital for each of the following services:

	(1) AP Registered Nurses FTE	**(2) Physician Assistants FTE**
1. Internal Medicine/Hospital	_____	_____
2. Anesthesia services (Certified registered nurse anesthetist)	_____	_____
3. Emergency department care	_____	_____
4. Other specialty care	_____	_____
5. Patient education	_____	_____
6. Case management	_____	_____
7. OB/GYN	_____	_____
8. Orthopedics	_____	_____
9. Oncology	_____	_____
10. Neurology	_____	_____
11. Psychology	_____	_____
12. Cardiology	_____	_____
13. Palliative Care	_____	_____
14. Other (please specify)	_____	_____

H. Total Facility Staffing (continued)

3. CONTRACTED STAFF

Please report the number of contracted FTEs for each occupational category (not on hospital payroll). Personnel that are on the hospital's payroll and reported in H(1) should not be reported here.

	Contracted FTEs
a. Registered nurses	_____
b. Radiology technicians	_____
c. Laboratory technicians	_____
d. Pharmacists, licensed	_____
e. Pharmacy technicians	_____
f. Respiratory therapists	_____
g. Contracted physicians	_____
h. All other contracted staff	_____

4. PRIVILEGED PHYSICIANS

Report the total number of physicians with privileges at your hospital by type of relationship with the hospital. The sum of the physicians reported in **4**a-**4**i should equal the total number of privileged physicians (**4**j) in the hospital.

	(1) Total Employed	**(2) Total Individual Contract**	**(3) Total Group Contract**	**(4) Not Employed or Under Contract**	**(5) Total Privileged (add columns 1-4)**
a. Primary care (general practitioner, general internal medicine, family practice, general pediatrics).....	_____	_____	_____	_____	_____
b. Obstetrics/gynecology.....	_____	_____	_____	_____	_____
c. Emergency medicine.....	_____	_____	_____	_____	_____
d. Hospitalist.....	_____	_____	_____	_____	_____
e. Intensivist.....	_____	_____	_____	_____	_____
f. Radiologist.....	_____	_____	_____	_____	_____
g. Pathologist.....	_____	_____	_____	_____	_____
h. Anesthesiologist.....	_____	_____	_____	_____	_____
i. Other specialist.....	_____	_____	_____	_____	_____
j. Total (add 4a-4i)	_____	_____	_____	_____	_____

5. HOSPITALISTS

a. Do hospitalists provide care for patients in your hospital? (If no, please skip to **6**) Yes ☐ No ☐ (If yes, please report in E.**5b**)

b. If yes, please report the total number of full-time equivalent (FTE) hospitalists.... _____FTE

6. INTENSIVISTS

a. Do intensivists provide care for patients in your hospital? (If no, please skip to **7**) Yes ☐ No ☐ (If yes, please report in E.**6b**)

b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are authorized to care for ICU patients.)

	FTE	**Closed to Intensivists**
1. Medical-surgical intensive care	_____	☐
2. Cardiac intensive care	_____	☐
3. Neonatal intensive care	_____	☐

H. Total Facility Staffing (continued)

4.	Pediatric intensive care	_____	☐
5.	Other intensive care	_____	☐
6.	**Total**	_____	

7. FOREIGN EDUCATED STAFF

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2024 vs. 2023? More ☐ Less ☐ Same ☐ Did not hire foreign nurses ☐

b. From which countries/continents are you recruiting foreign-educated nurses? (check all that apply)
Africa ☐ South Korea ☐ Canada ☐ Philippines ☐ China ☐ India ☐ Other ☐

c. How many international medical graduates are providing care in your hospital? _____

8. WORKFORCE

a. How is your hospital incorporating workforce as part of the strategic planning process: (Check all that apply)

1. ☐ Conduct needs assessment
2. ☐ Leadership succession planning
3. ☐ Talent development plan
4. ☐ Recruitment & retention planning
5. ☐ Partnerships with elementary/HS (K-12) to develop interest in health care careers
6. ☐ Training program partnership with community colleges, vocational training programs
7. ☐ Well-being programs (peer support, well-being measurement, team efficiency efforts)
8. ☐ Workplace violence/de-escalation trainings/programming
9. ☐ Benefits such as tuition reimbursement
10. ☐ Transition to practice programs
11. ☐ Support for ongoing professional development for clinical staff
12. ☐ Support for ongoing development for non-clinical staff
13. ☐ None of the above

b. If your hospital hired RN's during the reporting period, how many were new graduates from nursing schools? _____

2024 American Hospital Association ANNUAL SURVEY

I. SUPPLEMENTAL INFORMATION

Use this space for comments or to elaborate on any information supplied on this survey. Refer to the response by page, section and item name.

Please indicate below whether or not you agree to these types of disclosure:
[☐] I hereby grant AHA permission to release my hospital's revenue data to external users that the AHA determines have a legitimate and worthwhile need to gain access to these data subject to the user's agreement with the AHA not to release hospital specific information.

_____ _____
Chief Executive Officer Date

[☐] I do not grant AHA permission to release my confidential data.

_____ _____
Chief Executive Officer Date

With the exception of restrictions protecting certain confidential information, the results of this survey may be publicly released.

Thank you for your cooperation in completing this survey. If there are any questions about your responses to this survey, who should be contacted?

_____ _____ (_____)_____-_____
Name (please print) Title (Area Code) Telephone Number

_____/_____/_____ _____ (_____)_____
Date of Completion Chief Executive Officer Hospital's Main Fax Number

Contact Email address: _____

NOTE: PLEASE PHOTOCOPY THE INFORMATION FOR YOUR HOSPITAL FILE BEFORE RETURNING THE ORIGINAL FORM TO THE AMERICAN HOSPITAL ASSOCIATION. ALSO, PLEASE FORWARD A PHOTOCOPY OF THE COMPLETED QUESTIONNAIRE TO YOUR STATE HOSPITAL ASSOCIATION.

THANK YOU

2024 American Hospital Association ANNUAL SURVEY

SECTION A
REPORTING PERIOD
Instructions

INSTRUCTIONS AND DEFINITIONS FOR THE 2023 ANNUAL SURVEY OF HOSPITALS.

For purposes of this survey, a hospital is defined as the organization or corporate entity licensed or registered as a hospital by a state to provide diagnostic and therapeutic patient services for a variety of medical conditions, both surgical and nonsurgical.

1. **Reporting period used (beginning and ending date**): Record the beginning and ending dates of the reporting period in an eight-digit number: for example, January 1, 2024 should be shown as 01/01/2024. Number of days should equal the time span between the two dates that the hospital was open. If you are reporting for less than **366** days, utilization and finances should be presented for days reported only.
2. **Were you in operation 12 full months at the end of your reporting period?** If you are reporting for less than **366** days, utilization and finances should be presented for days reported only.
   - **b. Number of days open during reporting period**: Number of days should equal the time span between the two dates that the hospital was open.

SECTION B
ORGANIZATIONAL STRUCTURE
Instructions and Definitions

1. CONTROL

Check the box to the left of the type of organization that is responsible for establishing policy for overall operation of the hospital.

Government, nonfederal.

State. Controlled by an agency of state government.

County. Controlled by an agency of county government.

City. Controlled by an agency of municipal government.

City-County. Controlled jointly by agencies of municipal and county governments.

Hospital district or authority. Controlled by a political subdivision of a state, county, or city created solely for the purpose of establishing and maintaining medical care or health-related care institutions.

Nongovernment, not for profit. Controlled by not-for-profit organizations, including religious organizations (Catholic hospitals, for example), community hospitals, cooperative hospitals, hospitals operated by fraternal societies, and so forth.

Investor owned, for profit. Controlled on a for profit basis by an individual, partnership, or a profit making corporation.

Government, federal. Controlled by an agency or department of the federal government.

2. SERVICE

a. Indicate the ONE category that best describes the type of service that your hospital provides to the majority of patients.

General medical and surgical. Provides diagnostic and therapeutic services to patients for a variety of medical conditions, both surgical and nonsurgical.

Hospital unit of an institution. Provides diagnostic and therapeutic services to patients in an institution.

Hospital unit within a facility for persons with intellectual disabilities. Provides diagnostic and therapeutic services to persons with intellectual disabilities.

Surgical. An acute care specialty hospital where 2/3 or more of its inpatient claims are for surgical/diagnosis related groups.

Psychiatric. Provides diagnostic and therapeutic services to patients with mental or emotional disorders.

Tuberculosis and other respiratory diseases. Provides medical care and rehabilitative services to patients for whom the primary diagnosis is tuberculosis or other respiratory diseases.

Cancer. Provides medical care to patients for whom the primary diagnosis is cancer.

Heart. Provides diagnosis and treatment of heart disease.

Obstetrics and gynecology. Provides medical and surgical treatment to pregnant women and to mothers following delivery. Also provides diagnostic and therapeutic services to women with diseases or disorders of the reproductive organs.

Eye, ear, nose, and throat. Provides diagnosis and treatment of diseases and injuries of the eyes, ears, nose, and throat.

Rehabilitation. Provides a comprehensive array of restoration services for people with disabilities and all support services necessary to help them attain their maximum functional capacity.

Orthopedic. Provides corrective treatment of deformities, diseases, and ailments of the locomotive apparatus, especially affecting the limbs, bones, muscles, and joints.

Chronic disease. Provides medical and skilled nursing services to patients with long-term illnesses who are not in an acute phase, but who require an intensity of services not available in nursing homes.

Intellectual disabilities. Provides health-related care on a regular basis to patients with developmental or intellectual disabilities who cannot be treated in a skilled nursing unit.

Acute long-term care hospital. Provides high acuity interdisciplinary services to medically complex patients that require more intensive recuperation and care than can be provided in a typical nursing facility.

Substance use disorder. Provides diagnostic and therapeutic services to patients with a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over use of substances such as alcohol, prescription, and non-prescription drugs. Substance use disorders range in severity, duration, and complexity from mild to severe.

b. REH. Rural Emergency Hospital is a new Medicare Provider designation established by Congress through the Consolidated Appropriations Act of 2021. REH facilities are meant to reinforce access to outpatient medical services and reduce health disparities in areas that may not be able to sustain a full-service hospital.

3. OTHER

a. Children admissions. A hospital whose primary focus is the health and treatment of children and adolescents, with 80% admissions 18 years or younger.

b. Physician group. Cooperative practice of medicine by a **group** of **physicians**, each of whom as a rule specializes in some particular field.

c. **Acute long-term care hospital.** Provides high acuity interdisciplinary services to medically complex patients that require more intensive recuperation and care than can be provided in a typical nursing facility.
d. **Co-located hospitals.** Co-location refers to two or more entities, with separate CMS Certification Numbers occupying the same building, or conjoined buildings.
e. **Group purchasing organization.** An organization whose primary function is to negotiate contracts for the purpose of purchasing for members of the group or has a central supply site for its members.
f. **Distributor.** An entity that typically does not manufacture most of its own products but purchases and re-sells these products. Such a business usually maintains an inventory of products for sales to hospitals and physician offices and others.

SECTION C
FACILITIES AND SERVICES
Instructions and Definitions

Owned/provided by the hospital or its subsidiary. All patient revenues, expenses and utilization related to the provision of the service are reflected in the hospital's statistics reported elsewhere in this survey.
Provided by my health system (in my local community). Another health care provider in the same system as your hospital provides the service and patient revenue, expenses, and utilization related to the provision of the service are recorded at the point where the service was provided and would not be reflected in your hospital's statistics reported elsewhere in this survey. (A system is a corporate body that owns, leases, religiously sponsors and/or manages health providers)
Provided through a partnership or joint venture with another provider that is not in my system. All patient revenues and utilization related to the provision of the service are recorded at the site where the service was provided and would not be reflected in your hospital statistics reported elsewhere in this survey. (A joint venture is a contractual arrangement between two or more parties forming an unincorporated business. The participants in the arrangement remain independent and separate outside of the venture's purpose.)

1. **General medical-surgical care.** Provides acute care to patients in medical and surgical units on the basis of physicians' orders and approved nursing care plans.
2. **Pediatric medical-surgical care.** Provides acute care to pediatric patients on the basis of physicians' orders and approved nursing care plans.
3. **Obstetrics.** Provides medical and surgical treatment to pregnant women and to mothers following delivery. Also provides diagnostic and therapeutic services to women with diseases or disorders of the reproductive organs.
   For service owned or provided by the hospital, level should be designated:
   Level I: unit provides services for uncomplicated maternity and newborn cases
   Level II: unit provides services for uncomplicated cases, the majority of complicated problems, and special neonatal services
   Level III: unit provides services for all serious illnesses and abnormalities and is supervised by a full-time maternal/fetal specialist
   Level IV: on-site medical and surgical care of the most complex maternal conditions and critically ill pregnant women and fetuses throughout antepartum, intrapartum, and postpartum care.
4. **Medical-surgical intensive care.** Provides patient care of a more intensive nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care. Includes mixed intensive care units.
5. **Cardiac intensive care.** Provides patient care of a more specialized nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care. May include myocardial infarction, pulmonary care, and heart transplant units.
6. **Neonatal intensive care.** A unit that must be separate from the newborn nursery providing intensive care to all sick infants including those with the very lowest birth weights (less than 1500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery, and special care for the sickest infants born in the hospital or transferred from another institution. A full-time neonatologist serves as director of the NICU.
   Neonatal Intensive Care Units (NICUs) are classified into levels by the American Academy of Pediatrics (AAP) based on their capabilities.
   The levels are as follows:
   Level I: Well newborn nursery
   Level II: Special care nursery
   Level III: Neonatal intensive care unit (NICU)
   Level IV: Regional neonatal intensive-care unit (regional NICU)
7. **Neonatal intermediate care.** A unit that must be separate from the normal newborn nursery and that provides intermediate and/or recovery care and some specialized services, including immediate resuscitation, intravenous therapy, and capacity for prolonged oxygen therapy and monitoring.
8. **Pediatric intensive care.** Provides care to pediatric patients that is of a more intensive nature than that usually provided to pediatric patients. The unit is staffed with specially trained personnel and contains monitoring and specialized support equipment for treatment of patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care.

9. **Burn care.** Provides care to severely burned patients. Severely burned patients are those with any of the following: (1)

second-degree burns of more than 25% total body surface area for adults or 20% total body surface area for children: (2) third-degree burns of more than 10% total body surface area; (3) any severe burns of the hands, face, eyes, ears, or feet; or (4) all inhalation injuries, electrical burns, complicated burn injuries involving fractures and other major traumas, and all other poor risk factors.

10. **Other special care.** Provides care to patients requiring care more intensive than that provided in the acute area, yet not sufficiently intensive to require admission to an intensive care unit. Patients admitted to this area are usually transferred here from an intensive care unit once their condition has improved. These units are sometimes referred to as definitive observation, step-down or progressive care units.
11. **Other intensive care.** A specially staffed, specialty equipped, separate section of a hospital dedicated to the observation, care, and treatment of patients with life-threatening illnesses, injuries, or complications from which recovery is possible. It provides special expertise and facilities for the support of vital function and utilizes the skill of medical nursing and other staff experienced in the management of these problems.
12. **Physical rehabilitation.** Provides care encompassing a comprehensive array of restoration services for people with disabilities and all support services necessary to help patients attain their maximum functional capacity.
13. **Inpatient substance use disorder care.** Provides diagnostic and therapeutic services to patients with a medical illness characterized by clinically significant impairments in health, social function, and voluntary control over use of substances such as alcohol, prescription, and non-prescription drugs. Includes care for inpatient/residential treatment for patients whose course of treatment involves more intensive care than provided in an outpatient setting or where patient requires supervised withdrawal.
14. **Inpatient psychiatric care.** Provides acute or long-term care to patients with mental or emotional disorders, including patients admitted for diagnosis and those admitted for treatment of psychiatric disorders, on the basis of physicians' orders and approved nursing care plans. Long-term care may include intensive supervision to persons with chronic/severe mental illness.
15. **Skilled nursing care.** Provides non-acute medical and skilled nursing care services, therapy, and social services under the supervision of a licensed registered nurse on a 24-hour basis.
16. **Intermediate nursing care.** Provides health-related services (skilled nursing care and social services) to residents with a variety of physical conditions or functional disabilities. These residents do not require the care provided by a hospital or skilled nursing facility, but do need supervision and support services
17. **Acute long-term care.** Provides specialized acute hospital care to medically complex patients who are critically ill, have multisystem complications and/or failure, and require hospitalization averaging 25 days, in a facility offering specialized treatment programs and therapeutic intervention on a 24-hour/7 days a week basis
18. **Other long-term care.** Provision of long-term care other than skilled nursing care or intermediate care for those who do not require daily medical or nursing services but may requires some assistance in the activities of daily living. This can include residential care, elderly care, or care facilities for those with developmental or intellectual disabilities.
19. **Biocontainment patient care unit.** A permanent unit that provides the first line of treatment for people affected by bio-terrorism or highly hazardous communicable diseases. The unit is equipped to safely care for anyone exposed to a highly contagious and dangerous disease. Please do not report temporary COVID-19 units on this line.
20. **Other care.** (specify) Any type of care other than those listed above.
    The sum of the beds reported in Section C 1-20 should equal what you have reported in Section E(2b) for beds set up and staffed.
21. **Adult day care program.** Program providing supervision, medical and psychological care, and social activities for older adults who live at home or in another family setting but cannot be alone or prefer to be with others during the day. May include intake assessment, health monitoring, occupational therapy, personal care, noon meal, and transportation services
22. **Ambulatory surgery center.** Facility that provides care to patients requiring surgery that are admitted and discharged on the same day. Ambulatory surgery centers are distinct from same day surgical units within the hospital outpatient departments for purposes of Medicare payment
23. **Ambulance services.** Provision of ambulance service to the ill and injured who require medical attention on a scheduled and unscheduled basis.
24. **Air ambulance services.** Aircraft and especially a helicopter equipped for transporting the injured or sick. Most air ambulances carry critically ill or injured patients, whose condition could rapidly change for the worse.
25. **Freestanding outpatient care center.** A facility owned and operated by the hospital that is physically separate from the hospital and provides various medical treatments and diagnostic services on an outpatient basis only. Laboratory and radiology services are usually available.
26. **Home health services.** Service providing nursing, therapy, and health-related homemaker or social services in the patient's home.
27. **Hospice program.** A program providing palliative care, chiefly medical relief of pain and supportive services, addressing the emotional, social, financial, and legal needs of terminally ill patients and their families. Care can be provided in a variety of settings, both inpatient and at home.
28. **Hospital-based outpatient care center-services**. Organized hospital health care services offered by appointment on an ambulatory basis. Services may include outpatient surgery, examination, diagnosis, and treatment of a variety of medical conditions on a nonemergency basis, and laboratory and other diagnostic testing as ordered by staff or outside physician referral.
29. **Hospital at Home Program.** Hospital-at-home enable some patients who need acute-level care to receive care in their homes, rather than in a hospital.
30. **Outpatient surgery.** Scheduled surgical services provided to patients who do not remain in the hospital overnight. The surgery may be performed in operating suites also use for inpatient surgery, specially designated surgical suites for outpatient

surgery, or procedure rooms within an outpatient care facility.

31. **Indigent care clinic.** Health care services for uninsured and underinsured persons where care is free of charge or charged on a sliding scale. This would include "free clinics" staffed by volunteer practitioners, but could also be staffed by employees with the sponsoring health care organization subsidizing the cost of service.
32. **Rural health clinic.** A clinic located in a rural, medically under-served area in the United States that has a separate reimbursement structure from the standard medical office under the Medicare and Medicaid programs.
33. **Airborne infection isolation room.** A single-occupancy room for patient care where environmental factors are controlled in an effort to minimize the transmission of those infectious agents, usually spread person to person by droplet nuclei associated with coughing and inhalation. Such rooms typically have specific ventilation requirements for controlled ventilation, air pressure and filtration.
34. **Cardiology and cardiac surgery services.** Services which include the diagnosis and treatment of diseases and disorders involving the heart and circulatory system.
    a. **Adult cardiology services.** A range of clinical services offering diagnostic and interventional procedures to manage the full range of adult heart conditions.
    b. **Pediatric cardiology services.** Specialized services of medicine that focuses on the diagnosis and treatment of heart conditions in children. This includes congenital heart defects, arrhythmias, and acquired heart diseases such as Kawasaki disease and rheumatic fever.
    c. **Adult diagnostic catheterization.** (Also called coronary angiography or coronary arteriography) is used to assist in diagnosing complex heart conditions. Cardiac angiography involves the insertion of a tiny catheter into the artery in the groin then carefully threading the catheter up into the aorta where the coronary arteries originate. Once the catheter is in place, a dye is injected which allows the cardiologist to see the size, shape, and distribution of the coronary arteries. These images are used to diagnose heart disease and to determine, among other things, whether or not surgery is indicated.
    d. **Pediatric diagnostic catheterization.** A procedure in which a long, flexible tube (catheter) is put into a blood vessel of children experiencing cardiac issues. The doctor then guides the catheter into the heart to find and treat heart problems.
    e. **Adult interventional cardiac catheterization.** Nonsurgical procedure that utilizes the same basic principles as diagnostic catheterization and then uses advanced techniques to improve the heart's function. It can be a less invasive alternative to heart surgery.
    f. **Pediatric interventional cardiac catheterization.** Nonsurgical procedure that utilizes the same basic principles as diagnostic catheterization and then uses advanced techniques to improve the heart's function of children experiencing cardiac issues. It can be a less invasive alternative to heart surgery.
    g. **Adult cardiac surgery.** Includes minimally invasive procedures that include surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.
    h. **Pediatric cardiac surgery.** Includes minimally invasive procedures that include surgery done with only a small incision or no incision at all, such as through a laparoscope or an endoscope and more invasive major surgical procedures that include open chest and open heart surgery.
    i. **Adult cardiac electrophysiology.** Evaluation and management of patients with complex rhythm or conduction abnormalities, including diagnostic testing, treatment of arrhythmias by catheter ablation or drug therapy, and pacemaker/defibrillator implantation and follow-up.
    j. **Pediatric cardiac electrophysiology.** Evaluation and management of child patients with complex rhythm or conduction abnormalities, including diagnostic testing, treatment of arrhythmias by catheter ablation or drug therapy, and pacemaker/defibrillator implantation and follow-up.
    k. **Cardiac rehabilitation.** A medically supervised program to help heart patients recover quickly and improve their overall physical and mental functioning. The goal is to reduce risk of another cardiac event or to keep an already present heart condition from getting worse. Cardiac rehabilitation programs include: counseling to patients, an exercise program, helping patients modify risk factors such as smoking and high blood pressure, providing vocational guidance to enable the patient to return to work, supplying information on physical limitations and lending emotional support.
35. **Chemotherapy.** An organized program for the treatment of cancer by the use of drugs or chemicals.
36. **Hemodialysis.** Provision of equipment and personnel for the treatment of renal insufficiency on an inpatient or outpatient basis.
37. **Oncology services.** Inpatient and outpatient services for patients with cancer, including comprehensive care, support and guidance in addition to patient education and prevention, chemotherapy, counseling and other treatment methods.
38. **Neurological services.** Services provided by the hospital dealing with the operative and nonoperative management of disorders of the central, peripheral, and autonomic nervous systems.
39. **Orthopedic services.** Services provided for the prevention or correction of injuries or disorders of the skeletal system and associated muscles, joints and ligaments.
40. **Pain management program.** A recognized clinical service or program providing specialized medical care, drugs or therapies for the management of acute or chronic pain and other distressing symptoms, administered by specially trained physicians and other clinicians, to patients suffering from acute illnesses of diverse causes.
41. **Palliative care program.** An organized program providing specialized medical care, drugs or therapies for the management of acute or chronic pain and/or the control of symptoms administered by specially trained physicians and other clinicians; and supportive care services, such as counseling on advanced directives, spiritual care, and social services, to patients with

advanced diseases and their families.

42. **Palliative care inpatient unit.** A physically discreet, inpatient nursing unit where the focus is palliative care. The patient care focus is on symptom relief for complex patients who may be continuing to undergo primary treatment. Care is delivered by palliative medicine specialists.
43. **Radiology, diagnostic.** The branch of radiology that deals with the utilization of all modalities of radiant energy in medical diagnoses and therapeutic procedures using radiologic guidance. This includes, but is not restricted to, imaging techniques and methodologies utilizing radiation emitted by x-ray tubes, radionuclides, and ultrasonographic devices and the radiofrequency electromagnetic radiation emitted by atoms
    a. **CT Scanner.** Computed tomographic scanner for head or whole body scans
    b. **Diagnostic radioisotope facility.** The use of radioactive isotopes (Radiopharmaceuticals) as tracers or indicators to detect an abnormal condition or disease.
    c. **Electron beam computed tomography (EBCT).** A high-tech computed tomography scan used to detect coronary artery disease by measuring coronary calcifications. This imaging procedure uses electron beams which are magnetically steered to produce a visual of the coronary artery and the images are produced faster than conventional CT scans.
    d. **Full-field digital mammography (FFDM).** Combines the x-ray generators and tubes used in analog screen-film mammography (SFM) with a detector plate that converts the x-rays into a digital signal.
    e. **Magnetic Resonance Imaging (MRI).** The use of a uniform magnetic field and radio frequencies to study tissue and structure of the body. This procedure enables the visualization of biochemical activity of the cell in vivo without the use of ionizing radiation, radioisotopic substances or high-frequency sound.
    f. **Intraoperative magnetic resonance imaging.** An integrated surgery system which provides an MRI system in an operating room. The system allows for immediate evaluation of the degree to tumor resection while the patient is undergoing a surgical resection. Intraoperative MRI exists when an MRI (low-field or high-field) is placed in the operating theater and is used during surgical resection without moving the patient from the operating room to the diagnostic imaging suite.
    g. **Magnetoencephalography (MEG).** A noninvasive neurophysiological measurement tool used to study magnetic fields generated by neuronal activity of the brain. MEG provides direct information about the dynamics of evoked and spontaneous neural activity and its location in the brain. The primary uses of MEG include assisting surgeons in localizing the source of epilepsy, sensory mapping, and the study of brain function. When it is combined with structural imaging, it is known as magnetic source imaging (MSI).
    h. **Multi-slice spiral computed tomography (<64 slice CT).** A specialized computed tomography procedure that provides three-dimensional processing and allows narrower and multiple slices with increased spatial resolution and faster scanning times as compared to a regular computed tomography scan.
    i. **Multi-slice spiral computed tomography (64+ slice CT).** Involves the acquisition of volumetric tomographic x-ray absorption data expressed in Hounsfield units using multiple rows of detectors. 64+ systems reconstruct the equivalent of 64 or more slices to cover the imaged volume.
    j. **Positron emission tomography (PET).** A nuclear medicine imaging technology which uses radioactive (positron emitting) isotopes created in a cyclotron or generator and computers to produce composite pictures of the brain and heart at work. PET scanning produces sectional images depicting metabolic activity or blood flow rather than anatomy.
    k. **Positron emission tomography/CT (PET/CT).** Provides metabolic functional information for the monitoring of chemotherapy, radiotherapy and surgical planning.
    l. **Single photon emission computerized tomography (SPECT).** A nuclear medicine imaging technology that combines existing technology of gamma camera imaging with computed tomographic imaging technology to provide a clearer and more precise image.
    m. **Ultrasound.** The use of acoustic waves above the range of 20,000 cycles per second to visualize internal body structures.
44. **Radiology, therapeutic.** The branch of medicine concerned with radioactive substances and using various techniques of visualization, with the diagnosis and treatment of disease using any of the various sources of radiant energy. Services could include: megavoltage radiation therapy; radioactive implants; stereotactic radiosurgery; therapeutic radioisotope facility; X-ray radiation therapy.
    a. **Image-guided radiation therapy (IGRT).** Automated system for image-guided radiation therapy that enables clinicians to obtain high-resolution x- ray images to pinpoint tumor sites, adjust patient positioning when necessary, and complete a treatment, all within the standard treatment time slot, allowing for more effective cancer treatments.
    b. **Intensity-modulated radiation therapy (IMRT).** A type of three-dimensional radiation therapy which improves treatment delivery by targeting a tumor in a way that is likely to decrease damage to normal tissues and allows for varying intensities.
    c. **Stereotactic radiosurgery.** A radiotherapy modality that delivers a high dosage of radiation to a discrete treatment area in as few as one treatment session. Includes Gamma Knife, Cyberknife, etc.
    d. **Proton beam therapy.** A form of radiation therapy which administers proton beams. While producing the same biologic effects as x-ray beams, the energy distribution of protons differs from conventional x-ray beams: proton beams can be more precisely focused ion tissue volumes in a three-dimensional pattern, resulting in less surrounding tissue damage than conventional radiation therapy, permitting administration of higher doses.
    e. **Shaped beam radiation system.** A precise, noninvasive treatment that involves targeted beams of radiation that mirror the exact size and shape of a tumor at a specific area to shrink or destroy cancerous cells. This procedure

delivers a therapeutic dose of radiation that conforms precisely to the shape of the tumor, thus minimizing the risk to nearby tissues.

f. **Basic interventional radiology.** A medical sub-specialty of radiology utilizing minimally-invasive image-guided procedures to diagnose and treat diseases in nearly every organ system.

45. **Physical rehabilitation services.** A program providing medical, health-related, therapy, social, and/or vocational services to help people with disabilities attain or retain their maximum functional capacity.
    a. **Assistive technology center.** A program providing access to specialized hardware and software with adaptations allowing individuals greater independence with mobility, dexterity, or increased communication options.
    b. **Electrodiagnostic services.** Diagnostic testing services for nerve and muscle function such as nerve conduction studies and needle electromyography.
    c. **Physical rehabilitation outpatient services.** Outpatient program providing medical, health-related, therapy, social, and/or vocational services to help people with disabilities attain or retain their maximum functional capacity.
    d. **Prosthetic and orthotic services.** Services providing comprehensive prosthetic and orthotic evaluation, fitting, and training.
    e. **Robot-assisted walking therapy.** A form of physical therapy that uses a robotic device to assist patients who are relearning how to walk.
    f. **Simulated rehabilitation environment.** Rehabilitation focused on retraining functional skills in a contextually appropriate environment (simulated home and community settings) or in a traditional setting (gymnasium) using motor learning principles.
46. **Transplant services.** The branch of medicine that transfers an organ or tissue from one person to another or from one body part to another, to replace a diseased structure or to restore function or to change appearance. Services could include: Bone marrow, heart, lung, kidney, intestine, or tissue transplant. Please include heart/lung or other multi-transplant surgeries in 'other.'
    a. **Bone marrow.** A specialized therapy for patients with certain cancers or other diseases. A bone marrow transplant involves taking cells that are normally found in the bone marrow (stem cells), filtering those cells, and giving them back either to the donor (patient) or to another person.
    b. **Heart.** A surgery to remove the diseased heart from a person and replace it with a healthy one from an organ donor.
    c. **Kidney.** A surgery done to replace a diseased or injured kidney with a healthy kidney from a donor. The kidney may come from a deceased organ donor or from a living donor.
    d. **Liver.** A liver transplant is surgery to replace a diseased liver with a healthy liver from another person. A whole liver may be transplanted or just part of one. In most cases the healthy liver will come from an organ donor who has just died.
    e. **Lung.** Surgery done to remove a diseased lung and replace it with a healthy lung from another person. The surgery may be done for one lung or for both.
    f. **Tissue.** A surgical procedure in which tissue or a group of cells are removed from one person (the donor) and transplanted into another person (the recipient) or moved from one site to another in the same person.
    g. **Other.** A transplant surgery that does not fit into the above categories.
47. **Bariatric/weight control services.** The medical practice of weight reduction.
48. **Birthing room/LDR room/LDRP room.** A single-room type of maternity care with a more homelike setting for families than the traditional three-room unit (labor/delivery/recovery) with a separate postpartum area. A birthing room combines labor and delivery in one room. An LDR room accommodates three stages in the birthing process--labor, delivery, and recovery. An LDRP room accommodates all four stages of the birth process--labor, delivery, recovery, and postpartum.
49. **Chiropractic services.** An organized clinical service including spinal manipulation or adjustment and related diagnostic and therapeutic services.
50. **Complementary and alternative medicine services.** Organized hospital services or formal arrangements to providers that provide care or treatment not based solely on traditional western allopathic medical teachings as instructed in most U.S. medical schools. Includes any of the following: acupuncture, chiropractic, homeopathy, osteopathy, diet and lifestyle changes, herbal medicine, massage therapy, etc.
51. **Computer assisted orthopedic surgery (CAOS).** Orthopedic surgery using computer technology, enabling three-dimensional graphic models to visualize a patient's anatomy.
52. **Dental services.** An organized dental service or dentists on staff, not necessarily involving special facilities, providing dental or oral services to inpatients or outpatients.
53. **Endoscopic services.** Services related to the medical procedure that allows a doctor to observe the inside of the body without performing major surgery. An endoscope (fiberscope) is a long flexible tube with a lens at one end and a video camera at the other.
    a. **Optical colonoscopy.** An examination of the interior of the colon using a long, flexible, lighted tube with a small built-in camera.
    b. **Endoscopic ultrasound.** Specially designed endoscope that incorporates an ultrasound transducer used to obtain detailed images of organs in the chest and abdomen. The endoscope can be passed through the mouth or the anus. When combined with needle biopsy the procedure can assist in diagnosis of disease and staging of cancer.
    c. **Ablation of Barrett's esophagus.** Premalignant condition that can lead to adenocarcinoma of the esophagus. The nonsurgical ablation of premalignant tissue in Barrett's esophagus by the application of thermal energy or light through an endoscope passed from the mouth into the esophagus.
    d. **Esophageal impedance study.** A test in which a catheter is placed through the nose into the esophagus to measure whether gas or liquids are passing from the stomach into the esophagus and causing symptoms.

e. **Endoscopic retrograde cholangiopancreatography (ERCP).** A procedure in which a catheter is introduced through an endoscope into the bile ducts and pancreatic ducts. Injection of contrast material permits detailed x-ray of these structures. The procedure is used diagnostically as well as therapeutically to relieve obstruction or remove stones.

54. **Extracorporal shock wave lithotripter (ESWL).** A medical device used for treating stones in the kidney or urethra. The device disintegrates kidney stones noninvasively through the transmission of acoustic shock waves directed at the stones.
55. **Fertility clinic.** A specialized program set in an infertility center that provides counseling and education as well as advanced reproductive techniques such as: injectable therapy, reproductive surgeries, treatment for endometriosis, male factor infertility, tubal reversals, in vitro fertilization (IVF), donor eggs, and other such services to help patients achieve successful pregnancies.
56. **Geriatric services.** The branch of medicine dealing with the physiology of aging and the diagnosis and treatment of disease affecting the aged. Services could include: adult day care; Alzheimer's diagnostic-assessment services; comprehensive geriatric assessment; emergency response system; geriatric acute care unit; and/or geriatric clinics.
57. **Health research.** Organized hospital research program in any of the following areas: basic research, clinical research, community health research, and/or research on innovative health care delivery.
58. **HIV/AIDS services.** Diagnosis, treatment, continuing care planning, and counseling services for HIV/AIDS patients and their families. Could include: HIV/AIDS unit, special unit or designated team, general inpatient care, or specialized outpatient program.
59. **Occupational health services.** Includes services designed to protect the safety of employees from hazards in the work environment.
60. **Patient controlled analgesia (PCA).** Intravenously administered pain medicine under the patient's control. The patient has a button on the end of a cord than can be pushed at will, whenever more pain medicine is desired. This button will only deliver more pain medicine at predetermined intervals, as programmed by the doctor's order.
61. **Primary care department.** Primary care department. A unit or clinic within the hospital that provides primary care services (e.g., general pediatric care, general internal medicine, family practice, gynecology) through hospital-salaried medical and/or nursing staff, focusing on evaluating and diagnosing medical problems and providing medical treatment on an outpatient basis.
62. **Robotic surgery.** The use of mechanical guidance devices to remotely manipulate surgical instrumentation.
63. **Sleep center.** Specially equipped and staffed center for the diagnosis and treatment of sleep disorders.
64. **Sports medicine.** Provision of diagnostic screening, assessment, clinical and rehabilitation services for the prevention and treatment of sports-related injuries.
65. **Stroke care.** A range of services to reduce death and disability through the provision of specialist multidisciplinary care for diagnosis, emergency treatments, normalization of homeostasis, prevention of complications, rehabilitation and secondary prevention.
66. **Swing bed services.** A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. To be eligible a hospital must have a Medicare provider agreement in place, have fewer than 100 beds, be located in a rural area, not have a 24-hour nursing service waiver in effect, have not been terminated from the program in the prior two years, and meet various service conditions.
67. **Women's health center/services.** An area set aside for coordinated education and treatment services specifically for and promoted to women as provided by this special unit. Services may or may not include obstetrics but include a range of services other than OB. (Not related to pregnancy or postpartum care).
68. **Wound management services.** Services for patients with chronic wounds and nonhealing wounds often resulting from diabetes, poor circulation, improper seating and immunocompromising conditions. The goals are to progress chronic wounds through stages of healing, reduce and eliminate infections, increase physical function to minimize complications from current wounds and prevent future chronic wounds. Wound management services are provided on an inpatient or outpatient basis, depending on the intensity of service needed.
69. **Case management.** A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive and continuous services and the coordination of payment and reimbursement for care.
70. **Chaplaincy/pastoral care services.** A service ministering religious activities and providing pastoral counseling to patients, their families, and staff of a health care organization.
71. **Community outreach.** A program that systematically interacts with the community to identify those in need of services, alerting persons and their families to the availability of services, locating needed services, and enabling persons to enter the service delivery system.
72. **Support groups.** A hospital sponsored program that allows a group of individuals with common experiences or issues who meet periodically to share experiences, problems, and solutions in order to support each other.
73. **Social work services.** Could include: organized services that are properly directed and sufficiently staffed by qualified individuals who provide assistance and counseling to patients and their families in dealing with social, emotional, and environmental problems associated with illness or disability, often in the context of financial or discharge planning coordination.
74. **Transportation to health facilities (non-emergency).** A long-term care support service designed to assist the mobility of the elderly. Some programs offer improved financial access by offering reduced rates and barrier-free buses or vans with ramps and lifts to assist the elderly or people with disabilities; others offer subsidies for public transport systems or operate mini-bus services exclusively for use by senior citizens.
75. **Volunteer services department.** An organized hospital department responsible for coordinating the services of volunteers working within the institution.
76. **Volunteer community organization.** Initiatives that engage individuals to offer their time, services, and expertise to assist in various non-medical tasks within a healthcare setting. The primary purpose of these programs is to provide support, comfort, and companionship to patients, families, and staff members.

77. **Enrollment (insurance) assistance services.** A program that provides enrollment assistance for patients who are potentially eligible for public health insurance programs such as Medicaid, State Children's Health Insurance, or local/state indigent care programs. The specific services offered could include explanation of benefits, assist applicants in completing the application and locating all relevant documents, conduct eligibility interviews, and/or forward applications and documentation to state/local social service or health agency.
78. **Employment support services.** Services designed to support individuals with significant disabilities to seek and maintain employment.
79. **Housing Services**
    a. **Assisted living.** A special combination of housing, supportive services, personalized assistance and health care designed to respond to the individual needs of those who need help in activities of daily living and instrumental activities of daily living. Supportive services are available, 24 hours a day, to meet scheduled and unscheduled needs, in a way that promotes maximum independence and dignity for each resident and encourages the involvement of a resident's family, neighbor and friends.
    b. **Retirement housing.** A facility that provides social activities to senior citizens, usually retired persons, who do not require healthcare, but some short-term skilled nursing care may be provided. A retirement center may furnish housing and may also have acute hospital and long-term care facilities, or it may arrange for acute and long-term care through affiliated institutions.
    c. **Supportive housing services.** A hospital program that provides decent, safe, affordable, community-based housing with flexible support services designed to help the individual or family stay housed and live a more productive life in the community.
80. **Linguistic/translation services.** Services provided by the hospital designed to make health care more accessible to non-English speaking patients and their physicians.
81. **Meal delivery services.** A hospital sponsored program which delivers meals to people, usually the elderly, who are unable to prepare their own meals. Low cost, nutritional meals are delivered to individuals' homes on a regular basis.
82. **Mobile health services.** Vans and other vehicles used for delivery of primary care services.
83. **Patient education center.** Written goals and objectives for the patient and/or family related to therapeutic regimens, medical procedures, and self-care.
84. **Patient representative services.** Organized hospital services providing personnel through whom patients and staff can seek solutions to institutional problems affecting the delivery of high quality care and services.
85. **Prenatal and Postpartum services.** Pregnancy care consists of prenatal (before birth) and postpartum (after birth) healthcare for expectant mothers. It involves treatments and trainings to ensure a healthy pre-pregnancy, pregnancy, labor and delivery.
86. **Teen outreach services.** A program focusing on the teenager which encourages an improved health status and a healthful lifestyle including physical, emotional, mental, social, spiritual and economic health through education, exercise, nutrition and health promotion.

F. Emergency services. Health services that are provided after the onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in placing the patient's health in serious jeopardy.

87. **On-campus emergency department.** Hospital facilities for the provision of unscheduled outpatient services to patients whose conditions require immediate care.
88. **Off-campus emergency department.** A facility owned and operated by the hospital but physically separate from the hospital for the provision of unscheduled outpatient services to patients whose conditions require immediate care. A freestanding ED is not physically connected to a hospital but has all the necessary emergency staffing and equipment on site.
89. **Pediatric emergency department.** A recognized hospital emergency department capable of identifying those pediatric patients who are critically ill or injured, stabilizing pediatric patients, including the management of airway, breathing and circulation and providing an appropriate transfer to a definitive care facility.
90. **Trauma center.** A facility to provide emergency and specialized intensive care to critically ill and injured patients. For the facility to be provided by the hospital, it must be located in your hospital. In addition, the utilization, expense, and revenue from the provision of trauma services must be reported in Sections E and F of the survey.
    For the service owned or provided by the hospital, please specify the trauma center level:
    Level I: A regional resource trauma center, which is capable of providing total care for every aspect of injury and plays a leadership role in trauma research and education.
    Level II: A community trauma center, which is capable of providing trauma care to all but the most severely injured patients who require highly specialized care.
    Level III: A rural trauma hospital, which is capable of providing care to a large number of injury victims and can resuscitate and stabilize more severely injured patients so that they can be transported to level 1 or 2 facilities.
    Level IV: A Level 4 Trauma Center has demonstrated an ability to provide advanced trauma life support (ATLS) prior to transfer of patients to a higher-level trauma center. It provides evaluation, stabilization, and diagnostic capabilities for injured patients.
    Level V: A Level 5 Trauma Center provides initial evaluation, stabilization and diagnostic capabilities and prepares patients for transfer to higher levels of care.

    a. **Does your hospital own the trauma certification?** The American College of Surgeons (ACS) provides verification of trauma centers. It verifies that the facility has the resources available for the trauma patient. The ACS will evaluate a facility's preparedness, resources, policies, and quality improvement process. Verification by the ACS is valid for three years.

91. **Urgent care center.** A facility that provides care and treatment for problems that are not life threatening but require attention over the short term.
92. **Alzheimer center.** Facility that offers care to persons with Alzheimer's disease and their families through an integrated program of clinical services, research, and education.
93. **Arthritis treatment center.** Specifically equipped and staffed center for the diagnosis and treatment of arthritis and other joint disorders.
94. **Blood donor center.** A facility that performs, or is responsible for the collection, processing, testing or distribution of blood and components.
95. **Breast cancer screening/mammograms.** Mammography screening - The use of breast x-ray to detect unsuspected breast cancer in asymptomatic women. Diagnostic mammography - The x-ray imaging of breast tissue in symptomatic women who are considered to have a substantial likelihood of having breast cancer already.
96. **Diabetes prevention program.** Program to prevent or delay the onset of type 2 diabetes by offering evidence-based lifestyle changes based on research studies, which showed modest behavior changes helped individuals with prediabetes reduce their risk of developing type 2 diabetes.
97. **Fitness center.** Provides exercise, testing, or evaluation programs and fitness activities to the community and hospital employees.
98. **Community health education.** Education that provides health information to individuals and populations as well as support for personal, family and community health decisions with the objective of improving health status.
99. **Genetic testing/counseling.** Services equipped with adequate laboratory facilities and directed by a qualified physician to advise patients on potential genetic diagnosis of vulnerabilities to inherited diseases. A genetic test is the analysis of human DNA, RNA, chromosomes, proteins, and certain metabolites in order to detect heritable disease-related genotypes, mutations, phenotypes, or karyotypes for clinical purposes. Genetic tests can have diverse purposes, including the diagnosis of genetic diseases in newborns, children, and adults; the identification of future health risks; the prediction of drug responses; and the assessment of risks to future children.
100. **Health screening.** A preliminary procedure such as a test or examination to detect the most characteristic sign or signs of a disorder that may require further investigation.
101. **Tobacco treatment/cessation program.** Organized hospital services with the purpose of ending tobacco-use habits of patients addicted to tobacco/nicotine.
102. **Children's wellness program.** A program that encourages improved health status and a healthful lifestyle of children through health education, exercise, nutrition, and health promotion.
103. **Early intervention treatment (formerly crisis prevention).** Services provided in order to promote physical and mental wellbeing and the early identification of disease and ill health prior to the onset and recognition of symptoms so as to permit early treatment.
104. **Immunization program.** Program that plans, coordinates and conducts immunization services in the community.
105. **Nutrition programs.** Services within a health care facility which are designed to provide inexpensive, nutritionally sound meals to patients.
106. **Violence prevention programs**
    a. **Workplace.** A violence prevention program with goals and objectives for preventing workplace violence against staff and patients.
    b. **Community.** A program that targets the underlying circumstances that contribute to violence such as poor housing, insufficient job training, and/or substance abuse through means such direct involvement and support, education, mentoring, anger management, crisis intervention and training programs would also qualify. For example, it can assist victims of violent crimes, to hospital or to community services to prevent further victimization or retaliation.

H. **Telehealth Services.** A broad variety of technologies and tactics to deliver virtual medical, public health, health education delivery and support services using telecommunications technologies. Telehealth is used more commonly as it describes the wide range of diagnosis and management, education, and other related fields of health care. This includes, but are not limited to: dentistry, counseling, physical and occupational therapy, home health, chronic disease monitoring and management, disaster management and consumer and professional education.

107. **Consultation and office visits.** Telehealth visits are synchronous visits between a patient and provider that are co-located through the use of two-way, interactive, real-time audio and/or video communication.
108. **eICU.** An electronic intensive care unit (eICU), also referred to as a tele-ICU, is a form of telemedicine that uses state of the art technology to provide an additional layer of critical care service. The goal of an eICU is to optimize clinical experience and facilitate 24-hour a day care by ICU caregivers.
109. **Telehealth stroke care.** Stroke telemedicine is a consultative modality that facilitates the care of patients with acute stroke by specialists at stroke centers.
110. **Psychiatric treatment.** Telepsychiatry is the use of telehealth visits to supplement a range of services including psychiatric evaluations, therapy, patient education, and medication management.
111. **Substance use disorder treatment.** Telehealth helps individuals with a substance use disorder access different types of health care professionals, including: primary care providers, addiction specialist, psychiatrists.
112. **Remote patient monitoring.** The use of digital technologies to collect medical and other forms of health data from individuals in one location and electronically transmit the information securely to health care providers in a different location for assessment and recommendation.
    a. **Post-discharge.** Utilizing telehealth visits to evaluate a patient's post-discharge experience after hospital treatment.
    b. **Ongoing chronic care management.** Non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.

c. **Other remote patient monitoring.** Remote patient monitoring that does not fit into the above categories.

113. **Other telehealth.** Telehealth services that do not fit into the above categories.

114. **Virtual colonoscopy.** Noninvasive screening procedure used to visualize, analyze and detect cancerous or potentially cancerous polyps in the colon.

115. **Psychiatric services.** Services provided by the hospital that offer immediate initial evaluation and treatment to patients with mental or emotional disorders.
   a. **Psychiatric consultation/liaison services.** Provides organized psychiatric consultation/liaison services to nonpsychiatric hospital staff and/or departments on psychological aspects of medical care that may be generic or specific to individual patients. Consultation-liaison psychiatrists work to help people suffering from a combination of mental and physical illness by consulting with them and liaising with other members of their care team.
   b. **Psychiatric pediatric services.** The branch of medicine focused on the diagnosis, treatment and prevention of mental, emotional and behavioral disorders in pediatric patients. Please report the number of staffed beds. The beds reported here should be included in the staffed bed count for 14. Inpatient Psychiatric Care.
   c. **Psychiatric geriatric services.** Provides care to elderly patients with mental or emotional disorders, including those admitted for diagnosis and those admitted for treatment. Please report the number of staffed beds. The beds reported here should be included in the staffed bed count for 14 Inpatient Psychiatric Care.
   d. **Psychiatric education services.** Provides psychiatric educational services to community agencies and workers such as schools, police, courts, public health nurses, welfare agencies, clergy, and so forth. The purpose is to expand the mental health knowledge and competence of personnel not working in the mental health field and to promote good mental health through improved understanding, attitudes, and behavioral patterns.
   e. **Psychiatric emergency services.** Services of facilities available on a 24-hour basis to provide immediate unscheduled outpatient care, diagnosis, evaluation, crisis intervention, and assistance to persons suffering acute emotional or mental distress.
   f. **Psychiatric outpatient services.** Provides psychiatric services beyond what are offered in intensive outpatient programs or partial hospitalizations.
   g. **Psychiatric intensive outpatient services.** A prescribed course of treatment in which the patient receives outpatient care no less than three times a week (which might include more than one service/day).
   h. **Social and community psychiatric services.** Social psychiatry deals with social factors associated with psychiatric morbidity, social effects of mental illness, psycho-social disorders and social approaches to psychiatric care. Community psychiatry focuses on detection, prevention, early treatment and rehabilitation of emotional and behavioral disorders as they develop in a community.
   i. **Forensic psychiatric services.** A medical subspecialty that includes research and clinical practice in many areas in which psychiatric is applied to legal issues.
   j. **Prenatal and postpartum psychiatric and/or substance use disorder services.** Psychiatric and/or substance use disorder care for prenatal and postpartum patients.
   k. **Psychiatric partial hospitalization services – adult.** Organized hospital services providing intensive day/evening outpatient services of three hours or more in duration, distinguished from other outpatient visits of one hour.
   l. **Psychiatric partial hospitalization services – pediatric.** A structured, intensive mental health care program for children and adolescents with severe mental health or substance use disorders. PHP mental health providers offer a range of services, such as individual therapy, skill development, and medication management, all in one location.
   m. **Psychiatric residential treatment – adult.** Overnight psychiatric care in conjunction with an intensive treatment program in a setting other than a hospital.
   n. **Psychiatric residential treatment – pediatric.** A residential treatment program is a 24 hour-a-day, year-round program that provides intensive help for children or youth with serious emotional, behavioral, or mental health needs. Residential treatment centers (RTCs) are usually located in the community and offer various on-site treatment services such as diagnostic evaluation, development of an individual treatment plan, and individual and group therapy.
   o. **Suicide prevention services.** A collection of efforts to reduce the risk of suicide. These efforts may occur at the individual, relationship, community and society levels.

116. **Substance use disorder services**
   a. **Substance use disorder pediatric services.** Provides diagnostic and therapeutic services to pediatric patients with alcoholism or other drug dependencies. Includes care for inpatient/residential treatment for patients whose course of treatment involves more intensive care that provided in an outpatient setting or where patients require supervised withdrawal. Please report staffed beds. The beds reported here should be included in the staffed bed count for 13. Inpatient Substance use Disorder Care.
   b. **Substance use disorder outpatient services.** Organized hospital services that provide medical care and/or rehabilitative treatment services to outpatients for whom the primary diagnosis is alcoholism or other chemical dependency.
   c. **Substance use disorder partial hospitalization services.** Organized hospital services providing intensive day/evening outpatient services of three hours or more in duration, distinguished from other outpatient visits of one hour.
   d. **Medication assisted treatment for opioid-use disorder.** Medication assisted treatment (MAT) for opioid-use is the use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of opioid-use disorders.
   e. **Medication assisted treatment for other substance use disorders.** Medication assisted treatment (MAT) is the

use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders.

117. **Integration.** Integration means routinely coupling medical services with behavioral health services and could range from co-located physical and behavioral health providers, with some screening and treatment planning, to fully integrated care where behavioral and physical health providers function as a true team in a shared practice.

- **a.** **Emergency services.** Health services that are provided after the onset of a medical condition that manifests itself by symptoms of sufficient severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a prudent layperson, who possesses an average knowledge of health and medicine, to result in placing the patient's health in serious jeopardy.
- **b.** **Primary care services.** Health services that cover a range of prevention, wellness, and treatment for common illnesses. Primary care providers include doctors, nurses, nurse practitioners, and physician assistants. They often maintain long-term relationships with patients and advise and treat a range of health-related issues.
- **c.** **Acute inpatient care.** Provides specialized acute hospital care to medically complex patients who are critically ill, have multisystem complications and/or failure, and require hospitalization.
- **d.** **Extended care.** Provides specialized acute hospital care to medically complex patients who are critically ill, have multisystem complications and/or failure, and require hospitalization averaging 25 days. Extended care can be offered in a hospital or extended care facility.

118. **Psychiatric consultation & liaison services.** Provides organized psychiatric consultation/liaison services to nonpsychiatric hospital staff and/or departments on psychological aspects of medical care that may be generic or specific to individual patients. Consultation-liaison psychiatrists work to help people suffering from a combination of mental and physical illness by consulting with them and liaising with other members of their care team.

119. **Addiction/substance use disorder consultation & liaison services.** Provides organized consultation/liaison services to nonpsychiatric hospital staff and/or departments to reduce the mortality and morbidity associated with substance use disorders by improving access to evidence-based addiction treatment while in a hospital. This could include risk assessment and diagnostic testing and providing different treatment resources.

120. **Psychiatric disorders.** A broad range of mental illnesses that significantly disturb thinking, moods, and behavior that cause significant dysfunction in one's life.

121. **Substance use disorders.** A range of medical illnesses characterized by clinically significant impairments in health, social function, and voluntary control over use of substances such as alcohol, prescription and non-prescription drugs.

122. **Physician Arrangements.** Physician arrangements are agreements between physicians and other entities, such as hospitals or insurers, that involve the exchange of money or services. These arrangements can include compensation, referrals, or the outsourcing of medical services.

- **a.** **Practice organization**
  1. **Employed model or group owned/operated by the hospital/health system.** Physicians are directly employed by the hospital/health system or by a separate medical practice/group entity that is ultimately part of the hospital/health system governance structure, receiving a salary and benefits.
  2. **Foundation model.** Physicians are employed by a foundation associated with your hospital, providing a mix of autonomy and organizational support.
  3. **Independent Practice Association (IPA).** Physicians are part of a network that negotiates contracts collectively while maintaining their independence.
  4. **Independent group owned/operated by its partners.** Physicians work together under a single administrative entity that is owned by the group's partners separate from the hospital/health system.
  5. **Independent group owned/operated by a third party.** Physicians work together under a single administrative entity that is owned by a third party separate from the hospital/health system.
  6. **Independent solo practice.** Physicians operate independently without being part of a larger group or network.
  7. **Other.** Physicians whose practices are organized in a manner that does not fit into the above categories. Please specify.
- **b.** **Relationship with hospital**
  1. **Employed.** Physicians are directly employed by the hospital/health system and are members of the hospital medical staff.
  2. **Contract group.** Physicians provide services under contractual agreements with your hospital but are not directly employed.
  3. **Privileges only.** Physicians have privileges to serve on the hospital's medical staff without being employed or contracted to do so.
  4. **Other.** Physicians whose relationships with the hospital/health system do not fit into the above categories. Please specify.
- **c.** **Physician specialty arrangement**
  1. **Single specialty.** Physician groups are composed of members who practice within the same specialty.
  2. **Multispecialty.** Physician groups include members from multiple specialties, allowing for comprehensive care.
  3. **Other.** Physician groups that do not fit into the above categories. Please specify.
- **d.** **Of the physician practices owned by the hospital, what percentage are primary care?**
- **e.** **Of the physician practices owned by the hospital, what percentage are specialty care?**

123. Joint ventures

a. Joint venture arrangement. A joint venture is a commercial enterprise formed by two or more separate entities that combine their resources to achieve a common purpose. In healthcare, hospitals will partner with other hospitals or insurance companies to enhance the ability to collaborate with other partners to gain expert expertise without increased payroll. Joint venture models are based on shared financial responsibility.

b. Types of services involved in joint ventures

1. **Limited-service hospital.** A hospital that provides a limited number of services – often rural hospitals.
2. **Ambulatory surgical centers.** Facility that provides care to patients requiring surgery that are admitted and discharged on the same day. Ambulatory surgery centers are distinct from same day surgical units within the hospital outpatient departments for purposes of Medicare payment.
3. **Imaging centers.** An imaging center is a healthcare facility that provides imaging services. Procedures that imaging centers perform include MRIs, X-Rays, CT scans, PET CT/MRI, fluoroscopy, interventional radiology, radiation oncology, angiography, dual energy x-ray absorptiometry (DEXA), mammography or CyberKnife/Gamma Knife services.
4. **Other.** Types of services involved in joint ventures that do not fit into the above categories. Please specify.

c. Limited-service types

1. **Cardiac.** An organized range of clinical services offering diagnostic and interventional procedures to manage the full range of adult heart conditions.
2. **Orthopedic.** A range of services that aim at the treatment of the musculoskeletal system. This includes bones, joints, ligaments, tendons, and muscles.
3. **Surgical.** A range of services related to surgical treatments. These include the use of operation room and recovery room, operative and cutting-procedures, treatment of fractures and dislocations, surgical dressings, and other medically necessary services.
4. **Other.** Types of services provided by a limited-service hospital that do not fit into the above categories. Please specify.

d. Does your hospital participate in joint venture arrangements with organizations other than physician groups?

124.

a. Community Mental Health Center. According to the American Psychological Association, a community mental health center is a facility or facilities that are community-based and provide mental health services, sometimes as an alternative to the care that mental hospitals provide. SAMHSA reported that, as of 2019, approximately 2,700 community mental health centers were in operation. They are supported by sources such as county and state funding programs, federal funding through programs such as Medicaid and Medicare, private insurance and cash payments. The centers treat both children and adults, including individuals who are chronically mentally ill or have been discharged from an inpatient mental health facility.

b. Certified Community Behavioral Health Clinics (CCBHCs). These entities, a new provider type in Medicaid, are designed to provide a comprehensive range of mental health and substance use disorder services to vulnerable individuals. In return, CCBHCs receive an enhanced Medicaid reimbursement rate based on their anticipated costs of expanding services to meet the needs of these complex populations. CCBHCs are non-profit organizations or units of a local government behavioral health authority. They must directly provide (or contract with partner organizations to provide) nine types of services, with an emphasis on the provision of 24-hour crisis care, evidence-based practices, care coordination with local primary care and hospital partners, and integration with physical health care.

SECTION D
INSURANCE AND ALTERNATIVE PAYMENT MODELS
Instructions and Definitions

1. **Health plan.** An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or other arrangement under which health services for individuals are provided or the expenses of such services are paid.
2. **Joint venture.** A joint venture is a commercial enterprise formed by two or more separate entities that combine their resources to achieve a common purpose. In healthcare, hospitals will partner with other hospitals or insurance companies to enhance the ability to collaborate with other partners to gain expert expertise without increased payroll. Joint venture models are based on shared financial responsibility.
3. **If yes to 1 and/or 2 above, please indicate the insurance product(s). (Check all that apply).**
   a. **Medicare advantage.** Health Insurance program within Part C of Medicare. Medicare Advantage plans provide a managed health care plan (typically a health maintenance organization (HMO) but also often a preferred provider organization (PPO) or another type of managed care arrangement) that is paid based on a monthly capitated fee. This Part C of Medicare provides beneficiaries an alternative to "Original Medicare" Parts A and B Medicare, which provides insurance for the same medical services but pays providers a fee for service (FFS) directly rather than through managed care plans.
   b. **Medicaid managed care.** Services in through an arrangement between a state Medicaid agency and managed care organizations (MCOs) that accept a set payment – "capitation" – for these services.
   c. **Health insurance marketplace ("exchange").** Also called health exchanges, are organizations set up to facilitate the purchase of health insurance in each state in accordance with Patient Protection and Affordable Care Act.

   d. Marketplaces provide a set of government-regulated and standardized health care plans from which individuals may purchase health insurance policies eligible for federal subsidies.
   e. **Small group.** A group health plan that covers employees of an employer that has less than 50 employees.
   f. **Large group.** A group health plan that covers employees of an employer that has 51 or more employees.
   g. **Other.** Health insurance coverage offered to individuals other than in connection with a group health plan.

4. **Health plan.** An insurance policy or contract, medical or hospital service agreement, membership or subscription contract, or other arrangement under which health services for individuals are provided or the expenses of such services are paid.

   Capitated payments. An at-risk payment arrangement in which an organization receives a fixed prearranged payment and in turn guarantees to deliver or arrange all medically necessary care required by enrollees in the capitated plan. The fixed amount is specified within contractual agreements between the payer and the involved organization. The fixed payment amount is based on an actuarial assessment of the services required by enrollees and the costs of providing these services, recognizing enrollees' adjustment factors such as age, sex, and family size.
   a. **In-network.** In network refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.
   b. **Out-of-network.** Physicians, hospitals or other healthcare providers who do not participate in a health plan's provider network. This means that the provider has not signed a contract agreeing to accept the insurer's negotiated prices.

5. **Bundled payments.** Bundling is a payment mechanism whereby a provider entity (primary or specialty) receives a single payment for services provided across one or parts of the care continuum. For example, an entity might receive a single payment for the hospital and physician services provided as part of an inpatient stay or might receive a single payment for the post-acute care services involved in a single episode of care. The entity then has responsibility for compensating each of the individual providers involved in the episode of care.
   a. **In-network.** In network refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.
   b. **Out-of-network.** Physicians, hospitals or other healthcare providers who do not participate in a health plan's provider network. This means that the provider has not signed a contract agreeing to accept the insurer's negotiated prices.

6. **Shared-risk contracts.** A payment arrangement in which a hospital and a managed care organization share the risk of adverse claims experience. Methods for sharing risk could include: capitation with partial refunds or supplements if billed hospital charges or costs differ from capitated payments, and service or discharge-based payments with withholds and bonus payouts that depend on expenditure targets.
   a. **In-network.** In network refers to providers or health care facilities that are part of a health plan's network of providers with which it has negotiated a discount.
   b. **Out-of-network.** Physicians, hospitals or other healthcare providers who do not participate in a health plan's provider network. This means that the provider has not signed a contract agreeing to accept the insurer's negotiated prices.

7. **Does your hospital or health system fund the health benefits for your employees?**

8. **Capitated payments.** An at-risk payment arrangement in which an organization receives a fixed prearranged payment and in turn guarantees to deliver or arrange all medically necessary care required by enrollees in the capitated plan. The fixed amount is specified within contractual agreements between the payer and the involved organization. The fixed payment amount is based on an actuarial assessment of the services required by enrollees and the costs of providing these services, recognizing enrollees' adjustment factors such as age, sex, and family size.

9. **Bundled Payments.** Bundling is a payment mechanism whereby a provider entity (primary or specialty) receives a single payment for services provided across one or parts of the care continuum. For example, an entity might receive a single payment for the hospital and physician services provided as part of an inpatient stay or might receive a single payment for the post-acute care services involved in a single episode of care. The entity then has responsibility for compensating each of the individual providers involved in the episode of care.
   a. **If yes, for which of the following payers and medical/surgical conditions does your hospital have a bundled payment arrangement? (Check all that apply).**
      1. **Cardiovascular.** Relating to the heart and blood vessels**.**
      2. **Orthopedic.** The branch of medicine dealing with the correction of deformities of bones or muscles.
      3. **Oncologic.** The medical specialty that focuses on cancer, including its diagnosis, treatment, prevention, and study.
      4. **Neurology.** The branch of medicine that deals with the diagnosis and treatment of disorders of the nervous system.
      5. **Hematology.** The study of blood and blood disorders.
      6. **Gastrointestinal.** The branch of medicine that deals with the stomach and the intestines.
      7. **Pulmonary.** The branch of medicine that deals with the lungs.
      8. **Infectious disease.** The branch of medicine that deals with diagnosing and treating illnesses caused by bacteria, viruses, fungi, or parasites.
      9. **Hospitalist.** Physicians whose primary professional focus is the care of hospitalized medical patients (through clinical, education, administrative and research activity).
      10. **Nephrology.** The branch of medicine that deals with the physiology and diseases of the kidneys.
      11. **Obstetrics.** The branch of medicine and surgery concerned with childbirth and the care of women giving birth.
      12. **Endocrinology.** The branch of medicine concerned with endocrine glands and hormones.

13. **Psychiatric disorders.** Mental illnesses that involve a behavioral, emotional, or cognitive dysfunction that causes significant distress or impairment.
14. **Substance use disorders.** Medical illnesses characterized by clinically significant impairments in health, social function, and voluntary control over use of substances such as alcohol, prescription and non-prescription drugs.
15. **Other.** Medical/Surgical conditions that do not fit into the above categories.

10. a. Upside/Downside risk. Upside risk refers to the uncertain upward potential for a financial instrument, market, sector, or economy. Upside risk is positive, which means it can work to an investor or company's favor. It is the opposite of downside risk, which allows observers to determine how much they may lose.

10. Shared risk. A payment arrangement in which a hospital and a managed care organization share the risk of adverse claims experience. Methods for sharing risk could include capitation with partial refunds or supplements if billed hospital charges or costs differ from capitated payments, and service or discharge-based payments with withholds and bonus payouts that depend on expenditure targets.

11. Coalition of employers. A group of businesses that work together to improve healthcare, reduce costs, or advocate for policy change.

12. Commercial payers. Private insurance companies that provide health insurance plans. They are also known as commercial health insurance providers.

14.a. Accountable care organization (ACO). An ACO contract has two essential elements: (1) accountability for the total costs of care for the population of patients attributed to the primary care physicians in the organization; (2) financial incentives that link the magnitude of bonus payments to performance on quality measures (which could include technical quality, patient experience and/or health outcome measures). This will generally involve a contract where the payer establishes a target budget for one or more years for the total costs of care for the agreed-upon patient population, the payer tracks actual spending and performance on quality; and the provider receives bonus payments that could include a share of savings that are (or are not) contingent on meeting quality targets, with (or without) additional bonuses related to performance on those quality measures.

b.

1. **Medicare shared savings program.** For fee-for-service beneficiaries. The Shared Savings Program has different tracks that allow ACOs to select an arrangement that makes the most sense for their organization.
   Next generation. An ACO Model that is an initiative for ACOs that are experienced in coordinating care for populations of patients. It allows these provider groups to assume higher levels of financial risk and reward.
2. **Medicare advantage.** Health Insurance program within Part C of Medicare. Medicare Advantage plans provide a managed health care plan (typically a health maintenance organization (HMO) but also often a preferred provider organization (PPO) or another type of managed care arrangement) that is paid based on a monthly capitated fee. This part of Medicare provides beneficiaries an alternative to "Original Medicare" Parts A and B Medicare, which provides insurance for the same medical services but pays providers a fee for service (FFS) directly rather than through managed care plans.
3. **Commercial insurance plan.** Private insurance companies that provide health insurance plans. They are also known as commercial health insurance providers.
4. **Medicaid.** A public health insurance program for some people or families with limited incomes and resources, including children, pregnant women, older adults, and people with disabilities. People who receive Medicaid have most or all of their health care services paid for by U.S. federal, state, and local governments.

c. Medicare shared savings program tracks. ACOs may participate in the MSSP for agreement periods of at least five years, under one of two tracks: the BASIC track (which includes a glide path for eligible ACOs), or the ENHANCED track, which offers the highest level of risk and potential reward. ACOs participating in the BASIC track's glide path may begin under a one-sided model and progress through incremental levels of increasing risk and potential reward. Within the BASIC track there are 5 levels (A through E) with increasing levels of risk. Generally, ACOs in the BASIC track must move up one level each year until they reach the highest level of risk (Level E).

5. **Original MSSP program.** The Medicare Shared Savings Program (MSSP) is a voluntary payment model that encourages healthcare providers to work together to improve the quality of care for Medicare beneficiaries.
6. **Comprehensive end-stage renal disease (ESRD) care.** The model is designed to identify, test, and evaluate new ways to improve care for Medicare beneficiaries with end-stage renal disease (ESRD.)

d. Accountable care contracts. An ACO contract has two essential elements: (1) accountability for the total costs of care for the population of patients attributed to the primary care physicians in the organization; (2) financial incentives that link the magnitude of bonus payments to performance on quality measures (which could include technical quality, patient experience and/or health outcome measures). This will generally involve a contract where the payer establishes a target budget for one or more years for the total costs of care for the agreed-upon patient population, the payer tracks actual spending and performance on quality; and the provider receives bonus payments that could include a share of savings that are (or are not) contingent on meeting quality targets, with (or without) additional bonuses related to performance on those quality measures.

15. Medical home program. The medical home concept refers to the provision of comprehensive primary care services that facilitates communication and shared decision-making between the patient, his/her primary care providers, other providers, and the patient's family.

SECTION E
TOTAL FACILITY BEDS AND UTILIZATION
Instructions and Definitions

Please report beds and utilization data for the 12-month period that is consistent with the period reported in Section A. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate.

1. **Nursing Home Unit/Facility.** A unit or facility that provides care for people who don't need to be in a hospital but cannot be cared for at home. The services provided can include medical, health, personal care, and supervision as needed. Patients in these units generally have severe illness, disability, or cognitive impairment (i.e., problems with thinking, learning, or memory).
    a. **Designated Nursery.** A separate unit outside of the birthing parent's Hospital room where newborns are cared for including feeding, changing diapers, monitoring vital signs, and basic medical interventions as needed. This does not include a Neonatal Intensive Care Unit (NICU).
2. Please report beds and utilization data for the reporting period stated in Section A. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate. Please refer to specific definitions in the Glossary under the Print button, and reporting instructions illustrated with an exclamation mark next to each question. Note: $, < > = . symbols are NOT allowed. The values shown in red below are the figures we have on file for you from last year. Please use these as reference as you fill out this year's data.
    a. **Total licensed beds.** Licensed bed capacity. The maximum number of beds authorized by state licensing (certifying) agency.
    b. **Beds set up and staffed.** Reported at the end of the reporting period. Include bed facilities for use by inpatients that have no other bed facilities (e.g., pediatric bassinets, isolation units, quiet rooms, and reception assigned/reserved beds). Exclude newborn bassinets and special procedures beds who have other bed facilities assigned/reserved for them (e.g., labor room, post anesthesia or postoperative recovery, holding, and observation beds).
    c. **Bassinets set up and staffed.** Report the number of normal newborn bassinets. Do not include neonatal intensive care or intermediate care bassinets. These should be reported in Section C Facilities and Services , questions 6 and or 7.
    d. **Births.** Total births should exclude fetal deaths.
    e. **Admissions.** Include the number of adult and pediatric admissions (exclude births). This figure should include all patients admitted during the reporting period, including neonatal and swing admissions.
    f. **Discharges.** Hospital discharge describes the point at which inpatient hospital care ends, with ongoing care transferred to other primary, community or domestic environments.
    g. **Inpatient days.** Report the number of adult and pediatric days of care (i.e., patient day/census day/occupied bed day) between the census-taking hours on two successive calendar days during the reporting period. Include: days of care for infants born in the hospital and cared for in neonatal care unit; swing bed inpatient days. Exclude: days of care normal infants born in the hospital but do include those for the mothers.
    h. **Emergency department visits.** Include all visits to the emergency unit. Emergency outpatients can be admitted to the inpatient areas of the hospital, but they are still counted as emergency visits and subsequently as inpatient admissions.
    i. **Outpatient visits.** Visit by a patient who is not lodged in the hospital while receiving care. Each appearance of an outpatient in each unit constitutes one visit regardless of the number of diagnostic/therapeutic treatments. Include all clinic visits, referred visits, observation services, outpatient surgeries (also reported on line E2l), home health service visits (i.e., visits by home health personnel to a patient's residence), and emergency department visits (also reported on line E2h). Clinic visits should reflect total visits to each specialized medical unit responsible for the diagnosis and treatment on an outpatient, nonemergency basis (i.e., alcoholism, dental, gynecology, etc.). Visits to the satellite clinics and primary group practices should be included if revenue is received by the hospital. Referred visits should reflect total number of outpatient ancillary visits to each specialty unit of the hospital established for providing technical aid used in the diagnosis (i.e., diagnostic radiology, EKG, pharmacy, etc.) and treatment of patients. Observation services are those services furnished on a hospital's premises, including use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Observation services usually do not exceed 24 hours. However, there is no hourly limit on the extent to which they may be used.
    j. **Inpatient surgical operations.** Count each patient undergoing surgery as one surgical operation regardless of the number of surgical procedures that were performed while the patient was in the operating or procedure room.
    k. **Operating rooms.** A unit/room of a hospital or other health care facility in which surgical procedures requiring anesthesia are performed.
    l. **Outpatient surgical operations.** Operations performed on patients who do not remain in the hospital overnight. Include all operations whether performed in the inpatient operating rooms or in procedure rooms located in an outpatient facility. Include an endoscopy only when used as an operative tool and not when used for diagnosis alone. Count each patient undergoing surgery as one surgical operation regardless of the number of surgical procedures that were performed while the patient was in the operating or procedure room.

3. **Utilization by payer.** Please report utilization data for the period reported in Section A Reporting Period. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate. Round to the nearest dollar. Note: $, < > = . symbols are NOT allowed. The values shown in red below are the figures we have on file for you from last year. Please use these as reference as you fill out this year's data.

a.

1. Medicare inpatient discharges. The total amount of discharges where Medicare, including Medicare Managed Care Plan is the source of payment.

2. Managed Care Medicare Discharges. A discharge day where a Medicare Managed Care Plan is the source of payment.

b.

1. Medicare inpatient days. The total amount of inpatient days where Medicare, including Medicare Managed Care Plan, is the source of payment.

2. Managed Care Medicare Inpatient Days. An inpatient day where a Medicare Managed Care Plan is the source of payment.

c.

1. Medicaid inpatient discharges. The total amount of discharges where Medicaid, including Medicaid Managed Care Plan, is the source of payment.

2. Managed Care Medicaid Discharges. A discharge day where a Medicaid Managed Care Plan is the source of payment.

d.

1. Medicaid inpatient days. The total amount of inpatient days where Medicaid, including Medicaid Managed Care Plan, is the source of payment.

2. Managed Care Medicaid Discharges. A discharge day where a Medicaid Managed Care Plan is the source of payment.

e.

1. Self-pay inpatient discharges. The total amount of discharges where no insurance was used and the patient directly paid for the medical services provided.

2. Self-pay inpatient days. The total amount of inpatient days where no insurance was used and the patient directly paid for the medical services provided.

f.

1. Commercial inpatient discharges. The total amount of discharges where commercial insurance plans are the source of payment.

2. Commercial inpatient days. The total amount of inpatient days where commercial insurance plans are the source of payment.

g.

1. Other payer inpatient discharges. The total amount of discharges where the source of payment does not fit into the above categories.

2. Other payer inpatient days. The total amount of inpatient days where the source of payment does not fit into the above categories.

4. **Utilization of Telehealth/Virtual Care.** The definitions used herein represent one approach to understanding telehealth/virtual care. The AHA is aware that different organizations use different definitions for these terms and that Medicare defines them in a more narrow way than they are used in the field. The definitions we chose are meant to balance the statutory and regulatory use of the terms with the way they are understood by providers on the ground.

a. Video visits. Synchronous visits between patient and provider that are not co-located, through the use of two-way, interactive, real-time audio and video communication.

b. Audio visits. Synchronous visits between a patient and a provider that are not co-located, through the use of two-way, interactive, real-time audio-only communication.

c. Remote patient monitoring (RPM). Use of medical devices to collect and transmit physiologic data to providers. Services include medical device set up, patient education, transmission of data, and interpretation and analysis of results.

d. Remote therapeutic monitoring (RTM). Collection and transmission of non-physiologic data to providers. Services include medical device set up, patient education, transmission of data, and interpretation and analysis of results.

e. Other virtual services. All other synchronous or asynchronous interactions between a provider and patient or provider and provider delivered remotely, including messages, eConsults, and virtual check-ins.

f. eVisits. Non-face-to-face patient-initiated communications through an online patient portal.

g. E-Consults. Synchronous or asynchronous two-way communication between primary care clinicians and specialists.

h. Virtual check-ins. Brief communication technology-based service (including synchronous audio or asynchronous exchange of video or images).

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SECTION F
TOTAL FACILITY FINANCES
Instructions and Definitions

Please report financial data for the 12-month period that is consistent with the period reported in Section A. Report financial data for reporting period only. Include within your operations all activities that are wholly owned by the hospital, including subsidiary corporations regardless of where the activity is physically located. Please do not include within your operations distinct and separate divisions that may be owned by your hospital's parent corporation. If final figures are not available, please estimate. Round to the nearest dollar.

1. Financial

- **a. Net patient revenue.** Reported at the estimated net realizable amounts from patients, third-party payers, and others for services rendered, including estimated retroactive adjustments under reimbursement agreements with third-party payers. Retroactive adjustments are accrued on an estimated basis in the period the related services are rendered and adjusted in future periods, as final settlements are determined.
- **b. Tax appropriations.** A predetermined amount set aside by the government from its taxing authority to support the operation of the hospital.
- **c. Other operating revenue.** Revenue from services other than health care provided to patients, as well as sales and services to nonpatients. Revenue that arises from the normal day-to-day operations from services other than health care provided to patients. Includes sales and services to nonpatients, and revenue from miscellaneous sources (rental of hospital space, sale of cafeteria meals, gift shop sales). Also include operating gains in this category.
- d. **Nonoperating revenue.** Includes investment income, extraordinary gains and other nonoperating gains.
- **e. Total revenue.** (add net patient revenue, tax appropriations, other operating revenue and nonoperating revenue)
- **f. Payroll expenses.** Include payroll for all personnel including medical and dental residents/interns and trainees.
- **g. Employee benefits.** Includes social security, group insurance, retirement benefits, workman's compensation, unemployment insurance, etc.
- **h. Depreciation expense.** Report only the depreciation expense applicable to the reporting period. The amount also should be included in accumulated depreciation (F6b.).
- i. **Interest expense.** Report interest expense for the reporting period only.
- **j. Pharmacy expense.** Includes the cost of drugs and pharmacy supplies requested to patient care departments and drugs charged to patients.
- **k. Supply expense.** The net cost of all tangible items that are expensed including freight, standard distribution cost, and sales and use tax minus rebates. This would exclude labor, labor-related expenses and services as well as some tangible items that are frequently provided as part of labor costs.
- **l. All other expenses.** Any total facility expenses not included in F1f-F1k.
- **m. Total expenses.** Includes all payroll and non-payroll expenses as well as any nonoperating losses (including extraordinary losses). Treat bad debt as a deduction from gross patient revenue and not as an expense.
- **n. Allocation from corporate office.**
- **o. Does your hospital monitor the expenses specifically related to collecting payments from insurers?**
- **p. If yes, what percent of your hospital's revenue was spent on collecting reimbursement from insurers?**

2. Revenue by Type

- **a. Total gross inpatient revenue.** The hospital's full established rates (charges) for all services rendered to inpatients.
- **b. Total gross outpatient revenue.** The hospital's full established rates (charges) for all services rendered to outpatients.
- **c. Total gross patient revenue.** Total gross patient revenue (add total gross inpatient revenue and total gross outpatient revenue).

3. Uncompensated care & provider taxes. Care for which no payment is expected or no charge is made. It is the sum of bad debt and charity care absorbed by a hospital or other health care organization in providing medical care for patients who are uninsured or are unable to pay.

- **a. Bad Debt.** The provision for actual or expected uncollectibles resulting from the extension of credit. Report as a deduction from revenue. For Question 4 (Revenue by payer), if you cannot break out your bad debt by payer, deduct the amount from self-pay.
  - **1. If yes, how much is from patients with insurance?** Report on bad debt rendered from patients who paid for medical services through insurance, including XXX.
- **b. Financial assistance (includes charity).** Health services that were never expected to result in cash inflows. Charity care results from a provider's policy to provide health care services free of charge to individuals who meet certain financial criteria. For purposes of this survey, charity care is measured on the basis of revenue forgone at full established rates.
- **c. Full charge.**
- **d. Medicaid tax/assessment program.** Dollars paid as a result of a state law that authorizes collecting revenue from specified categories of providers. Federal matching funds may be received for the revenue collected from providers and some or all of the revenues may be returned directly or indirectly back to providers in the form of a Medicaid payment.
- **e. If yes, please report the total gross amount paid into the program.**
- **f. Due to differing accounting standards, please indicate whether the provider tax/assessment amount is included in:**
  - **1. Total expenses.** Includes all payroll and non-payroll expenses as well as any nonoperating losses (including extraordinary losses). Treat bad debt as a deduction from gross patient revenue and not as an expense.
  - **2. Deductions from net patient revenue.**

4. Revenue by Payer

a. Government

1. Medicare. Should agree with the Medicare utilization reported in questions E3a1-E3b2.

a. Fee for service patient revenue. Include traditional Medicare fee-for-service.

b. Medicare Managed Care Revenue. Revenue rendered from arrangements between a state Medicare agency and the hospital-controlled forms of financing for the delivery of medical services between the hospital and Medicare. Medicare Managed Care. Revenue rendered through an arrangement between a state Medicaid agency.

c. Total. Medicare revenue (add Medicare fee for service patient revenue and Medicare managed care revenue).

2. Medicaid. Should agree with Medicaid utilization reported in questions E3c1-E3d2.

a. Fee for service patient revenue. Fee for service patient revenue. Do not include Medicaid supplemental or state directed payments. Report in 'net' column only.

b. Medicaid managed care. Base payments for services earned through Medicaid managed care organizations (MCOs) that accept a set payment – "capitation" – for these services. Do not include Medicaid supplemental or state directed payments.

c. Medicaid graduate medical education (GME) payments. Payments for the cost of approved graduate medical education (GME) programs, minus associated provider taxes assessments. Report in 'net' column only.

d. Medicaid disproportionate share hospital payments. DSH payments minus associated provider taxes or assessments. Report in 'net' column only.

e. Medicaid state directed payments. Medicaid state directed payments earned as value-based payment arrangements or standard payment rate increases, minus associated provider taxes or assessments. Report in 'net' column only.

f. Other Medicaid Supplemental Payments (not including Medicaid DSH Payments or Medicaid State Directed Payments). Medicaid supplemental payments that do not fit into the above categories and are not Medicaid DSH payments or Medicaid State Directed Payments, minus associated provider taxes or assessments. Report in 'net' column only.

g. Other Medicaid. Any Medicaid payments that are not included in lines 4a2a-h, minus associated provider taxes or assessments. Report in 'net' column only.

h. Total Medicaid. Total Medicaid Revenue (add 4a2a-g).

3. Other Government. Examples of other government - CHIP (Children's health insurance program), and TRICARE (for military and families).

b. Nongovernment.

1. Self-pay. Payments coming directly from patients, rather than insurance.

2. Third-party payers.

a. **Managed Care (nongovernment).** Revenue rendered through prepaid health plan arrangements with providers and third party insurers (including HMO and PPO plans).

b. Other third-party payers. Third-party payers other than Managed Care.

c. Total third-party payers. Total third-party payers (add Managed Care (nongovernment) and other third-party payers)

3. All other nongovernment. Examples of all other non-government - Workers' compensation.

c. Total. Total Revenue (gross should equal F2c and net should equal F1a)

d. If you report Medicaid Supplemental Payments on line 4a(2)f, please break the payment total into inpatient and outpatient care.

e. If you are a government owned facility (control codes 12-16), does your facility participate in the Medicaid intergovernmental transfer or certified public expenditures program?

f. If yes, please report gross and net revenue.

5. Financial Performance – Margin. Please enter as a percentage (%).

a. Total Margin. Total income over total revenue. Nonoperating income is included in revenue in the total margin.

b. Operating Margin. Measure of profit per dollar of revenue calculated by dividing net operating income by operating revenues.

c. EBITDA Margin. Earnings before interest, tax depreciation and amortization (EBITDA) divided by total revenue.

d. Medicare Margin. (Medicare revenue-Medicare expenses)/Medicare revenue. Medicare revenue = Patient revenue received from the Medicare program including traditional Medicare, Medicare Advantage, and any ACO, Bundled Payment, or other pilot program (net of disallowances). Medicare expenses = Cost of patient care for Medicare beneficiaries in traditional Medicare, Medicare Advantage and any ACO, Bundled Payment, or other pilot program. If actual costs cannot be obtained, use cost-to-charge ratios to estimate based on Medicare charges.

e. Medicaid Margin. (Medicaid revenue-Medicaid expenses)/Medicaid revenue. Medicaid revenue = Patient revenue received from the Medicaid program including traditional Medicaid, Medicaid Managed Care, and any ACO, Bundled Payment, or other pilot program (net of disallowances). Medicaid expenses = Cost of patient care for Medicaid beneficiaries in traditional Medicaid, Medicaid Managed Care and any ACO, Bundled Payment, or other pilot program. If actual costs cannot be obtained, use cost-to-charge ratios to estimate based on Medicaid charges.

6. Fixed Assets. Represent land and physical properties that are consumed or used in the creation of economic activity by the health care entity. The historical or acquisition costs are used in recording fixed assets. Net plant, property, and equipment represent the original costs of these items less accumulated depreciation and amortization.

a. Property, plant, and equipment at cost. Report the total initial purchase amounts for any and all land and physical properties, physical facilities, machinery, and equipment used in services.

b. Accumulated Depreciation. Accounting for the annual reduction of an asset's value up to a single point in its usable life.

c. **Net property, plant, and equipment.** Report the difference of Accumulated depreciation (6b) from Property, plant, and equipment as cost (6a). (6a-6b)

d. **Gross square footage.** Include all inpatient, outpatient, office, and support space used for or in support of your health care activities. Exclude exterior, roof, and garage space in the figure.

7. **Capital expenses.** Expenses used to acquire assets, including buildings, remodeling projects, equipment, or property.

SECTION G
INFORMATION TECHNOLOGY AND CYBERSECURITY
Instructions and Definitions

1. **Information technology and cybersecurity.** If you are part of a larger health system, report the overall system cyber budget and related numbers, unless each hospital in the system has their own independent cyber budget.

a. **Overall IT budget.** The allocated budget for all IT items for the fiscal year (staffing, operations, supplies etc.).

b. **Number of internal IT staff (in FTEs).** Number of full-time equivalent (FTE) staff employed in the IT department/organization and on the payroll.

c. **Cybersecurity.** Measures taken to protect against the criminal or unauthorized use of electronic data.

d. **Number of internal staff devoted to cybersecurity (in FTEs).** FTEs on the organization's payroll devoted to cybersecurity.

e. **Number of outsourced staff devoted to cybersecurity (in FTEs).** i.e., contracted staff FTEs devoted to cybersecurity.

f. **What position does your cybersecurity lead report to?**

g. **Enterprise risk issue.** A potential problem or event that could significantly impact an organization's ability to achieve its strategic objectives. Enterprise risk is about assessing all the risks of the institution, from operational, to information technology to reputational risk on an ongoing basis, establishing an appetite for risk, and making sure conformity to that risk appetite is monitored and pervades the institution.

h. **How often is the board briefed on cybersecurity?**

i. **Cybersecurity threat.**

1. Ransomware. Ransomware attacks, in which hackers disrupt business operations (i.e. scheduling patient care, patient appointments and procedures) and/or encrypt sensitive data until the victim pays a ransom, are the most common cybersecurity threats facing health care providers today. These attacks can cause ambulance diversions, loss of diagnostic technology, and impact the delivery of patient care.

2. Ransomware which may disrupt business operations.

3. Protected health information (PHI). Any information in the medical record or designated record set that can be used to identify an individual and that was created, used, or disclosed in the course of providing a health care service such as diagnosis or treatment

Personally identifiable information (PII). Any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means

4. Intellectual property. A work or invention that is the result of creativity, such as a manuscript or a design, to which one has rights and for which one may apply for a patent, copyright, trademark, etc.

5. Cyber risk exposure through business associates. Business associate as conduit for cyber-attacks or theft of your data stored by third parties.

6. Technology supply chain cyber risk. An attack on the technology or software supply chain is one in which an adversary introduces vulnerabilities into software or technology products which are then delivered to end users where the vulnerability can be exploited on the end-user system. The Solar Winds attack is an example of this type of attack. These attacks cause ambulance diversions and interrupt critical health care delivery, such as radiation oncology. They can also result in a loss of diagnostic technology, driving additional risk to patients and the delivery of care.

7. Supply chain cyber risk/attack. A supply chain cyber-attack is one in which a vulnerability is introduced to a technology product during production or in the delivery process to the end user. Once the end user deploys the product, they are exposed to the vulnerability. These attacks cause ambulance diversions and interrupt critical health care delivery, such as radiation oncology. They can also result in a loss of diagnostic technology, driving additional risk to patients and the delivery of care.

8. Medical device cyber risk. In medical device cybersecurity, the risk is typically associated with an unauthorized person (threat) accessing the device(s) of one or more patients by exploiting a vulnerability (such as a security weakness in the device's software or firmware).

9. Phishing. The fraudulent practice of sending emails or other messages purporting to be from reputable companies in order to induce individuals to reveal personal information, such as passwords and credit card numbers

Malware. Software that is specifically designed to disrupt, damage, or gain unauthorized access to a computer.

10. Social engineering attacks. Social engineering attacks manipulate people into sharing information that they shouldn't share, downloading software that they shouldn't download, visiting websites they shouldn't visit, sending money to criminals or making other mistakes that compromise their personal or organizational security.

j. What do you feel your largest cybersecurity challenges are in defending against threats in 1i?

1. Recruitment and retention of cybersecurity professionals.
2. Funding.
3. Technology.
4. Leadership support.
5. Staff support.
6. Government support (explain in other option below).
7. Lack of cyber threat information sharing.
8. Other.

k. Does your organization use any of the following cybersecurity techniques?

1. Multi-factor-authentication (MFA) for remote access. Most remote access security implementations include multi-factor authentication (MFA), which requires users to verify their identity with one or two additional authentication factors. Users might need to employ a one-time passcode sent via text, a physical USB key, or a facial recognition function.

2. Network segmentation. A network security technique that divides a network into smaller subnetworks to improve security and performance.

3. Network redundancy. The process of providing multiple paths for traffic so that data can keep flowing even in the event of a failure.

4. Immutable backup. A backup copy of your data that cannot be altered, deleted, or changed in any way.

5. Intrusion detection system. An intrusion detection system (IDS) is a network security tool that monitors network traffic and devices for known malicious activity.

6. Cybersecurity education. Cybersecurity awareness training often teaches response procedures for addressing and managing risks to computer systems. Teams can learn how to identify threats like cyber-attacks, data hacks and phishing activities, along with the protocols for assessing the risk level, reporting the incident and fixing the issue.

7. Security operations center (SOC). Usually pronounced "sock" and sometimes called an information security operations center, or ISOC—is an in-house or outsourced team of IT security professionals dedicated to monitoring an organization's entire IT infrastructure 24x7.

8. Patch management. The process of applying firmware and software updates to improve functionality, close security vulnerabilities and optimize performance.

9. Forced password change every 90 days or less.

10. Cyber incident response plan. A written document, formally approved by the senior leadership team, that helps your organization before, during, and after a confirmed or suspected security incident.

11. Cross-functional cyber incident response exercise. A simulated cybersecurity scenario where individuals from different departments within an organization, such as IT, legal, communications, and operations, work together to practice responding to a simulated cyber-attack, allowing them to test their incident response plan and identify areas for improvement by collaborating across various functional roles.

12. FBI. Federal Bureau of Investigation
CISA. Cybersecurity and Infrastructure Security Agency

13. Third party risk management. The practice of evaluating and then mitigating the risks introduced by vendors, suppliers, contractors, or business partners, both before establishing a business relationship and during the business partnership by evaluating their practices and ensuring they meet necessary security and compliance standards to protect the organization's operations, data, and reputation.

l. Manual downtime procedures. A set of predefined steps to minimize disruption and ensure patient safety during a system or network outage.

m. Cybersecurity posture. An organization's overall cybersecurity strength, or how well it can respond to cyber threats.

1. Funding.
2. Staffing.
3. Legacy technology. An older computer system, software application, or technology infrastructure that is still in use but is considered outdated or is no longer actively supported or developed.
4. Leadership support.
5. Organizational culture.
6. Non-compliant third parties/business associates.

2. Artificial Intelligence (AI). Artificial Intelligence (AI) encompasses a broad range of technologies that enable machines to simulate human intelligence and perform tasks that typically require human cognitive abilities. For the purposes of the following survey questions, please consider AI to include any of the technologies below when answering the questions.

Artificial Intelligence (AI). The use of computer systems to perform tasks that typically require human intelligence, such as decision-making, pattern recognition, and learning.
Generative AI (gen-AI). AI systems that generate new content, such as text, images, or data, based on learned patterns.
Machine Learning (ML) A subset of AI where computer systems improve their performance over time through experience (data) without explicit programming.
Robotic Process Automation (RPA) The automation of repetitive tasks using software robots, often in administrative functions.
Natural Language Processing (NLP). A branch of AI focused on enabling machines to understand and respond to human language, applied in areas such as text analysis, medical documentation, and chatbots.
Computer Vision. A branch of AI that enables machines to interpret and make decisions based on visual inputs like medical images, used in diagnostics and imaging.

(1) Not implementing. Your hospital is not currently using AI in this area, and there are no immediate plans to do so.
(2) Exploring. Your hospital is researching or planning how AI could be implemented in this area, but no active deployment or testing is taking place.
(3) Piloting/Testing: Your hospital is running small-scale pilots or tests with AI solutions in this area, often limited to specific departments or teams.
(4) Expanding: Your hospital has successfully piloted AI in this area and is in the process of rolling out the technology more broadly across departments or use cases.
(5) Fully integrated: AI is fully integrated into your hospital's operations for this area, with consistent and widespread usage.
(0) Don't know: You are not familiar with the status of AI implementation in this area at your hospital.

SECTION H
TOTAL FACILITY STAFFING
Instructions and Definitions

Report full-time (35 hours or more) and part-time (less than 35 hours) personnel who were on the hospital/facility **payroll at the end of your reporting period.** Include members of religious orders for whom dollar equivalents were reported. Exclude private-duty nurses, volunteers, and all personnel whose salary is financed entirely by outside research grants. Exclude physicians and dentists who are paid on a fee basis.

- **FTE** is the total number of hours **worked** (excluding non-worked hours such as PTO, etc.) by all employees over the full (12 month) reporting period divided by the normal number of hours worked by a full-time employee for that same time period.
  - For example, if your hospital considers a normal workweek for a full-time employee to be 40 hours, a total of 2,080 would be worked over a full year (52 weeks). If the total number of hours worked by all employees on the payroll is 208,000, then the number of Full-Time Equivalents (FTE) is 100 (employees).
  - The FTE calculation for a specific occupational category should be based on the number of hours worked by staff employed in that specific category.

For each occupational category, please report the number of staff vacancies as of the last day of your reporting period.

A vacancy is defined as a budgeted staff position which is unfilled as of the last day of the reporting period and for which the hospital is actively seeking either a full-time or part-time permanent replacement. Personnel who work in more than one area should be included only in the category of their **primary responsibility and should be counted only once.**

1. **Full-Time Equivalent (FTE)**. The total number of hours worked (excluding all non-worked hours such as PTO, etc.) by all employees over the full 12-month reporting period, divided by the normal number of hours worked by a full-time employee for that same time period. For example, if your hospital considers a normal workweek for a full-time employee to be 40 hours, a total of 2,080 would be worked over a full year (52 weeks). If the total number of hours worked by all employees on the payroll is 208,000, then the number of full-time equivalents (FTE) is 100 (employees). The FTE calculation for a specific occupational category such as registered nurses is exactly the same. The calculation for each occupational category should be based on the number of hours worked by staff employed in that specific category.

Vacancy. A budgeted staff position which is unfilled as of the last day of the reporting period and for which the hospital is actively seeking either a full-time or part-time permanent replacement.

a. **Physicians.** Include only those physicians engaged in clinical practice and on the payroll. Those who hold administrative positions should be reported in all other personnel.
b. **Dentists.** Include only those dentists engaged in clinical practice and on the payroll. Those who hold administrative positions should be reported in all other personnel.
c. **Medical residents/interns.**
d. **Dental residents/interns.**
e. **Other trainees.** A trainee is a person who has not completed the necessary requirements for certification or met the qualifications required for full salary under a related occupational category. Exclude medical and dental residents/interns who should be reported on line 1c-d.
f. **Registered nurses.** Nurses who have graduated from approved schools of nursing and who are currently registered by the state. They are responsible for the nature and quality of all nursing care that patients receive. Do not include any registered nurses more appropriately reported in other occupational categories, such as facility administrators, and therefore listed under all other personnel.
g. **Licensed practical (vocational) nurses.** Nurses who have graduated from an approved school of practical (vocational) nursing who work under the supervision of registered nurses and/or physicians.
h. **Nursing assistive personnel.** Certified nursing assistant or equivalent unlicensed staff who assist registered nurses in providing patient care related services as assigned by and under the supervision of a registered nurse.
i. **Radiology technicians.** Technical positions in imaging fields, including, but not limited to, radiology, sonography, nuclear medicine, radiation therapy, CT, MRI.
j. **Laboratory technicians.** Professional and technical positions in all areas of the laboratory, including, but not limited to, histology, phlebotomy, microbiology, pathology, chemistry, etc.
k. **Pharmacists, licensed.** Persons licensed within the state who are concerned with the preparation and distribution of medicinal products.
l. **Pharmacy technicians.** Persons who assist the pharmacist with selected activities, including medication profile reviews for drug incompatibilities, typing labels and prescription packaging, handling of purchase records and inventory control.
m. **Respiratory Therapists.** Allied health professionals who specialize in scientific knowledge and theory of clinical problems of respiratory care.

Duties include the collection and evaluation of patient data to determine an appropriate care plan, selection and assembly of equipment, conduction of therapeutic procedures, and modification of prescribed plans to achieve one or more specific objectives.

n. All other personnel. This should include all other personnel not already accounted for in other categories.

o. Total facility personnel. Add 1a-1n. Includes the total facility personnel - hospital plus nursing home type

p. unit/facility personnel (for those hospitals that own and operate a nursing home type unit/facility). Total facility personnel (a-o) should include hospital and nursing home type unit/facility, if applicable. Nursing home type unit/facility personnel should also be reported separately in 1p and 1q.

q. Nursing home type unit/facility registered nurses. These lines should be filled out only by hospitals that own and operate a nursing home type unit/facility, where only one legal entity is vested with title to the physical property or operates under the authority of a duly executed lease of the physical property. If nursing home type unit/facility personnel are reported on the total facility personnel lines (1a-1n) but cannot be broken out, please leave blank.

r. Total nursing home type unit/facility personnel. These lines should be filled out only by hospitals that own and operate a nursing home type unit/facility, where only one legal entity is vested with title to the physical property or operates under the authority of a duly executed lease of the physical property. If nursing home type unit/facility personnel are reported on the total facility personnel lines (1a-1n) but cannot be broken out, please leave blank.

s. Please break out the FTE's for the following staffing below. Staffing included below should be on the HOSPITAL's payroll.

1.Therapy roles (OT/PT/Speech). Therapy roles related to the physical wellbeing of a patient.

2. Virtual nurses. Any nurse that provides remote care via telehealth or other virtual means.

3. Psychiatrists. A psychiatrist is a medical doctor (an M.D. or D.O.) who specializes in mental health, including substance use disorders. Psychiatrists are qualified to assess both the mental and physical aspects of psychological problems.

4. Psychologists. Psychologists have a doctoral degree in psychology from an organized, sequential program in a regionally accredited university or professional school.

5. Social workers. Social work is a profession in which trained professionals are devoted to helping vulnerable people and communities work through challenges they face in everyday life; united in their commitment to advocating for and improving the lives of individuals, families, groups and societies. Social workers are found in every facet of community life, including schools, hospitals, mental health clinics, senior centers, elected office, private practices, prisons, military, corporations, and in numerous public and private agencies.

6. Counselor. An individual professionally trained in counseling, psychology, or other clinical areas like nursing to address environmental factors that influence health, promote wellness, prevent disease, and help patients with illnesses. A counselor specializes in one or more counseling areas, including but not limited to vocational counseling, rehabilitation counseling, educational counseling, substance abuse counseling, marriage and relationship counseling, and family counseling. Counselors may have a title such as Licensed Professional Counselor (LPC), Licensed Clinical Professional Counselor (LCPC), Licensed Mental Health Practitioner (LMHP), or another state-issued licensed title.

7. Case managers. Case managers are healthcare professionals who serve as patient advocates, supporting, guiding, and coordinating care for patients, families and caregivers as they navigate their health and wellness journeys. They serve as the center of communication, connecting individuals/caregivers with members of the healthcare team and community to impact acute and chronic disease management and improve population health

8. Community health workers. A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served. This trusting relationship enables the worker to serve as a liaison/link/intermediary between health/social services and the community to facilitate access to services and improve the quality and cultural competence of service delivery.

9. Peer support specialists. A peer support specialist is someone with the lived experience of recovery from a mental health condition, substance use disorder, or both. They provide non-clinical, strengths-based support, informed by their own recovery journey, to others experiencing similar challenges. Peer support specialists may be credentialed through their state. Peer support workers may be referred to by different names depending upon the setting in which they practice. Common titles include: peer specialists, peer recovery coaches, peer advocates, and peer recovery support specialists.

10. Tech roles. Patient care technician, medical technician, radiology/imaging technician, ultrasound technician, EEG technician, etc.

11. Administrative and billing support staff. Staff who assist with the billing cycle and other administrative tasks.

12. Certified registered nurse anesthetist (CRNA). A registered nurse who has specialized training in anesthesia. They can administer anesthesia for procedures and surgeries.

13. Clinical nurse specialist (CNS). An Advanced Practice Registered Nurse (APRN) prepared by a master's, doctoral, or post-graduate certificate level CNS program. CNSs diagnose, prescribe, and treat patients and specialty populations across the continuum of care.

14. Physician assistants (PAs). Medical providers, most with graduate-level educations, who are licensed to diagnose and treat illness and disease and to prescribe medication for patients.

15. Nurse practitioner (NP). A nurse who has advanced clinical education and training. NPs share many of the same duties as doctors. They perform physical exams, diagnose and treat diseases and other health conditions, and prescribe medication. A nurse practitioner must have a graduate-level degree of education.

16. Certified nurse-midwife (CNM). A primary health care provider to women of all ages throughout their lives. CNMs focus on gynecologic and family planning services, as well as preconception, pregnancy, childbirth, postpartum and

newborn care.

17. Clinical pharmacist practitioner (CPP). A licensed pharmacist who is approved to provide drug therapy management, including controlled substances, under the direction of, or under the supervision of a licensed physician.

a. How much clinician time is being spent on administrative tasks, i.e. billing/prior auth/RCM? Calculation of time spent on non-direct patient care.

b. For your medical residents/interns reported above (H.1c,column 1) please indicate the number of full-time personnel on payroll by specialty.

1. Primary care (general practitioner, general internal medicine, family practice, general pediatrics, geriatrics).

2. Other specialties.

2. Advanced practice provider (APP). A term encompassing non-physician providers of the following disciplines: clinical nurse specialists, clinical pharmacist practitioners, nurse anesthetists, nurse midwives, nurse practitioners, and physician assistants/associates.

a. Do Advanced Practice Providers provide care for patients in your hospital? (If no, please skip to 3).

b. If yes, please report the number of FTE for Advanced Practice Nurses and Physician Assistants (PAs) who provide care for patients in your hospital for each of the following services.

1. Internal medicine/hospitalist. Physicians whose primary professional focus is the care of hospitalized medical patients (through clinical, education, administrative and research activity).

2. Anesthesia. The use of medicines to prevent pain during surgery and other procedures.

Certified registered nurse anesthetist. An advanced practice registered nurse (APRN) who administers anesthesia and other medications. They also take care of and monitor people who receive or are recovering from anesthesia.

3. Emergency department care. The provision of unscheduled outpatient services to patients whose conditions require immediate care in the emergency department setting.

4. Other specialty care. A clinic that provides specialized medical care beyond the scope of primary care.

5. Patient education. Goals and objectives for the patient and/or family related to therapeutic regimens, medical procedures and self-care.

6. Case management. A system of assessment, treatment planning, referral and follow-up that ensures the provision of comprehensive and continuous services and the coordination of payment and reimbursement for care.

7. Obstetrician-Gynecologist (OB/GYN). A physician who provides medical and surgical treatment to pregnant women and to mothers following delivery. Also provides diagnostic and therapeutic services to women with diseases or disorders of the reproductive organs.

8. Orthopedics. The branch of medicine dealing with the correction of deformities of bones or muscles.

9. Oncology. The medical specialty that focuses on cancer, including its diagnosis, treatment, prevention, and study.

10. Neurology. The branch of medicine that deals with the diagnosis and treatment of disorders of the nervous system.

11. Psychology. The scientific study of the human mind and its functions, especially those affecting behavior in a given context.

12. Cardiology. The branch of medicine that deals with diseases and abnormalities of the heart.

13. Palliative Care. Specialized medical care that focuses on providing relief from pain and other symptoms of a serious illness.

14. Other. Care provided by Advanced Practice Providers that does not fit into the above categories. Please specify.

3. Contracted staff. Please report the number of contracted FTEs for each occupational category (not on hospital payroll). Personnel that are on the hospital's payroll and reported in H1 (Staffing) should not be reported here.

a. Registered nurses. Nurses who have graduated from approved schools of nursing and who are currently registered by the state. They are responsible for the nature and quality of all nursing care that patients receive. Do not include any registered nurses more appropriately reported in other occupational categories, such as facility administrators, and therefore listed under all other personnel.

b. Radiology technicians. Technical positions in imaging fields, including, but not limited to, radiology, sonography, nuclear medicine, radiation therapy, CT, MRI.

c. Laboratory technicians. Professional and technical positions in all areas of the laboratory, including, but not limited to, histology, phlebotomy, microbiology, pathology, chemistry, etc.

d. Pharmacists, licensed. Persons licensed within the state who are concerned with the preparation and distribution of medicinal products.

e. Pharmacy technicians. Persons who assist the pharmacist with selected activities, including medication profile reviews for drug incompatibilities, typing labels and prescription packaging, handling of purchase records and inventory control.

f. Respiratory therapists. Allied health professionals who specialize in scientific knowledge and theory of clinical problems of respiratory care. Duties include the collection and evaluation of patient data to determine an appropriate care plan, selection and assembly of equipment, conduction of therapeutic procedures, and modification of prescribed plans to achieve one or more specific objectives.

g. All other contracted staff. Contracted staff that do not fit into the above categories.

4. Privileged physicians. Report the total number of physicians (by type) on the medical staff with privileges except those with courtesy, honorary and provisional privileges. Do not include residents or interns. Physicians that provide only non-clinical services (administrative services, medical director services, etc.) should be excluded.

Report the total number of physicians with privileges at your hospital by type of relationship with the hospital. The sum of the

physicians reported in 4a-4i should equal the total number of privileged physicians (4j) in the hospital.
Employed by your hospital. Physicians that are either direct hospital employees or employees of a hospital subsidiary corporation.
Individual contract. An independent physician under a formal contract to provide services at your hospital including at outpatient facilities, clinics, and offices.

Group contract. A physician that is part of a group (group practice, faculty practice plan or medical foundation) under a formal contract to provide services at your hospital including at inpatient and outpatient facilities, clinics and offices.
Not employed or under contract. Other physicians with privileges that have no employment or contractual relationship with the hospital to provide services.

- **a. Primary care.** A physician that provides primary care services including general practice, general internal medicine, family practice, general pediatrics, and geriatrics.
- **b. Obstetrics/gynecology.** A physician who provides medical and surgical treatment to pregnant women and to mothers following delivery. Also provides diagnostic and therapeutic services to women with diseases or disorders of the reproductive organs.
- **c. Emergency medicine.** Physicians who provide care in the emergency department.
- **d. Hospitalist.** Physicians whose primary professional focus is the care of hospitalized medical patients (through clinical, education, administrative and research activity).
- **e. Intensivist.** A physician with special training to work with critically ill patients. Intensivists generally provide medical-surgical, cardiac, neonatal, pediatric, and other types of intensive care.
- **f. Radiologist.** A physician who has specialized training in imaging, including but not limited to radiology, sonography, nuclear medicine, radiation therapy, CT, MRI.
- **g. Pathologist.** A physician who examines samples of body tissues for diagnostic purposes.
- **h. Anesthesiologist.** A physician who specializes in administering medications or other agents that prevent or relieve pain, especially during surgery.
- **i. Other specialist.** Other physicians not included in the above categories that specialize in a specific type of medical care.

5. Hospitalists. Physicians whose primary professional focus is the care of hospitalized medical patients (through clinical, education, administrative and research activity).

- **a. Do hospitalists provide care for patients in your hospital? (If no, please skip to 6)**
- **b. If yes, please report the total number of full-time equivalent (FTE) hospitalists.**

6. Intensivists. Physicians with special training to work with critically ill patients. Intensivists generally provide medical-surgical, cardiac, neonatal, pediatric and other types of intensive care.

- **a. Do intensivists provide care for patients in your hospital? (If no, please skip to 7)**
- **b. If yes, please report the total number of FTE intensivists and assign them to the following areas. Please indicate whether the intensive care area is closed to intensivists. (Meaning that only intensivists are authorized to care for ICU patients).**

1. Medical-surgical intensive care. Provides patient care of a more intensive nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. These units are staffed with specially trained nursing personnel and contain monitoring and specialized support equipment for patients who because of shock, trauma or other life-threatening conditions require intensified comprehensive observation and care. Includes mixed intensive care units.

2. Cardiac intensive care. Provides patient care of a more specialized nature than the usual medical and surgical care, on the basis of physicians' orders and approved nursing care plans. The unit is staffed with specially trained nursing personnel and contains monitoring and specialized support or treatment equipment for patients who, because of heart seizure, open-heart surgery, or other life-threatening conditions, require intensified, comprehensive observation and care. May include myocardial infarction, pulmonary care, and heart transplant units.

3. Neonatal intensive care. A unit that must be separate from the newborn nursery providing intensive care to all sick infants including those with the very lowest birth weights (less than 1500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery, and special care for the sickest infants born in the hospital or transferred from another institution. A full-time neonatologist serves as director of the NICU.
Neonatal Intensive Care Units (NICUs) are classified into levels by the American Academy of Pediatrics (AAP) based on their capabilities. The levels are as follows:
Level I: Well newborn nursery
Level II: Special care nursery
Level III: Neonatal intensive care unit (NICU)
Level IV: Regional neonatal intensive-care unit (regional NICU)
4. Pediatric intensive care. Provides care to pediatric patients that is of a more intensive nature than that usually provided to pediatric patients. The unit is staffed with specially trained personnel and contains monitoring and specialized support equipment for treatment of patients who, because of shock, trauma, or other life-threatening conditions, require intensified, comprehensive observation and care.
5. Other intensive care. Intensive care that does not fit into the above categories.

7. Foreign-educated staff. Individuals who are foreign born and received basic nursing education in a foreign country. In general,

many of these nurses come to the US on employment-based visas which allow them to obtain a green card.

a. Did your facility hire more foreign-educated nurses (including contract or agency nurses) to help fill RN vacancies in 2024 vs. 2023?

b. From which countries/continents are you recruiting foreign-educated nurses? (Check all that apply).

c. How many international medical graduates are providing care in your hospital?

8. Workforce.

a. Does your hospital use artificial intelligence (AI) or machine learning in the following? (Check all that apply).

1. Predicting staffing needs. Hospital indicates whether or not they use AI or machine learning to predict staffing needs.

2. Predicting patient demand. Hospital indicates whether or not they use AI or machine learning to predict patient demand.

3. Staff scheduling. Hospital indicates whether or not they use AI or machine learning to create staffing schedule.

4. Automating routine tasks. Hospital indicates whether or not they use AI or machine learning to automate routine tasks.

5. Optimizing administrative and clinical workflows. Hospital indicates whether or not they use AI or machine learning to optimize administrative and clinical workflows.

b. Strategic planning process. A process in which an organization's leaders define their vision for the future and identify their organization's goals and objectives.

1. Needs assessment. A systematic process for determining and addressing needs, or "gaps", between current conditions, and desired conditions, or "wants."

2. Leadership succession planning. The process of identifying and developing new leaders to succeed current leaders.

3. Talent development plan. The organizational process of positioning employees for career advancement in a way that aligns with the company's mission.

4. Recruitment & retention planning. A strategic process where an organization identifies its future staffing needs, actively attracts qualified candidates to fill those positions (recruitment), and then implements strategies to keep those employees engaged and satisfied within the company to minimize turnover (retention).

5. Partnerships with elementary/HS to develop interest in health care careers.

6. Training program partnership with community colleges, vocational training programs.

7. Well-being programs (peer support, well-being measurement, team efficiency efforts).

8. Workplace violence/de-escalation trainings/programming.

9. Benefits such as tuition reimbursement.

10. Transition to practice program. A structured, supportive program designed to help newly licensed healthcare professionals, particularly nurses, bridge the gap between their academic education and the real-world demands of clinical practice.

11. Support for ongoing professional development for clinical staff.

12. Support for ongoing development for non-clinical staff.

13. None of the above.

c. If your hospital hired RNs during the reporting period, how many were new graduates from nursing schools?

2024 American Hospital Association ANNUAL SURVEY
DEPARTMENT OF STATE HEALTH SERVICES SURVEY SUPPLEMENT

The Department of State Health Services hospital data survey supplement requests more specific information for several areas previously addressed in the American Hospital Association survey. Please be consistent in using established definitions and in coordinating responses between similar sections of the survey and supplement when referenced.

F10. OWNERSHIP

a. Please classify the ownership of your hospital. (check only one):

GOVERNMENT, NONFEDERAL
- ☐ 12 State
- ☐ 13 County
- ☐ 14 City
- ☐ 15 City-County
- ☐ 16 Hospital District
- ☐ 17 Hospital Authority

NONGOVERNMENT, NOT-FOR-PROFIT
- ☐ 21 Church
- ☐ 23 Other not-for-profit

INVESTOR-OWNED, FOR-PROFIT
- ☐ 31 Individual
- ☐ 32 Partnership
- ☐ 33 Corporation

b. Did the ownership of your facility change during this reporting period or from your previous reporting period? ..... ☐ Yes ☐ No

1. If yes, using the numerical ownership classification above, what was the ownership before the change? ..... _____

c. NATIONAL PROVIDER IDENTIFIER (NPI)

1. Does your hospital have its new National Provider Identifier (NPI) from the National Plan and Provider Enumeration System?

☐ Yes ☐ No If yes, please report the ten digit NPI? _ _ _ _ _ _ _ _ _ _

d. Please provide the hospital license number. _____

G11. INPATIENT NEWBORN CARE

a. Indicate the **total number of deliveries** for your fiscal year. Deliveries should be considered as occurring at 20 or more weeks of gestation. Deliveries CAN be different than BIRTHS (item E2d1, page 13). Stillbirths are to be included with deliveries and multiple births count as ONE delivery..... _____

b. If your hospital **DOES NOT HAVE A NEONATAL INTENSIVE CARE UNIT (NICU)**, indicate the number of newborns transferred from your hospital to other hospitals for neonatal care..... ..... _____

c. If your hospital **HAS A NICU**

1. Indicate the number of newborns admitted **TO** your NICU as transfers from other hospitals ..... _____
2. Indicate the number of newborns transferred **FROM** your NICU to other hospitals for further inpatient care..... _____
3. Indicate the number of newborns delivered at your hospital and admitted to your NICU..... _____

d. Indicate your facility's highest level of NICU on the last day of your 2024 fiscal year, as established by the official DSHS Neonatal Levels of Care Designation Program, pursuant to House Bill 15, 83rd Legislature, Regular Session, 2013:

Level I	Level II	Level III	Level IV	Not Applicable
☐	☐	☐	☐	☐

e. Was the day-to-day operation of the hospital's NICU contracted out during your fiscal year?
If yes, please provide the name, city, and state of the organization that managed your hospital's NICU:
Name: _____ City: _____ State: _____

H. PSYCHIATRIC, ALCOHOLISM/CHEMICAL DEPENDENCY, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDDs, formerly Mental Retardation), PARTIAL HOSPITALIZATION CARE

9. Inpatient Care/Partial Hospitalization. Please indicate the number of admissions, discharges and inpatient days for each of the categories of care specified below. Count each admission and discharge **only once** according to the **major category of care** provided. For partial hospitalization record admissions, discharges and number of visits.

	Admissions	Discharges	Inpatient Days/Visits
a. Psychiatric, 30 days or less	_____	_____	_____
b. Psychiatric, more than 30 days.....	_____	_____	_____
c. Chemical dependency (including Alcoholism)	_____	_____	_____
d. Intellectual and Developmental Disabilities (IDD)	_____	_____	_____
e. Partial hospitalization	_____	_____	_____

H. PSYCHIATRIC, ALCOHOLISM/CHEMICAL DEPENDENCY, INTELLECTUAL AND DEVELOPMENTAL DISABILITIES (IDDs), AND PARTIAL HOSPITALIZATION CARE (continued)

10. **Outpatient Visits**. Please record the number of psychiatric and chemical dependency (including alcoholism) outpatient visits for each of the categories below. Do not report occasions of service in any category.

	Psychiatric Visits	Chemical Dependency Visits (including Alcoholism)
a. Emergency	_____	_____
b. Clinic/Other	_____	_____
c. Total	_____	_____

I. INPATIENT AND OUTPATIENT BAD DEBT AND CHARITY CHARGES

PLEASE USE THE DEFINITIONS ON PAGE 60 IN COMPLETING THIS SECTION. THE DEFINITIONS FOR BAD DEBT CHARGES AND CHARITY CHARGES IN ITEMS 1 AND 2 ARE DIFFERENT FROM THE AHA DEFINITIONS (page 41).

1. INPATIENT AND OUTPATIENT BAD DEBT CHARGES

a. Inpatient Bad Debt charges ..... $ _____
b. Outpatient Bad Debt charges ..... $ _____
c. TOTAL BAD DEBT CHARGES (please add lines a and b) ..... $ _____
d. Bad debt from uninsured patients ..... $ _____
(1) Inpatient bad debt charges from uninsured patients ..... $ _____
(2) Outpatient bad debt charges from uninsured patients ..... $ _____
(3) State government payments for uninsured patients ..... $ _____
(4) Local government payments for uninsured patients ..... $ _____
(5) Patient payments from uninsured patients ..... $ _____
(6) Other third party payments for uninsured patients ..... $ _____
e. Bad debt from partially insured patients ..... $ _____
(1) Inpatient bad debt charges from partially insured patients ..... $ _____
(2) Outpatient bad debt charges from partially insured patients ..... $ _____
(3) Private insurance payments from partially insured patients ..... $ _____
(4) Patient payments from partially insured patients ..... $ _____
(5) Other third party payments for partially insured patients ..... $ _____

2. INPATIENT AND OUTPATIENT CHARITY CHARGES

a. Inpatient Charity charges ..... $ _____
b. Outpatient Charity charges ..... $ _____
c. TOTAL CHARITY CHARGES (please add lines a and b) ..... $ _____
d. State government payments for specific charity patients ..... $ _____
e. Local government payments for specific charity patients ..... $ _____
f. Private insurance payments for charity patients ..... $ _____
g. Patient payments for charity care ..... $ _____
h. Other third party payments for charity care patients ..... $ _____

3. PAYMENTS RECEIVED FOR INPATIENT CARE FROM OTHER GOVERNMENTAL SOURCES (Exclude Medicaid Payments)

	PAYMENTS RECEIVED
a. Local Government - Inpatient Care Only (County, City)	$ _____
b. State Government - Inpatient Care Only (CSHCN, Kidney Health Care, etc.)	$ _____

4. INPATIENT DAYS

	INPATIENT DAYS
a. Please report the total number of newborn nursery days	_____
b. Please report the total number of swing bed inpatient days that the swing beds were used in the provision of swing services.	_____

5. NON-TEXAS RESIDENT MEDICAID ELIGIBLE PATIENTS

Please report the total number of inpatient days attributable to individuals eligible for Medicaid in another state (please exclude Medicaid days reported in E2d1 on page 13) ..... _____

J. OTHER FINANCIAL AND UTILIZATION DATA
(please see the definitions on page 61 in completing this section)

1. FINANCIAL DATA

a. TOTAL GROSS PATIENT SERVICE REVENUE FROM SELECTED GOVERNMENT SOURCES — **GROSS SOURCES OF REVENUE**

(1) Medicaid (including Inpatient and Outpatient)

(a) Fee for service patient revenue (Do not include Medicaid DSH or 1115 Waiver payments) ..... $ _____

(b) Managed care revenue ..... $ _____

(c) Total (a+b) (please add lines a through b - Must equal F4a2e1 on page 15) ..... $ _____

(2) Other Government Sources of Revenue (including Inpatient and Outpatient)

(a) Local Government (County, City) ..... $ _____

(b) State Government (CSHCN, Kidney Health Care, CHIP, etc.) ..... $ _____

(c) Other Government (TRICARE formerly known as CHAMPUS, please specify type): $ _____

(d) TOTAL Other Government (please add lines a through c - Must equal F4a3(1) on page 15) ..... $ _____

b. NET PATIENT SERVICE REVENUE FROM SELECTED GOVERNMENT SOURCES — **NET SOURCES OF REVENUE**

(1) Trauma ..... $ _____

(2) Tobacco Settlement ..... $ _____

(3) Kidney Health. ..... $ _____

(4) Children with Special Health Care Needs ..... $ _____

(5) Crime Victims ..... $ _____

(6) Local Government

(a) County Indigent: ..... $ _____

(b) Hospital District: ..... $ _____

(c) City/County Government: ..... $ _____

(7) Federal Government: ..... $ _____

(8) Other Government Revenue: ..... $ _____

a. Other Government (Please Specify Type):

c. MEDICAID DISPROPORTIONATE SHARE HOSPITAL PAYMENTS (DSH) ..... $ _____

d. 1115 WAIVERS

(2) Uncompensated Care Payments ..... $ _____

e. TOTAL ASSETS AND LIABILITIES — **ASSETS/LIABILITIES**

(1) Please report the amount of total hospital assets. ..... $ _____

(2) Please report the amount of total hospital liabilities and fund balance ..... $ _____

f. CHARITABLE CONTRIBUTIONS — **CHARITABLE CONTRABUTIONS**

Indicate charitable contributions received by your hospital during this fiscal year (exclude contributions which are restricted to capital expenditure usage). $ _____

2. ADMISSIONS - Indicate total hospital admissions for your fiscal year for each of the categories specified in section J.2. Count each admission **only once** according to the **MAJOR PAYER SOURCE** of the patient.

a. GOVERNMENT SOURCES OF REVENUE ADMISSIONS — **ADMISSIONS**

(1) Medicare (Title XVIII) inpatient admissions (including Medicare Managed Care) ..... _____

(a) How many Medicare admissions were Medicare Managed Care? ..... _____

(2) Medicaid (Title XIX) inpatient admissions (including Medicaid Managed Care) ..... _____

(a) How many Medicaid admissions were Medicaid Managed Care? ..... _____

J. OTHER FINANCIAL AND UTILIZATION DATA (continued)

(3) Other Government Sources of Revenue admissions

(a) Local Government admissions (County, City) ..... _____

(b) State Government admissions (CSHCN, Kidney Health Care, CHIP, etc.) ..... _____

(c) Other Government admissions (TRICARE, formerly known as CHAMPUS.) ..... _____

(d) Total Other Government admissions (add lines a through c) ..... _____

(4) TOTAL Government Sources of Revenue admissions (add lines 2a(1), 2a(2) and 2a(3)(d)) ..... _____

b. NONGOVERNMENT SOURCES OF REVENUE ADMISSIONS (Exclude Newborns)

(1) Self Pay admissions ..... _____

(2) Non-government third-party payers admissions

(a) HMO admissions..... _____

(b) PPO admissions..... _____

(c) Other third-party payer admissions..... _____

(d) TOTAL Non-government Third-Party Payers admissions (add lines a through c) _____

(3) Other Non-government admissions (please specify: _____)..... _____

(4) TOTAL Non-government Sources of Revenue admissions (add lines 2b(1), 2b(2)(d) and 2b(3))..... _____

c. TOTAL ADMISSIONS (add lines 2.a.4 and 2.b.4 - must equal E2e1 on page 13) ..... _____

3. SELECTED INPATIENT DAYS - Report inpatient days **ONLY** for these specific services **IF** the number of beds (# Beds) reported on page 4 (Section C) for these services is greater than zero. See page 61 for definitions.

	INPATIENT DAYS
(a) General medical-surgical care inpatient days (adult, include gynecology). (Report inpatient days if C1 #Beds >0)	_____
(b) Pediatric medical-surgical care inpatient days. (Report inpatient days if C2 # Beds is >0)	_____
(c) Cardiac intensive care inpatient days. (Report inpatient days if C5 # Beds is >0)	_____
(d) Pediatric intensive care inpatient days. (Report inpatient days if C8 # Beds is >0)	_____
(e) Obstetric care inpatient days. (Report inpatient days if C3 # Beds is >0)	_____

4. ADDITIONAL DATA

Please see the definitions on page 61 in completing this section.

(a) Total Discharges (exclude newborns, include neonatal and swing discharges)..... _____

(b) Total Discharge days (exclude newborns, include neonatal and swing days) ..... _____

(c) Medicare/Medicaid visits and revenue:	**ER Visits**	**Outpatient Visits**	**ER Revenue**	**Outpatient Revenue**
(1) Routine Medicare	_____	_____	_____	_____
(2) Medicare managed care	_____	_____	_____	_____
(3) Routine Medicaid.....	_____	_____	_____	_____
(4) Medicaid managed care.....	_____	_____	_____	_____

2024 American Hospital Association ANNUAL SURVEY

K. IMMUNIZATIONS AND PERINATAL DISEASE PREVENTION

Please refer to pages 53-54 in completing this section. If you have questions please contact the Immunization Unit, Texas Department of State Health Services at (512) 776-6035. Please send electronic copies of the Hepatitis B vaccination, patient immunization and/or employee immunization policy and standing orders, to Imm.Epi@dshs.texas.gov.

Name of person completing survey (Print): _____

Telephone #_____Ext: _____

Please indicate your professional category: ☐ **Nurse Practitioner** ☐ **MD or DO** ☐ **Clinical Nurse Manager** ☐ **Physician Assistant** ☐ **Administrative personnel** ☐ **Other - Please specify _____**

Please indicate your title: _____

1. HEPATITIS B PREVENTION

	Yes	No
a. Does your hospital provide inpatient labor and delivery services?	☐	☐
b. Does your hospital have a policy and standing orders to test all pregnant women for Hepatitis B surface antigen (HBsAg) upon admission for delivery?	☐	☐
c. Does your hospital have a protocol for informing the pediatric health care provider that an infant was born to an HBsAg positive woman or woman of HBsAg-unknown status?	☐	☐
d. Does your hospital have a policy and standing orders to administer hepatitis B immune globulin (HBIG) within 12 hours of delivery for all infants born to HBsAg positive women?.....	☐	☐
e. Does your hospital have a policy and standing orders to administer a dose of hepatitis B vaccine to all newborns born to HBsAg-positive mothers within 12 hours of birth?	☐	☐
f. Does your hospital have a policy and standing orders to administer a dose of hepatitis B vaccine to all newborns within 24 hours of birth?.....	☐	☐
g. Number of women tested for HBsAg at delivery during the previous year.....	_____	
h. Number of infants, born to all women, that received a dose of hepatitis B vaccine within 24 hours of delivery during the previous year	_____	
i. Number of infants, born to HBsAg positive women, that received hepatitis B immune goblin (HBIG) within 24 hours of delivery during the previous year.....	_____	

2. PERTUSSIS IMMUNIZATION

	Yes	No
a. Does your hospital provide outpatient prenatal clinic services?.....	☐	☐
b. If yes to K2a., does the outpatient prenatal clinic have a policy and standing orders to vaccinate all pregnant women with (Tetanus-Diphtheria-acellular Pertussis vaccine) Tdap?.....	☐	☐

3. RESPIRATORY SYNCYTIAL VIRUS IMMUNIZATION

	Yes	No
a. If yes to K2a., does the outpatient prenatal clinic have a policy and standing orders to vaccinate all pregnant women with one dose of the maternal RSV vaccine between 32 through 36 weeks?.....	☐	☐
b. Does your hospital have a policy and standing orders to administer the pediatric RSV Immmunization to neonates within one week of birth?.....	☐	☐

4. EMPLOYEE IMMUNIZATION

a. Indicate the type of employee policy that your hospital has below and vaccine(s) included (please check only one box for each vaccine):

	MMR	Hepatitis B	Influenza	Tdap or Td	Varicella
Mandatory for employment:	☐	☐	☐	☐	☐
Recommended for employment:	☐	☐	☐	☐	☐
Or					
Combination immunization policy:	☐	☐	☐	☐	☐
No Policy	☐	☐	☐	☐	☐

Tdap (Tetanus-Diphtheria-acellular Pertussis Vaccine); Td (Tetanus-Diphtheria Vaccine); MMR (Mumps Measles Rubella Vaccine)

5. GENERAL IMMUNIZATION SECTION

a. Does the hospital have a written policy to provide immunization information to all new parents at a child's birth and before release from the hospital? ☐ Yes ☐ No

b. Does the hospital offer new parents the opportunity to grant consent for immunization registry participation, or request exclusion from the registry, during birth certification registration? ☐ Yes ☐ No

c. If your hospital provides delivery services, is your hospital registered as a Texas Vaccines for Children (TVFC) provider that provides free vaccines to those children who qualify? ☐ Yes ☐ No

K. IMMUNIZATIONS AND PERINATAL DISEASE PREVENTION (continued)

6. PERINATAL HIV AND CONGENITAL SYPHILIS PREVENTION

Please refer to page 54 when completing this section. If you have questions, please contact the HIV/STD Section, Texas Department of State Health Services at (737) 255-4300. Please send electronic copies of the policy and standing orders to hivstd@dshs.texas.gov.

a. Does your hospital provide:

☐ Outpatient Prenatal Clinic Services ☐ Inpatient Delivery Services

(If neither service is provided, skip to L1 on page 55).

b. Does your outpatient prenatal clinic have a policy/standing delegation order to screen all pregnant women for HIV and/or syphilis at the first prenatal visits? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, check all that apply: ☐ HIV ☐ Syphilis

c. Does your outpatient prenatal clinic have a policy/standing delegation orders to screen all pregnant women for HIV and/or syphilis during the third trimester? (For syphilis, 28-32 weeks gestation)? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, check all that apply: ☐ HIV ☐ Syphilis

d. Does your outpatient prenatal clinic have a policy/standing delegation orders to conduct follow up testing on all pregnant women diagnosed with syphilis during their current pregnancy to evaluate their serologic response to treatment? ☐ Yes ☐ No

(If inpatient delivery services are not provided, skip to L1 on page 55).

e. Does your hospital have a policy/standing delegation orders to screen all pregnant women for HIV and/or syphilis upon admission for delivery? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, check all that apply:

☐ HIV ☐ Syphilis ☐ HIV, if no third trimester test result can be located

☐ Syphilis, if no third trimester result can be located ☐ Syphilis, if infant is stillborn

f. Does your hospital have a policy/standing delegation orders to administer intravenous (IV) zidovudine at delivery to women living with HIV and/or to administer HIV antiretroviral (ARV) medications within 6 to 12 hours post-delivery to all infants born to women living with HIV? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, check all that apply:

☐ Intravenous (IV) zidovudine at delivery to women living with HIV

☐ ARV medications within 6 to 12 hours post-delivery to infants born to women living with HIV

g. Does your hospital have a policy/standing delegation orders to provide a 4 to 6 week course of HIV antiretroviral (ARV) prophylaxis to all infants born to women living with HIV, upon discharge? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, check all that apply:

☐ By prescription ☐ Given 4 to 6 week supply prior to discharge

h. Does your hospital have a policy/standing delegation orders to refer infants to follow-up care post-discharge if clinically diagnosed with congenital syphilis? (If yes, please send an electronic copy of the policy/standing delegation orders)

☐ Yes ☐ No

i. Does your hospital have a policy/standing delegation orders to refer infants to follow-up care post-discharge if born to a mother living with HIV? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

1. If yes, does your hospital or clinic request results of follow up testing on infants born to mother living with HIV to verify testing was performed on the child in accordance with American Academy of Pediatrics, nucleic acid amplification testing performed at 14 to 21 days of age, at 1 to 2 months of age, and 4 to 6 months of age to identify or exclude HIV infection as early as possible.) ☐ Yes ☐ No

j. Does your hospital have a policy/standing delegation orders to test and treat all infants born to women diagnosed with syphilis during pregnancy? (If yes, please send an electronic copy of the policy/standing delegation orders.) ☐ Yes ☐ No

1. If yes, check all that apply:

☐ Test infants born to women diagnosed with syphilis during pregnancy

☐ Treat infants born to women diagnosed with syphilis post-delivery

K. IMMUNIZATIONS AND PERINATAL DISEASE PREVENTION (continued)

2. Does your hospital have a policy/standing delegation orders to evaluate infants born to persons diagnosed with syphilis?
   ☐ YES ☐ No
3. If yes, what evaluations are run on infants born to persons diagnosed with syphilis?
   ☐ Confirmation labs such as PCR, darkfield, IHC, or special stains
   ☐ Longbone x-rays
   ☐ CSF VDRL
   ☐ CSF proteins and WBC

k. Does your hospital have a policy/standing delegation orders to treat persons post-delivery who were diagnosed with syphilis upon admission for delivery? (If yes, please send an electronic copy of the policy/standing delegation orders) ☐ Yes ☐ No

l. Does your hospital have an electronic health record (EHR)? ☐ Yes ☐ No
   a. If yes, does your EHR have a mechanism to alert clinicians to abnormal lab results for HIV and Syphilis?
   ☐ Yes ☐ No

L. CHARITY CARE AND COMMUNITY BENEFITS INFORMATION

Please refer to the definitions on page 65 in completing this section

CHARITY ADMISSIONS

1. CHARITY ADMISSIONS (total number of charity inpatient only) ..... _____

2. CHARITY CARE POLICY

a. Has your hospital governing body adopted a charity care policy statement and formal hospital eligibility system that it uses to determine eligibility for the charity care services it provides? (IF YES, PLEASE RETURN A COPY OF THAT POLICY WITH THIS QUESTIONNAIRE via email HSU@dshs.texas.gov. Please include name of your hospital.) ☐ Yes ☐ No

b. If yes, does your charity care policy address:

(1) care for the "**financially** indigent"? ☐ Yes ☐ No

(2) care for the "**medically** indigent"? ☐ Yes ☐ No

AMOUNT

3. CHARITY PROVIDED THROUGH OTHER ORGANIZATIONS - Please indicate the unreimbursed cost of providing, funding or otherwise financially supporting health care services provided to financially indigent persons through other nonprofit or public outpatient clinics, hospitals or health care organizations. ..... **$** _____

4. COMMUNITY BENEFITS INFORMATION

a. Please provide an estimate of the unreimbursed cost of SUBSIDIZED HEALTH SERVICES reported separately for the following categories:

(1) Emergency Care ..... **$** _____

(2) Trauma Care ..... **$** _____

(3) Neonatal Intensive Care..... **$** _____

(4) Freestanding community clinics, e.g., rural health clinics. ..... **$** _____

(5) Collaborative efforts with local government(s) and/or private agency or agencies in preventive medicine, e.g., immunization programs. ..... **$** _____

(6) Other services that satisfy the definition of "subsidized health services" (please specify*):*

(a) _____ ..... **$** _____

(b) _____ ..... **$** _____

(c) _____ ..... **$** _____

(d) _____ ..... **$** _____

(e) _____ ..... **$** _____

b. Please indicate the amount of DONATIONS your hospital made during this reporting period **$** _____

c. Please indicate the total amount of funds received and expenses for RESEARCH:

(1) TOTAL AVAILABLE FUNDS ..... **$** _____

(2) LESS TOTAL EXPENSES..... **$** _____

(3) TOTAL NET FUNDS [Item 4c(1) - item 4c(2)]..... **$** _____

d. Please indicate the amount of funds received and expenses for EDUCATION separated into the following categories

(1) *Education of physicians, nurses, technicians and other medical professionals and health care providers.*

(a) TOTAL AVAILABLE FUNDS ..... **$** _____

(b) LESS TOTAL EXPENSES..... **$** _____

(c) TOTAL NET FUNDS [Item 4d(1)(a) - item 4d(1)(b)] ..... **$** _____

L. CHARITY CARE AND COMMUNITY BENEFITS INFORMATION (continued)

(2) *Scholarships and funding to medical schools, colleges, and universities for health professions education.*

(a) TOTAL AVAILABLE FUNDS ..... $ _____

(b) LESS TOTAL EXPENSES ..... $ _____

(c) TOTAL NET FUNDS [Item 4d(2)(a) - item 4d(2)(b)] ..... $ _____

(3) *Education of patients concerning diseases and home care in response to community needs.*

(a) TOTAL AVAILABLE FUNDS ..... $ _____

(b) LESS TOTAL EXPENSES ..... $ _____

(c) TOTAL NET FUNDS [Item 4d(3)(a) - item 4d(3)(b)] ..... $ _____

(4) *Community health education through informational programs, publications, and outreach activities in response to community needs.*

(a) TOTAL AVAILABLE FUNDS ..... $ _____

(b) LESS TOTAL EXPENSES ..... $ _____

(c) TOTAL NET FUNDS [Item 4d(4)(a) - item 4d(4)(b)] ..... $ _____

(5) *Other educational services that satisfy the definition of "education-related costs.".*

(a) TOTAL AVAILABLE FUNDS. ..... $ _____

(b) LESS TOTAL EXPENSES ..... $ _____

(c) TOTAL NET FUNDS [Item 4d(5)(a) - item 4d(5)(b)] ..... $ _____

5. LUMP SUM FUNDING

a. Medicare supplemental payments ..... $ _____

b. Tax revenue ..... $ _____

1. Intergovernmental transfers for DSH ..... $ _____

2. Intergovernmental transfers for 1115 Waivers ..... $ _____

3. Other intergovernmental transfers for Medicaid ..... $ _____

c. Collections from patients previously reported as uncompensated ..... $ _____

d. Collections from trauma patients previously reported as uncompensated ..... $ _____

M. ER VISITS FOR INSURED/UNINSURED PATIENTS

1. Total number of **visits** by **insured** patients **WHO WERE** treated in the ER and,
   a. Were **admitted** into the hospital: _____
   b. Were **not admitted** into the hospital: _____
2. Total number of **visits** by **uninsured** patients **WHO WERE** treated in the ER and,
   a. Were **admitted** into the hospital: _____
   b. Were **not admitted** into the hospital: _____
3. What percentage of your emergency visits are for medical conditions or services outside your hospital's area(s) of specialty? _____%
4. What percentage of your emergency visits are transferred to other facilities? _____%
5. How many Emergency Medical Clinics does the hospital have off-campus? _____

N. NURSING SERVICES

1. Has the governing body of the hospital adopted a nurse staffing policy as required by Section 257.003 in the Health and Safety Code? ☐ Yes ☐ No
2. Has the hospital established a nurse staffing committee as required by Section 257.004 in the Health and Safety Code? ☐ Yes ☐ No
3. Has the nurse staffing committee evaluated the hospital's official nurse services staffing plan as required by Section 257.004? ☐ Yes ☐ No
4. Has the nurse staffing committee reported results of the evaluation of the nurse services staffing plan to the hospital's governing body as required by Section 257.004? ☐ Yes ☐ No
5. Has the nurse staffing committee selected nurse-sensitive outcome measures to use in evaluating the hospital's official nurse services staffing plan as required by Section 257.005 in the Health and Safety Code? ☐ Yes ☐ No

6. What nurse-sensitive outcome measures have been selected to use in evaluating the hospital's official nurse services staffing plan as required by Section 257.005 in the Health and Safety Code?

7. How many International Board Certified Lactation Consultant (IBCLC) full-time equivalents (FTEs) does your facility have on staff?

#_____ budgeted FTEs #_____ filled FTEs

8. Does your hospital's board have any Registered Nurse (RN) members? ☐ Yes ☐ No
   a. If yes, does the RN board member have full voting privileges? ☐ Yes ☐ No

O. NEVER EVENTS

SB 203 (81st Legislative session) requires the reporting of preventable adverse events identified by the National Quality Forum (NQF) as "never events." A list of never events is available at: https://dshs.texas.gov/chs/hosp/hosp2.aspx

1. Does your facility keep electronic records of some or all of the "never" events identified by the NQF? ☐ Yes ☐ No
   a. If no, does your facility collect data on some or all of these never events at all? ☐ Yes ☐ No
   b. If yes, does your facility have the capability of electronically submitting patient level data on the "never" events to the State in a format that is used nationally such as HL7 (Health Level 7)? ☐ Yes ☐ No

The Serious Reportable Events in Healthcare can be found at http://www.dshs.texas.gov/chs/hosp/sreh.pdf and the Health Level 7 data standards can be found at http://www.dshs.texas.gov/chs/hosp/hl7.pdf

P. ELECTRONIC EXCHANGE:

Which of the following patient data does your hospital electronically exchange with one or more of the provider types listed below? (Check all that apply):

	With hospitals in your system	With hospitals outside of your system	With ambulatory providers inside of your system	With ambulatory providers outside of your system	Do not know
a. Patient demographics	☐	☐	☐	☐	☐
b. Laboratory results	☐	☐	☐	☐	☐
c. Medication history	☐	☐	☐	☐	☐
d. Radiology reports	☐	☐	☐	☐	☐
e. Clinical/Summary care record in any format	☐	☐	☐	☐	☐
f. Other types of patient data	☐	☐	☐	☐	☐
g. We do not exchange any patient data	☐	☐	☐	☐	☐
h. Allow access to electronic health records	☐	☐	☐	☐	☐

Q. CERTIFICATION STATEMENT:

I certify that the information provided on this survey is true, complete, and correct to the best of my knowledge.

Date of Completion _____ Signature of Administrator _____

Month/Day/Year

Name (please print) Title

Does your hospital or health system have an Internet or Homepage address? ☐ YES ☐ NO
If yes, please provide the address:
http:// _____

Thank you for your cooperation in completing this survey. If there are any questions about your survey, who should be contacted?

Primary Contact (please print) | Title | ( ) Telephone number | ( ) Fax Number
Electronic/Internet Mail address

Secondary Contact (please print) | Title | ( ) Telephone number | ( ) Fax Number
Electronic/Internet Mail address

Chief Nursing Officer (Director of Nursing) (please print) | Title | ( ) Telephone number | ( ) Fax Number
Electronic/Internet Mail Address

Electronic Health Records Privacy Officer (please print) | Title | ( ) Telephone number | ( ) Fax Number
Electronic/Internet Mail Address

NOTE: PLEASE COPY THIS SURVEY FORM FOR YOUR HOSPITAL FILE BEFORE RETURNING THE ORIGINAL FORM TO THE DEPARTMENT OF STATE HEALTH SERVICES. THANK YOU.

Please take a brief second to fill out the four question feedback survey in the link below.
https://tcnws.co1.qualtrics.com/jfe/form/SV_0lENJ4LgFt35DDv

2024 American Hospital Association ANNUAL SURVEY
Section G11
INPATIENT NEWBORN CARE
Instructions and Definitions

a. Deliveries are counted DIFFERENTLY than live births (as recorded in BIRTHS, item E1d1, page 13). Stillbirths are to be included with deliveries and multiple births count as only ONE delivery.
b. If your hospital does not have a neonatal intensive care unit as defined below, complete items G11a and G11b.
c. If your hospital has a neonatal intermediate and/or intensive care unit as defined below, complete items G11c, G11c1, G11c2, and G11c3 as applicable, based on your NICU level as established by the official DSHS Neonatal Levels of Care Designation Program, pursuant to House Bill 15, 83rd Legislature, Regular Session, 2013:

1. Level I (Well Nursery):

(1) provide care for mothers and their infants generally of >=35 weeks gestational age who have routine, transient perinatal problems;
(2) have skilled personnel with documented training, competencies and continuing education specific for the patient population served; and
(3) if an infant <35 weeks gestational age is retained, the facility shall provide the same level of care that the neonate would receive at a higher level designated neonatal facility and shall, through the Quality Assurance/Performance Improvement (QAPI) Program complete an in-depth critical review of the care provided.

2. Level II (Special Care Nursery):

(1) provide care for mothers and their infants of generally >=32 weeks gestational age and birth weight >=1500 grams who have physiologic immaturity or who have problems that are expected to resolve rapidly and are not anticipated to require subspecialty services on an urgent basis; and
(2) either provide care, including assisted endotracheal ventilation for less than 24 hours or nasal continuous positive airway pressure (NCPAP) until the infant's condition improves, or arrange for appropriate transfer to a higher level designated facility. If the facility performs neonatal surgery, the facility shall provide the same level of care that the neonate would receive at a higher level designated facility and shall, through the Quality Assurance/Performance Improvement (QAPI) Program, complete an in depth critical review of the care provided;
(3) provide skilled personnel that have documented training, competencies and annual continuing education specific for the patient population served; and
(4) if a facility is located more than 75 miles from the nearest Level III or IV designated neonatal facility and retains a neonate between 30 and 32 weeks of gestation having a birth weight of between 1250 - 1500 grams, the facility shall provide the same level of care that the neonate would receive at a higher level designated neonatal facility and shall, through the Quality Assurance/Performance Improvement (QAPI) Program, complete an in depth critical review of the care provided.

3. Level III (Neonatal Intensive Care Unit (ICU)):

(1) provide care for mothers and comprehensive care of their infants of all gestational ages with mild to critical illnesses or requiring sustained life support;
(2) provide for consultation to a full range of pediatric medical subspecialists and pediatric surgical specialists, and the capability to perform major pediatric surgery on-site or at another appropriate designated facility;
(3) have skilled medical staff and personnel with documented training, competencies and continuing education specific for the patient population served;
(4) facilitate transports; and
(5) provide outreach education to lower level designated facilities.

4. Level IV (Advanced Neonatal Intensive Care Unit (ICU)):

(1) provide care for the mothers and comprehensive care of their infants of all gestational ages with the most complex and critically ill neonates/infants with any medical problems, and/or requiring sustained life support;
(2) ensure that a comprehensive range of pediatric medical subspecialists and pediatric surgical subspecialists are available to arrive on-site for face to face consultation and care, and the capability to perform major pediatric surgery including the surgical repair of complex conditions;
(3) have skilled personnel with documented training, competencies and continuing education specific for the patient population served;
(4) facilitate transports; and
(5) provide outreach education to lower level designated facilities.

Neonatal Intensive Care Unit: A unit that must be separate from the newborn nursery providing intensive care to all sick infants including those with the very lowest birth weights (less than 1500 grams). NICU has potential for providing mechanical ventilation, neonatal surgery and specialty care for the sickest infants born in the hospital or transferred from another institution. A full-time neonatologist serves as director of the NICU.

For more information about the official DSHS NICU Designation Program, please visit:
https://dshs.texas.gov/emstraumasystems/neonatal.aspx

and the related Texas Administrative Code:

https://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=133&sch=J&rl=Y

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Section I
INPATIENT AND OUTPATIENT BAD DEBT AND CHARITY CHARGES
Instructions and Definitions

1. Charity Care: The unreimbursed cost to a hospital of providing, funding or otherwise financially supporting healthcare services on an inpatient or outpatient basis to a person classified by the hospital as financially or medically indigent or providing, funding or otherwise financially supporting healthcare services provided to financially indigent patients through other nonprofit or public outpatient clinics, hospitals, or health care organizations.
Bad Debt charges: Uncollectible inpatient and outpatient charges that result from the extension of credit.
Charity charges: Total amount of hospital charges for inpatient and outpatient services attributable to charity care in a cost reporting period. These charges do not include bad debt charges, contractual allowances or discounts (other than for indigent patients not eligible for medical assistance under the approved Medicaid state plan); that is, reductions or discounts in charges given to other third party payers such as, but not limited to, health maintenance organizations, Medicare, or Blue Cross.
Financially indigent: An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.
Medically indigent: A person whose medical or hospital bills after payment by third-party payers exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and the person is financially unable to pay the remaining bill.
Inpatient charges: Hospital-based charges, less any contractual or payer discount, for medical services the hospital provides.
Outpatient charges: Hospital-based charges, less any contractual or payer discount, for medical services the hospital provides.

2. Charity: Include those who qualify for free care under the hospital's eligibility system developed in compliance with Health and Safety Code Ch. 311. These patients are classified as **financially indigent** or **medically indigent**. For financially indigent patients, the patient's income level is under 200 percent of the Federal Poverty Level (FPL).
Local Payments: Includes payments received from local governments for specific patients. Excludes payments for public sector employees' care.
Other third party payments: Includes other third party payments received on behalf of patients. Examples include, but are not limited, to workers' compensation and auto insurance.
Partially insured: Includes cases where there is an unpaid patient balance after insurance at the time of reporting. Exclude any contractual or payer discount from the reported charges.
Patient payments: Includes payments received by the patient or their family.
Private insurance payments: Includes payments received from third party health insurance
State payments: Includes payments received from the State of Texas associated with particular individuals. Examples include, but are not limited to, Crime Victims Compensation, Kidney Health, Children with Special Health Care Needs, and burn victims. Lump sum payments that are made for care provided to groups of patients (such as trauma funding) should be reported below.
Uninsured or self-pay: Include charges for those patients who:

1. do not qualify for a government program,
2. have no private or third party insurance,
3. do not qualify for free or reduced price care under the hospital's eligibility system developed in compliance with Health and Safety Code Ch. 311, and
4. do not pay the full cost of their care.

Exclude inmates or prisoners.

Local Government Inpatient: Payments received for inpatient hospital services that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program. DO NOT include tax revenue or care which was provided under your facility's charity care policy, e.g., hospital district patients.
State Government Inpatient: Payments received for inpatient hospital services which were the responsibility of a unit of state government such as the Children with Special Health Care Needs, and the Kidney Health Program, and state trauma funds, etc.
Newborn Days: Report the number of inpatient days for normal newborn nursery. DO NOT include neonatal intensive or intermediate care inpatient days.
Swing Bed Services: A hospital bed that can be used to provide either acute or long-term care depending on community or patient needs. To be eligible, a hospital must have a Medicare provider agreement in place, have fewer than 100 beds, be located in a rural area, do not have a 24-hour nursing service waiver in effect, have not been terminated from the program in the prior two years, and meet various service conditions.

Section J
OTHER FINANCIAL AND UTILIZATION DATA
Instructions and Definitions

Account for all hospital admissions and patient days by the sources indicated. Exclude newborn utilization.
Local Government: Inpatient and Outpatient hospital services that were provided under the county Indigent Health Care Program or that were the responsibility of any city or county governmental program. DO NOT include care which was provided under your facility's charity care policy, e.g., hospital district patients.
State Government: Inpatient and Outpatient patient hospital services which were the responsibility of a unit of state government such as the Children with Special Health Care Needs, and the Kidney Health Program, etc.
Self-Pay: Hospital services for patients without any form of health insurance coverage, or hospital services not covered by a given patient's insurance.
Third Party Payer: Hospital services which were the responsibility of Blue Cross/Blue Shield and other commercial and/or private insurers.
Managed Care: Systems that integrate the financing and delivery of healthcare services to covered individuals by means of arrangements with selected providers to furnish comprehensive services to covered individuals, explicit criteria for the selection of participating health-care providers, differential coverage or payments of financial incentives for covered individuals to use providers and procedures associated with the plan and formal programs for quality assurance and utilization review.
Trauma: Funds provided by the Department of State Health Services from the Trauma Facility and Emergency Medical Services account.
Tobacco settlement: Funds provided from the master settlement agreement with tobacco companies for local governments and hospitals.
Kidney Health: Funds provided from the Kidney Health program at the Department of State Health Services.
Children with Special Health Care Needs: Funds provided from the CSHCN program at the Department of State Health Services.
Crime Victims: Include funds provided by the Office of Attorney General from the Crime Victims Compensation Fund for patient care of eligible crime victims.
County indigent: Include County government funding provided to care for indigent patients under the county indigent program.
Hospital district: Funding from the hospital district's tax revenue for the support of the hospital.
City/county government: Include payments from other city or county programs for uninsured residents but **exclude** funding for public employees' health care.
Federal funding: Include federal funds received directly, such as funding for immigrants or prisoners, Ryan White, etc., but exclude Medicare funding.
Other governmental revenue: Identify the amount and program name(s) of other governmental sources of net patient revenue.
Medicaid Disproportionate Share Hospital (DSH): Medicaid DSH payments received during the reporting period. These Medicaid DSH payments should match the payments included in Net Patient Revenue F1a on page 13 and F4a2d2 on page 15.
1115 Waivers: Uncompensated care (UC) pool payments are used to reimburse for uncompensated care costs as reported in the annual waiver application/UC cost report.

3. Selected Inpatient Days: Report inpatient days only for the specific category (i.e., pediatric, cardiac, etc.) and only if you have reported beds for that same category in Section C (# Beds) on page 4.

For example: Your hospital had pediatric patients, but you have 0 (zero) beds reported on page 4, item C2. You must report 0 (zero) pediatric inpatient days (these days would be included in the general medical/surgical category if you have reported beds for this category on page 4, item C1).

Please refer to page 25 for definitions of the various categories of care.

4. a. Total Discharges: Report the number of adult and pediatric discharges only (exclude newborns). This figure should include all patients discharged during the reporting period.

b. Total Discharge Days: Report the total number of patient days rendered to patients discharged during the reporting period; include days of care rendered to those patients prior to the beginning of the reporting period.

Section K
IMMUNIZATIONS AND PERINATAL DISEASE PREVENTION
Instructions and Definitions

K1. Hepatitis B Prevention:
Effective September 1, 1999, Texas law requires that all pregnant women be tested for hepatitis B surface antigen (HBsAg) at their prenatal examination and upon admission for delivery. An HBsAg positive result in a pregnant woman is a reportable condition in Texas and should be reported to the local or state health department. To eliminate transmission of hepatitis B and prevent perinatal hepatitis B infection, the Advisory Committee on Immunization Practices (ACIP) further recommends that:

1. Infants born to mothers who are HBsAg-positive should receive hepatitis B vaccine and hepatitis B immune globulin (HBIG) < 12 hours of birth;
2. Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine < 12 hours of birth. The mother should have blood drawn as soon as possible to determine her HBsAg status; if she is HBsAg-positive, the infant should receive HBIG as soon as possible (no later than age 1 week).
3. Full-term infants who are medically stable and weigh > 2,000 grams born to HBsAg-negative mothers should receive single-antigen hepatitis B vaccine within 24 hours of birth.
4. Preterm infants weighing < 2,000 grams born to HBsAg-negative mothers should receive the first dose of vaccine 1 month after birth or at hospital discharge.

Source: Prevention of Hepatitis B Virus Infection in the United States: Recommendations of the Advisory Committee on Immunization Practices. January 12, 2018.

K2. Pertussis Immunization

CDC's Advisory Committee on Immunization Practices recommends that all pregnant women:

1. Should receive Tdap during every pregnancy, preferably during the third trimester (between 27 and 36 weeks gestation) although Tdap may be given at any time during pregnancy.
2. For women not previously vaccinated with Tdap, if Tdap is not administered during pregnancy, Tdap should be administered immediately postpartum.
3. If a tetanus and diphtheria booster vaccination is indicated during pregnancy for a woman who has previously not received Tdap (i.e., more than 10 years since previous Td), then Tdap should be administered during pregnancy, preferably between 27 and 36 weeks gestation to maximize the maternal antibody response and passive antibody transfer to the infant.
4. As part of standard wound management care to prevent tetanus, a tetanus toxoid--containing vaccine might be recommended for wound management in a pregnant woman if 5 years or more have elapsed since last receiving Td. If a Td booster is recommended for a pregnant woman, health-care providers should administer Tdap.
5. To ensure protection against maternal and neonatal tetanus, pregnant women who have never been vaccinated against tetanus should receive three vaccinations containing tetanus and reduced diphtheria toxoids. The recommended schedule is 0, 4 weeks, and 6 through 12 months. Tdap should replace 1 dose of Td, preferably pregnancy between 27 and 36 weeks gestation to maximize the maternal antibody response and passive antibody transfer to the infant.

Source: Updated Recommendations for Use of Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine (Tdap) in Pregnant Women. Advisory Committee on Immunization Practices (ACIP), 2012. *MMWR* 2013; 62(07); 131-135.

K3. Respiratory Syncytial Virus Immunization

CDC's Advisory Committee on Immunization Practices recommends either the maternal RSV vaccination during pregnancy or RSV immunization administration to infants to prevent RSV-associated lower respiratory tract infection (LRTI).

1. Either maternal RSV vaccination during pregnancy at 32–36 weeks' gestation (between September and January in the United States) or the prenatal monoclonal antibodies immunization for infants aged <8 months who are born during or are entering their first RSV season is recommended to prevent RSV-associated LRTI in infants, but administration of both products is not needed for most infants.
2. Immunoprophylaxis with monoclonal antibodies is recommended for infants aged <8 months born during or entering their first RSV season whose mother did not receive RSV vaccine, whose mother's receipt of RSV vaccine is unknown, or who were born <14 days after maternal vaccination.
3. Immunoprophylaxis with monoclonal antibodies may be considered for infants born to vaccinated mothers in rare circumstances based on the clinical judgment of the health care provider. These situations include, but are not limited to, infants born to mothers who might not have mounted an adequate immune response to vaccination (e.g., persons with immunocompromising conditions) or who have conditions associated with reduced transplacental antibody transfer (e.g., persons living with HIV infection); infants who might have experienced loss of maternal antibodies; and infants with substantially increased risk for severe RSV disease (e.g., hemodynamically significant congenital heart disease, or intensive care admission requiring oxygen at hospital discharge).

Source: Use of the Pfizer Respiratory Syncytial Virus Vaccine During Pregnancy for the Prevention of Respiratory Syncytial Virus–Associated Lower Respiratory Tract Disease in Infants: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2024. MMWR 2024; 72(41);1115-1122.

K4. Employee Immunizations:

Comprehensive Vaccination Policy Recommended for All Healthcare Personnel:

HICPAC has encouraged any facility or organization that provides direct patient care to formulate a comprehensive vaccination policy for all healthcare personnel. The American Hospital Association has endorsed the concept of vaccination programs for both hospital personnel and patients. To ensure that all healthcare personnel are up to date with respect to recommended vaccines, facilities should review healthcare personnel vaccination and immunity status at the time of hire and on a regular basis (i.e., at least annually) with consideration of offering needed vaccines, if necessary, in conjunction with routine annual disease-prevention measures (e.g., influenza vaccination or tuberculin testing).

Source: Immunization of Health-Care Personnel: Recommendations of the Advisory Committee on Immunization Practices (ACIP), 2011. *MMWR* 2012; 60(RR07);1-45.

Employee Immunization Policy:

A hospital is considered to have a mandatory immunization policy if employees are REQUIRED to provide dates of vaccination or laboratory evidence of immunity. A hospital is considered to have a recommended immunization policy if vaccines are recommended for employees but are not required for employment. A hospital is considered to have a combination immunization policy if it REQUIRES vaccines for designated employees working in specified areas but only RECOMMENDS vaccines for other employees.

Source: Immunization of Health-Care Workers, Recommendations of the ACIP and the Hospital Infection Control Practices Advisory Committee (HICPAC), December 26, 1997.

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Section K
IMMUNIZATIONS AND PERINATAL DISEASE PREVENTION
Instructions and Definitions (continued)

K5. General Immunization Section:
ImmTrac-Texas Immunization Registry:
State law requires that a parent be given the opportunity to consent for immunization registry participation, or request exclusion from the registry, during birth certificate registration. Please assure that your hospital staff utilizes the Vital Statistics Unit Texas Electronic Registrar system for printing the ImmTrac Registration Form, follows appropriate procedures to offer the consent option to the parent, and forwards the completed form to the Vital Statistics Unit, please contact at (188) 963-7111. The option to "GRANT consent for registration" will initiate an immunization record in ImmTrac for children born in Texas. ImmTrac, the Texas Immunization Registry, is a no-cost service that offers a secure and confidential registry available to all Texans. ImmTrac safely consolidates and stores immunization information from multiple sources electronically in one centralized system. Texas law requires written consent for ImmTrac participation and limits access to the registry to only those individuals who have been authorized by law. If your facility is not currently registered for ImmTrac and would like more information, please visit https://www.dshs.state.tx.us/immunize/ImmTrac/provider-resources/ or call (512) 776-6035 for more information.

Hospital Immunization Practices Reviews:
The Immunization Unit, Department of State Health Services, is available to work with your facility to develop or implement hospital immunization policies and to review your current immunization practices. For additional information regarding hospital immunization policies and reviews, please contact the Immunization Unit at (512) 776-6035.

Texas Vaccines for Children:
The TVFC program offers free vaccine to eligible children in Texas through registered providers. If you are not currently a TVFC provider and would like more information on how to register as a TVFC provider, please visit http://www.dshs.state.tx.us/immunize/tvfc/tvfc_about.shtm or call (800) 252-9152 for more information.

K6. Perinatal HIV and Congenital Syphilis Prevention:
If you have questions, please contact the TB/HIV/STD Section, Texas Department of State Health Services at (737) 255-4300 or fax (512) 989-4015.
Perinatal HIV:
Texas law (Chapter 81.090 of the Texas Health and Safety Code) requires that all pregnant women be screened for human immunodeficiency virus (HIV) at their first prenatal visit and during the third trimester. If no record of third trimester test results are available, an expedited test for HIV must be conducted at delivery. Expedited HIV testing of infants at delivery is also required if a mother's results are undetermined. If the mother's HIV status is unknown, a maternal HIV test must be expedited and result obtained < 6 hours after birth and the newborn's blood must be drawn < 2 hours after birth.

HIV is a reportable condition in Texas and should be reported to the local or state health department.

The Texas Administrative Code supports the Texas Statute and provides details on the reporting process. TAC Title 25, Part 1, Chapter 97, Subchapter F outlines who, what, when, where and how to report cases of HIV and other STDs. A copy of the Texas Administrative Code is available here: http://texreg.sos.state.tx.us/public/readtac$ext.ViewTAC?tac_view=5&ti=25&pt=1&ch=97&sch=F&rl=Y.

The Texas Statute, Health and Safety Code, Chapter 81, Subchapter C establishes the reporting of HIV and AIDS to the local health authority. This subchapter outlines general reporting requirements for required entities in the state. A copy of the statute is available here: http://www.statutes.legis.state.tx.us/Docs/HS/pdf/HS.81.pdf.

Communicable disease reporting is exempt from HIPAA (Health Insurance Portability and Accountability Act of 1996). Additional information on HIV reporting requirements can be found online at http://www.dshs.state.tx.us/hivstd/healthcare/reporting.shtm.

To prevent perinatal HIV transmission, the Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission[2] recommends that:

1. Intravenous (IV) zidovudine should be administered to women living with HIV with HIV viral load >1,000 copies/mL (or unknown viral load) near delivery.
2. Intravenous (IV) zidovudine may be considered for women with HIV viral load between 50 and 999 copies/mL.
3. All infants exposed to HIV should receive antiretroviral (ARV) medication to reduce the risk of perinatal transmission of HIV. Infant ARV regimen should be determined based on maternal and infant factors that influence risk of HIV transmission.

If there are questions about the treatment of an infant exposed to HIV, please contact the Perinatal HIV hotline at (888) 448-8765 or refer to the "Guidelines for the Use of Antiretroviral Agents in Pediatric HIV Infection".

Congenital syphilis:
As of September 1, 2019 Texas law (Chapter 81.090 of the Texas Health and Safety Code) requires that all pregnant women be screened for syphilis at their first prenatal visit, during the third trimester (no sooner than 28 weeks gestation), and at time of delivery.

Syphilis is a reportable condition in Texas and should be reported to the local or state health department.

Promptly notify your local or regional health department of syphilis (any stage) at the time of diagnosis. Include pregnancy status in the report.

- All primary and secondary syphilis cases are required to be reported within 24-hours by telephone for public health follow-up.
- All other syphilis cases and syphilis test results are required to be reported within seven days (within three days for laboratories).
- To facilitate timely and adequate treatment for pregnant women, DSHS recommends reporting these syphilis diagnoses within 24 hours by telephone. For more information regarding reporting, please visit www.dshs.texas.gov/hivstd/healthcare/reporting.shtm

Texas healthcare providers are urged to:

- Screen all pregnant women for syphilis according to new testing requirements.
- Look for clinical signs/symptoms of syphilis in all patients.
- Treat patients with evidence of syphilis or recent exposure to syphilis on-site when possible. Document stage of syphilis and treatment administered.
- Report syphilis cases to your local or regional health department at the time of diagnosis. Include pregnancy status and treatment in the report.
- Test and evaluate newborns potentially exposed to syphilis in utero.
- Update electronic health record/electronic medical record systems to reflect new testing requirement.

Congenital Syphilis:

Texas law (Chapter 81.090 of the Texas Health and Safety Code) requires that all pregnant women be tested for syphilis at their first prenatal visit and again during the third trimester, between 28-32 weeks gestation. If no record of third trimester test results are available, a syphilis test must be performed at delivery. If mother's serological status is unknown at the time of delivery, then the newborn must be tested as well. Any woman who delivers a stillborn infant approximately 20 weeks gestation or older or approximately 500 grams or larger should be tested for syphilis.

1. CDC treatment guidelines for pregnant women with syphilis state that:
   a. Penicillin G is the only known effective antimicrobial for preventing maternal transmission to the fetus and treating fetal infection.
   b. Missed doses are not acceptable for pregnant women receiving therapy for late latent syphilis and pregnant women who miss any dose of therapy must repeat the full course of therapy.
   c. No proven alternatives to penicillin are available for treatment of syphilis during pregnancy and pregnant women who have a history of penicillin allergy should be desensitized and treated with penicillin.
2. CDC Evaluation and treatment guidelines for neonates state that:
   a. Treatment decisions should be made on the identification of syphilis in the mother; adequacy of mother's treatment; presence of clinical, laboratory, or radiographic evidence of syphilis in the neonate; and comparison of maternal (at delivery) and neonatal nontreponemal serologic titers.
   b. Infants with proven or highly probable congenital syphilis, should be treated with intravenous aqueous crystalline penicillin for 10 consecutive days.
   c. All infants with reactive nontreponemal tests should have a follow-up examinations and serologic testing every 3 months until the test becomes nonreactive.
      i. Infants with an abnormal CSF evaluation should undergo a repeat lumbar puncture approximately every 6 months until the results are normal.
3. **Send copies of Section K: Hepatitis B vaccination, patient immunization and/or employee immunization, to Imm.Epi@dshs.texas.gov**

Sources:

HIV, Syphilis and HBV Testing and Pregnancy: State Requirements for Texas Clinicians, Texas Department of State Health Services HIV/STD Program, June 2016.

Panel on Treatment of Pregnant Women with HIV Infection and Prevention of Perinatal Transmission. Recommendations for Use of Antiretroviral Drugs in Transmission in the United States. Available at http://aidsinfo.nih.gov/contentfiles/lvguidelines/PerinatalGL.pdf. Accessed January 23, 2019

2015 Sexually Transmitted Diseases Treatment Guidelines, Centers for Disease Control and Prevention, June 4, 2015

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Section L
CHARITY CARE AND COMMUNITY BENEFITS INFORMATION
Instructions and Definitions

2. a. Charity Care (provided by your hospital): Health care services provided, funded, or otherwise financially supported on an inpatient or outpatient basis to a person classified by the hospital as "financially indigent" or "medically indigent."
Hospital Eligibility System: The financial criteria and procedure used by a hospital to determine if a patient is eligible for charity care. The system shall include income levels and means testing indexed to the federal poverty guidelines, provided, however, that the hospital does not establish an eligibility system which sets the income level eligible for charity care lower than that required by counties under Section 61.023, or higher, in the case of the financially indigent, than 200 percent of the federal poverty guidelines. A hospital may determine that a person is financially or medically indigent pursuant to the hospital's eligibility system after health care services are provided.

b. Financially Indigent: An uninsured or underinsured person who is accepted for care with no obligation or a discounted obligation to pay for the services rendered based on the hospital's eligibility system.
Medically Indigent: A person whose medical or hospital bills after payment by third-party payers exceed a specified percentage of the patient's annual gross income, determined in accordance with the hospital's eligibility system, and who is financially unable to pay the remaining bill.

3. Charity Care (provided through other organizations): The total amount provided, funded or otherwise financially supported for health care services provided to financially indigent patients through OTHER nonprofit or public outpatient clinics, hospitals or health care organizations. **Please do NOT include charity care provided to the financially or medically indigent on an inpatient or outpatient basis in your facility.**

4. a. Subsidized Health Services: Those services provided by a hospital in response to community needs for which the reimbursement is less than the hospital's cost for providing the services and which must be subsidized by other hospital or nonprofit supporting entity revenue sources. Subsidized health services may include but are not limited to:

- emergency and trauma care;
- neonatal intensive care;
- freestanding community clinics; and
- collaborative efforts with local government or private agencies in preventive medicine, such as immunization programs.

b. Donations: The unreimbursed costs of providing cash and in-kind services and gifts, including facilities, equipment, personnel, and programs, to other nonprofit or public outpatient clinics, hospitals, or health care organizations.

c. Research-Related Costs: The reimbursed or unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting facilities, equipment, and personnel for medical and clinical research conducted in response to community needs.

d. Education-Related Costs: The reimbursed or unreimbursed cost to a hospital of providing, funding, or otherwise financially supporting educational benefits, services, and programs including:

- education of physicians, nurses, technicians, and other medical professionals and health care providers;
- provision of scholarships and funding to medical schools, colleges, and universities for health professions education;
- education of patients concerning diseases and home care in response to community needs; and
- community health education through informational programs, publications, and outreach activities in response to community needs.

Local Programs: Include County Indigent Health Care that covers all those under 21 percent Federal Poverty Level (FPL) who are not eligible for Medicaid. Also include other programs where a unit of local government pays for the care or provides insurance based on specific medical conditions and/or financial need. **Excludes** public sector employees' care and related payments.

State programs: Programs such as the Children's Health Insurance Program and the Kidney Health Program, where the State of Texas pays for care or provides insurance based on specific medical conditions and/or financial need. This includes care provided to state inmates or prisoners.

Medicare: Include charges for persons enrolled in the federal Medicare program under Title XVIII of the Social Security Act. Enrollees are typically elderly or the disabled.

5a. Medicare supplemental payments: Report reconciling or settle-up payments received from the federal government for the Medicare Program received during the reporting period, regardless of the data of service. These include Medicare DSH and IME.

5b. Tax revenue: Public hospitals shall report tax revenue or collections, less any intergovernmental transfers (IGTs) in support of Medicaid payments.

5b.1. Intergovernmental transfers for DSH: Tax revenues used as intergovernmental transfers (IGTs) to the state in support of the Disproportionate Share Hospital (DSH) program in Medicaid, if applicable.

5b.2. Intergovernmental transfers for 1115 Waivers: Tax revenues used as intergovernmental transfers (IGTs) to the state in support of the 1115 Waivers, if applicable.

5b.3. Other Intergovernmental transfers IGTs: Tax revenues used as intergovernmental transfers (IGTs) to the state to be used as match in federal funding programs, excluding DSH and UC Pool. Report only if applicable.

5c. Collections from patients previously reported as uncompensated: Payments from the patients whose care was reported as uncompensated (charity, self-pay/uninsured, or partially insured) received after reporting information to the state, regardless of the year of service. These amounts will not be used to recalculate prior year(s) residual uncompensated care but are considered available revenue to offset the cost of care provided to other patients in the current reporting period.

5d. Collections from patients meeting trauma eligibility previously reported as uncompensated: Payments from patients whose care was reported as uncompensated (charity, bad debt, uninsured/self-pay and/or partially insured) and eligible for reimbursement under the state trauma program received after reporting information to the state, regardless of the date of service. These payments are considered available revenue to offset the cost of care provided to trauma patients in the current reporting period.

7. An International Board Certified Lactation Consultant, or IBCLC, is a health care professional who specializes in the clinical management of breastfeeding and who is certified by the International Board of Lactation Consultant Examiners Inc. under the direction of the US National Commission for Certifying Agencies.

Section P
ELECTRONIC EXCHANGE
Instructions and Definitions

Electronic Exchange: Electronic exchange of patient healthcare information refers to exchanging of data through non-manual means, such as EHRs and/or portals, and excludes fax/paper.