

2006 ANNUAL HOSPITAL QUESTIONNAIRE (AHQ) INSTRUCTIONS

January 1, 2006 through December 31, 2006

- IMPORTANT NOTICE ABOUT SURVEY ACCURACY AND COMPLIANCE -

The information and data collected through this survey are used for state regulatory and planning purposes and are made available to public officials, advocacy groups, health care purchasers, and consumers. This survey is required under Department of Community Health Rule 111-2-2-.04 and other regulations. The failure to properly submit and/or fully complete all required surveys may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.05, .09 and other regulations or statutes.

The chief executive officer or principal administrator of the facility (who shall attest to the accuracy and completeness of the information provided) and your organization are responsible for ensuring the accuracy of the information and data reported in this survey. The sole responsibility for accuracy resides with the organization and the officials filing the survey. Accuracy at time of submission is particularly important. See Rule 111-2-2-.04(e) prohibiting survey revisions unless approved by the Department at its sole discretion.

Providing false or inaccurate information may result in adverse regulatory action pursuant to DCH Rules 111-2-2-.04(1)(b), 111-2-2-.05(1)(a)1, and 111-2-2-.05(1)(a)7, other regulations and statutes, and may constitute a crime under O.C.G.A. §§ 16-10-20 and 16-14-1.

USING THE ACCESS FORMS

The 2006 AHQ consists of ten Microsoft Access forms within a single database file. You must have Microsoft Access 2000 or a later version of Access in order to open the database and complete your survey. **Microsoft Access 97 is no longer supported.**

The AHQ is divided into the following sections, each representing an individual Microsoft Access form which can be found in the drop-down menu on the opening screen:

- AHQ Parts A-C
- AHQ Part D
- AHQ Parts E-F
- AHQ Part G
- Surgical Services Addendum
- Perinatal Services Addendum
- Psychiatric and Substance Abuse Services Addendum
- Long Term Care Hospital Services Addendum
- Patient Origin Table
- AHQ Signature Form

IF YOU NEED ASSISTANCE

When you are working in the database, you may view these instructions by clicking the Help button found on each form. You can get specific instructions for any **item in blue** on the form by clicking the item.

If you can't find the answer to your problem on the Help screens, check the "Frequently Asked Questions" document on the web page where you downloaded the database. This document will be updated periodically as new questions arise.

If you still have any questions after reviewing the documentation above, **please contact Matthew Jarrard with the Division of Health Planning at (404) 656-0467, or mjarrard@dch.ga.gov.**

INSTRUCTIONS FOR SUBMITTING THE DATABASE

The deadline for filing the completed 2006 AHQ database is February 29, 2008.

Once you have completed your survey and resolved any data validation issues, you should electronically submit the survey to the Department of Community Health (DCH). **Please do not fax or mail a hard copy.** Follow the steps below to submit your survey:

1. You must sign the Signature Form before submitting the database. The survey will not be deemed complete without an authorized signature.
2. Please be sure to print a copy of your completed forms before submission and retain a copy of the Access file for your records.
3. To submit your database, click the green Upload button on the survey opening screen and follow the on-screen instructions. Email submissions of survey databases will **no longer be accepted**. However, you may send any supplemental documents via email to the address listed in the previous section.

Survey Completion Status – Typically, a survey will be considered complete when a signed, completed version is received by the Division of Health Planning. All requested data elements must be provided; edit check, error messages, and validation rules must be addressed or in balance; and the survey must be signed in the appropriate location and manner. Once received and determined to be complete by the Division, the survey is considered a public record. DCH staff may not be able to process your survey immediately due to high volumes of survey submissions. You may follow-up a few days after submitting your survey to make sure your survey has been processed and is considered complete by the Division of Health Planning. The completed survey will be deemed complete on the day it is received by DCH even if it is processed later. The completion status of all surveys for each facility will be published on the DCH website on or after the survey due date.

Note: It is extremely important that you retain a copy of your completed survey (both the Access database and a printed copy).

Revising or Amending the Survey – Pursuant to Rule 111-2-2-.04(1)(e) surveys that are received and determined to be complete by the Division of Health Planning may not be revised after the survey due date without approval by DCH. Requests to revise must be submitted in writing to the Division of Health Planning with a detailed explanation of the revisions and any necessary documentation. The Division of Health Planning will consider revisions on a case-by-case basis and reserves the right to deny a request to revise. The Division may also determine that additional data, information, or documentation is needed to support the proposed revisions.

INSTRUCTIONS FOR COMPLETING THE SURVEY FORM

The Access database file may either be saved to a single computer or to an internal computer network. The database can be placed on a network so that multiple users can access and complete (or review) the survey at different times. Please be sure not to make copies of the database. Only one version of the database should be sent to the Division of Health Planning (DHP). The Access file should open automatically to an opening screen where you can select a form to complete or view. The drop-down menu on this opening screen allows respondents to select other forms to complete or edit. Forms can be completed in any order, except that Parts A-C should be completed before the Patient Origin Table and all forms and addenda (where applicable to your facility) must be completed before the Signature Form will accept an authorized signature. You should be able to print a blank copy of the survey from the "print" button included on each form or from the opening screen. Enter your facility's data using the survey form. Please be sure to provide an answer in every question. If the question does not apply to your facility please indicate "not applicable". Access does not have a "save" feature like other applications. Each change you make to the form will be saved automatically.

INSTRUCTIONS FOR COMPLETING THE SIGNATURE FORM

The database contains two types of forms. The first type is the survey form described above. This form is used to collect utilization data and information. The Signature Form is where the facility's chief executive or administrator electronically authorizes the survey for release to the Department of Community Health. The facility's chief executive officer or administrator must sign to certify that the responses are complete and accurate for the report period specified. A typed version of the signature is being accepted as an original signature pursuant to the Georgia Electronic Records and Signature Act.

The Signature Form also runs two types of data validation tests. The first determines if there are any totals that are required to be in balance that are out of balance (such as total admissions by race and total admissions by gender) or if any required fields were left blank. These first set of validation tests require resolution before the authorized signature will be accepted by the database. The second type of test determines if any reported information triggers a validation issue where certain data elements are not consistent with DHP records or generally accepted expectations (reporting neonatal care at a more clinically intensive level than authorized, for example). These should only require an explanation and would not preclude you from completing the survey. Unresolved data issues of this type should be addressed by an explanation in the provided comments box if the data is not changed or amended.

Data Validation Requirements – All edit and balance requirements and all required fields must be completed before the facility's administrator or chief executive can authorize the survey. You can determine if the required survey totals are in balance and that all required items are complete by clicking the "View Error Messages" button in the Data Validation Requirements section at the top of the Signature Form. This button produces the Data Validation Report containing a description of any out of balance totals and any required data items that are missing. The Data Validation Report can be printed and should be rerun until all items have been corrected.

Note: *Each item on the Data Validation Report must be corrected before the form will accept the authorized signature.*

PART A: GENERAL INFORMATION

Hospital Name and Address – Please insert your hospital's name and address as requested. Be sure to use the same name on each form of the AHQ and Addenda.

Medicaid and Medicare Numbers – Please enter the appropriate numbers for your facility. Do not enter dashes or alpha characters for either provider number.

Report Period - The required report period is 1/1/2006 to 12/31/2006 unless noted otherwise. If the facility was in operation a full year, 12 months of data must be reported even if the ownership or management of the facility changed. It is the responsibility of the current owner or operating entity to obtain data from the prior owner/operator if necessary. Please note if the facility was not in operation for the entire report period.

PART B: SURVEY CONTACT INFORMATION

Please provide contact information for the individual authorized to respond to questions regarding your facility's survey and addenda.

PART C: OWNERSHIP, PROGRAMS, and LICENSURE

For Part C, Question 1, please provide the following information as applicable to your facility. If certain fields do not apply the form will allow you to enter only "Not Applicable" in the Full Legal Name column.

1.a & 1.b - Owner - Provide the full legal name of the facility's owner and the owner's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change of ownership that has occurred since 12/31/2005.

1.c & 1.d - Operator - If the operating entity is other than the owner, provide the full legal name of the facility's operator and operator's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in operating entity that has occurred since 12/31/2005.

1.e & 1.f - Manager - If a management contract is in effect, provide the full legal name of the facility manager and the manager's parent organization, if any, as of the last day of the report period. Include the appropriate organizational type from the drop-down menu and the effective date of any change in management contractor that has occurred since 12/31/2005.

2. Changes - If changes occurred during or after the report period, explain and include the effective dates of any change.

3. Health Care System - A corporate body that may own and/or manage health provider facilities or health related subsidiaries, as well as non-health related facilities including freestanding facilities and/or subsidiary corporations.

4. Holding Company - Any company, incorporated or unincorporated, that is in a position to control or materially influence the management of one or more other companies by virtue of its ownership of securities and/or its rights to appoint directors in the company or companies.

5. Subsidiary - A company wholly controlled by another organization or one that is more than 50% owned by another organization.

6. Alliance - A formal organization, usually owned by shareholder/members that works on behalf of its individual members in the provision of services and products and in the promotion of activities and ventures.

7. Health Care Network - A group of hospitals, clinics, physicians, other health care providers, insurers, and/or community agencies that work together to coordinate and deliver a broad spectrum of services to their community.

8. Medical Errors - The Institute of Medicine defines a medical error as "the failure to complete a planned action as intended or the use of a wrong plan to achieve an aim." Medical errors can include any of the following:

- Diagnostic error, such as misdiagnosis leading to an incorrect choice of therapy, failure to use an indicated diagnostic test, misinterpretation of test results, and failure to act on abnormal results.
- Equipment failure, such as defibrillators with dead batteries or intravenous pumps whose valves are easily dislodged or bumped, causing increased doses of medication over too short a period.
- Infections, such as nosocomial and post-surgical wound infections.
- Blood transfusion-related injuries, such as giving a patient the blood of the incorrect type.
- Misinterpretation of other medical orders, such as failing to give a patient a salt-free meal, as ordered by a physician.

(Source: Agency for Healthcare Research and Quality)

9. Primary Care Physician Group Practice - Indicate whether the hospital owns or operates a primary care physician group practice.

Part C, Questions 10.a & 10.b

Health Maintenance Organization (HMO) - An organization that has management responsibility for providing comprehensive health care services on a prepayment basis to voluntarily enrolled persons within a designated population.

Preferred Provider Organization (PPO) - An organizational arrangement between providers and at least one group purchaser whereby health care services are purchased for a specific population at a negotiated rate. Providers are paid on a fee-for-service basis.

Physician Hospital Organization (PHO) - A type of managed care plan that assumes risk for providing a set of health care services to an enrolled population on behalf of one or more hospitals and affiliated physicians. Plans are paid on a prepaid basis with limited co-payments, and services are provided through a system of affiliated providers, who can be paid with different payment mechanisms ranging from capitation to fee for service. Physicians retain ownership of their practices, and may maintain significant business outside the PHO, and typically continue in their traditional style of practice. They do not always provide comprehensive services and may contract with an HMO or PPO.

Provider Service Organization (PSO) - An entity that assumes risk on behalf of one or more affiliated providers for a range of services. Plans are paid on a prepaid basis with limited co-payments, and services are provided through a system of affiliated providers, who can be paid with different payment mechanisms ranging from capitation to fee for service. Physicians retain ownership of their practices, and may maintain significant business outside the PSO, and typically continue in their traditional style of practice. They do not always provide comprehensive services and may contract with an HMO or PPO.

PART D: INPATIENT SERVICES

Note: Total admissions and inpatient days must balance throughout the AHQ.

1.a through 1.n

Beds Set-Up & Staffed - The number of beds that are ready for immediate occupancy by patients and that are staffed with personnel for immediate care of patients. Provide beds, admissions and inpatient days for each service for which beds were *designated* or *dedicated*.

If you designate or dedicate beds for obstetrics, pediatrics, etc., report these figures separately. Also, specify other services for which beds are designated such as Orthopedics or Neurology.

Include LDRP (labor/delivery/recovery/postpartum) beds in Obstetrics, but **do not** include LDR (labor/delivery/recovery) beds. Obstetrics data should not include gynecology data. Do not combine OB and GYN beds.

Inpatient Days - Also known as census days or occupied bed days, an inpatient day is defined as the care of one patient during the period between the census-taking hour of two successive calendar days. The day of discharge should not be counted. If a patient is admitted and discharged on the same day, then one day of inpatient care is counted.

Discharges and Discharge Days: The number of days each patient discharged during the report period spent in the hospital from date of admission or readmission to date of discharge, even if the patient was admitted prior to the first day of the report period. Report the service being rendered at the time of discharge from the hospital. A transfer from one service to another within the hospital should not be counted as a discharge.

SELECTED DEFINITIONS

Physical Rehabilitation - A special program that provides coordinated multi-disciplinary physical restorative services under the direction of a physician(s) knowledgeable and experienced in rehabilitation medicine.

Long Term Care Hospital (LTCH) – A hospital or hospital-within-a-hospital providing specialized acute hospital care in beds that are classified by Medicare pursuant to 42 CFR §412.23(e). Generally, LTCHs provide care to medically complex patients who are critically ill, have multi-system complications and/or failure, and require hospitalization averaging 25 days in a facility offering specialized treatment programs and therapeutic intervention. Services must be offered on a 24-hour/7-day a week basis that complies with appropriate HCFA regulations. LTAC beds require a separate license from acute care hospital beds.

Note: Do not include any Nursing Home beds or Swing Beds as Long Term Hospital Beds. The hospital in which the LTCH beds are located is responsible for reporting LTCH utilization (even if the LTCH beds are operated by another entity).

2. Utilization by Race/Ethnicity of Patient - Report admissions and inpatient days by race/ethnicity according to the indicated categories. These data are needed as an indication of the services rendered to population sub-groups. The totals here should agree with admissions and inpatient days reported elsewhere in the AHQ. The United States Census Bureau uses the following racial and ethnicity definitions:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.

Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Multi-Racial: A person having racial origins from two or more of the above definitions.

3. Utilization by Gender - Report admissions and inpatient days by gender. The totals here must balance to total admissions and inpatient days reported elsewhere in the AHQ.

4. Government Payment Source: Report total admissions and inpatient days for Medicare, Medicaid, and Peachcare for Kids. Include swing bed data and long-term acute care bed data, but **do not** include newborn/neonatal or SNF/ICF unit data.

6. Charges for Selected Services - Report the hospital's average charges as of 12/31/2006 for the services listed.

PART E: EMERGENCY DEPARTMENT AND OUTPATIENT CLINIC SERVICES

1. Emergency Visits - Report the total number of visits by patients seen in the emergency unit for true emergency purposes only. Include only those patients who were treated in the Emergency Department.

2. Inpatient Admissions from the Emergency Department: Report the number of patients who were admitted as hospital inpatients immediately following diagnosis and/or treatment in the Emergency Department.

3. Report the total number of beds available and dedicated for use by and within the Emergency Department as of the last day of the report period. Include normal emergency, trauma, and any other type of bed. Do not report rooms, but include all beds in all emergency department rooms.

4. As applicable, provide information on the number of beds or rooms dedicated for trauma, psychiatric/substance abuse, and other types of emergency department cases and the visits associated with these for the report period. If beds or rooms are dedicated to other types of specific emergency department visits, please specify. Do not include beds utilized for general use in the emergency department.

5. Report number of patients who were admitted to your emergency department (emergency only) who were then transferred to another healthcare institution. Report cases that were transferred from the emergency department only. Do not include cases that were admitted as inpatients to your hospital and then transferred.

6. Outpatient/Clinic/Other Visits - Report the total number of all other scheduled or unscheduled outpatient visits to clinics, other cost centers or to the emergency department for non-emergency services. Include physician referrals and outpatient/ambulatory surgery visits. Count an individual patient's visit as one regardless of the number of units or procedures performed.

7. Observation Visits: 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 to determine the need for possible admission to the hospital as an inpatient. Observation services usually do not exceed 24 hours.

8. Diverted Cases: If available, report the total number of patients which were diverted to other hospitals while your facility was on ambulance diversion and unable to accept ambulance visits. Report the total number of cases for the entire report period.

9. Ambulance Diversion Hours: Report the total number of hours for which your hospital was on ambulance diversion for the entire report period.

10. If available, report the number of patients who sought care in the emergency department but who left without being treated. Do not include patients who were transferred or diverted to another facility.

PART F: SERVICES AND FACILITIES

Complete the services and facilities table as requested. See below for definitions. Include services offered to inpatients, outpatients, or both. Place the appropriate code for each service that was offered either In-House or by Contract and use the appropriate codes to indicate whether the service was on-going, newly initiated, or discontinued during the report period. **If a service was not provided during the report period then indicate "not applicable." Do not leave any fields blank.** In reporting workloads, patients should only be counted once per service per report period whereas procedures and treatments should reflect the total performed or delivered even if they were provided multiple times to one patient. **Please Note: Units should indicate the number of machines (e.g. CTS, PET, or MRI machines).**

DEFINITIONS:

In-House: A service provided in the hospital by hospital personnel using hospital-based equipment.

Contract (including Mobile): A service contracted for by the hospital that is also hospital-based (*i.e.*, provided in the hospital or on its grounds) including mobile services provided on the hospital grounds. In this case the contractor may actually provide staff for the service.

Renal Dialysis: Equipment and personnel for the treatment of renal insufficiency.

Renal Extracorporeal Shock Wave Lithotripter (ESWL): A medical device used for treating stones (renal calculi) in the kidney or ureter by disintegrating the stones non-invasively through the transmission of acoustic shock waves directed at the stones. Count each patient only once regardless of the number of procedures performed. A procedure may involve one or more submersions and/or shock wave transmissions during a single patient encounter. Count each return treatment encounter as an additional procedure, but do not count the patient again.

Biliary Lithotripter: A medical device used for treating gallstones in the gall bladder by disintegrating the stones non-invasively through the transmission of acoustic shock waves directed at the stones. In reporting the workload total, count as one procedure each discrete patient treatment encounter. Count each return treatment encounter as an additional procedure, but do not count the patient again.

Other Organ/Tissue Transplants: Specify the type(s) of organ/tissue transplants, other than kidney or heart, performed and report the number of transplants by type.

C.T. Scanner: A computed tomographic scanner for head or whole body scans. Report as one procedure the

initial scan plus any necessary additional scan(s) of the same anatomic area of diagnostic interest done during a single visit. Include both head and body scans.

Radioisotope, Diagnostic: The use of radioactive isotopes (radiopharmaceuticals) as tracers or indicators to detect an abnormal condition or disease in the body.

Radioisotope, Therapeutic: The use of radioactive isotopes (radiopharmaceuticals) for the treatment of malignancies.

Positron Emission Tomography (PET): PET is 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.

Magnetic Resonance Imaging (MRI): A non-invasive diagnostic modality using a uniform magnetic field, radio frequencies, and computers to produce images of body organs and tissues without the use of ionizing radiation, radioisotopic substances, or high-frequency sound. In reporting the workload total, '# MRI procedures,' report as one procedure each discrete MRI study of one patient. A procedure may involve one or more scans of the same anatomical area of diagnostic interest during a single patient encounter.

Chemotherapy: Treatment of cancer by use of drugs and chemicals.

Respiratory Therapy: Facilities for the provision of respiratory therapy service to patients administered by a qualified respiratory therapist or specially trained individual.

Occupational Therapy: Facilities and services for the provision of occupational therapy prescribed by physicians and administered by, or under the direction of, a qualified occupational therapist.

Physical Therapy: Facilities and services for the provision of physical therapy prescribed by physicians and administered by, or under the direction of, a qualified physical therapist.

Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV) Service: An organized service or program providing laboratory and clinical tests to detect the virus that causes AIDS and/or providing specialized treatment for resulting infections and diseases brought on by the immune deficiency. Services may also include educational programs and counseling to hospital staff, the patients and their families.

Hospice: A program providing palliative care, chiefly medical relief of pain and supportive services, to terminally ill patients and assistance to their families in adjusting to the patient's illness and death.

Respite Care: Facilities and services that provide for short-term placement of individuals, usually geriatric, to help meet family emergencies, planned absences (such as vacations or hospitalization), or to allow family caregivers to shop or do errands.

PART G: FACILITY WORKFORCE INFORMATION

1. & 2. The Division of Health Planning collects workforce information to support the State's workforce planning activities. Please report the budgeted number of full-time staff (FTE) and the number of vacancies as of December 31, 2006. Please note that this reporting period is different than the Calendar Year used throughout the rest of the questionnaire.

Also, please report the average time your facility has spent during the past six months filling the listed vacant positions. Select one of the four time periods provided in the drop-down menu for each professional category.

- 3. Physician Race/Ethnicity** – Please report using the Census categories previously defined for Part D.
- 4. Physicians By Medical Staff Categories** - Report the number of practitioners in each of the medical clinical categories listed who have full privileges of admitting patients. Include both Allopathic and Osteopathic physicians. Report a physician who is board certified and admits in more than one specialty in all appropriate specialties. Also, indicate if the reported medical staff is hospital-based and the number that were enrolled as providers in any of the health plans administered by the Department of Community Health during the report period.
- 5. Non-Physicians** - Report the number of dentists (including oral surgeons), podiatrists, Certified Nurse Midwives, and other staff with clinical privileges in the hospital.

PART H: COMMENTS and SUGGESTIONS

Please share any comments about the survey or survey process in general. We welcome your feedback and suggestions. Please reserve comments related specifically to your data or explanations for unresolved data issues for the comments section of the Signature Form.

PATIENT ORIGIN TABLE

Note that the Patient Origin Table cannot be completed until Parts A-C are completed. Please complete the Patient Origin Table to reflect the county (or out-of-state) residence of each admission during the reporting period. The patient origin data entry table is formatted to allow you to capture patient origin for the AHQ and all required addenda. The hospital ID should display for each line of entry. The county column has a pull-down menu listing all 159 Georgia counties in alphabetical order with out-of-state listings for AL, FL, NC, SC, TN, and all other following. Please select patient origin location from this menu and provide total admissions for the report period.

Please be sure to enter data for all applicable service addenda. Your totals will be required to match corresponding total admissions reported elsewhere in the AHQ and Addenda.

FACILITY TOTAL (AHQ Parts A-G)– Report all adult and pediatric inpatient admissions for the report period by the patient’s county of residence. **Do not include newborns.** If admissions by county of residence is not available, the use of discharges by county can be used. Total admissions should balance to total admissions reported elsewhere in the 2006 AHQ.

SURGICAL SERVICES – Report the total number of ambulatory patients receiving services in the surgical suite for the report period by their county of residence. Total patients here should balance to totals reported in the Surgical Services Addendum.

PERINATAL SERVICES – If applicable, report the county of residence for all OB admissions during the report period. **Do not include any GYN patients.** Total admissions should balance to admissions reported in the Perinatal Services Addendum.

PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES -- If applicable, report the total admissions for each psychiatric and substance abuse program by the patient’s county of residence. Total admissions by program should balance to total psychiatric and substance abuse admissions by program reported in the Psychiatric and Substance Abuse Services Addendum.

LONG TERM ACRE HOSPITAL BEDS – Report total admissions to certified Long Term Acute Care or Long Term Care Hospital beds by the patient’s county of residence. The total LTCH admissions should balance to the totals reported on the LTCH Addendum. For LTCHs with-in-a-hospital the host hospital is responsible for providing this information.

2006 ANNUAL HOSPITAL QUESTIONNAIRE SURGICAL SERVICES ADDENDUM INSTRUCTIONS

January 1, 2006 through December 31, 2006

PART A

1. Report the number of surgery rooms as requested for the report period. Report only the surgery rooms in the CON-Approved operating room or surgical suite pursuant to Rule 111-2-2-.40 and 290-9-7-.28.

2. Report surgical procedures performed in the operating room or surgical suite only. Report as one procedure all activities directly related to a surgery. Any surgical activity not related to the primary reason for the surgery would be reported as a separate procedure. For example, a person having a tonsillectomy with adenoidectomy during a single patient encounter would be reported as one patient and one procedure; however, a person having a tonsillectomy with adenoidectomy and an excision of a benign facial tumor during a single patient encounter would be reported as one patient and two procedures.

Report cystoscopies and endoscopies if they are done in the operating room/surgical suite pursuant to Rule 290-9-7-.28.

Report all inpatient and outpatient procedures performed in the surgical suite, whether scheduled or performed under emergency situations.

3. Report total ambulatory patients by type of room. Note that there could be duplication of patients between types of rooms and surgery during the course of the reporting year since a patient could have more than one surgical procedure. A patient having three surgical procedures in your surgical suite during the reporting year would be counted 3 times.

Note: The Surgical Services Addendum requires that procedures and patients be reported for all reported rooms by type. If you report having a particular type of room (dedicated inpatient, or shared, for example) then you should also report utilization (zero or more procedures and patients) for this room type. Report the number of surgery rooms as requested for the report period.

PART B

Note that total ambulatory patients must balance throughout this section of the Surgical Services Addendum.

1. Report the total number of ambulatory patients by the Census race and ethnicity categories listed. Report ambulatory surgery patients only.

2. Report the total number of ambulatory patients by age category. Report ambulatory surgery patients only.

3. Report the total number of ambulatory patients by gender. Report ambulatory surgery patients only.

4. Report the ambulatory patients by payment source. Report Peachcare for Kids and Medicaid separately. Please report Peachcare for Kids as Third-Party. Note that patients could be present in more than one payment category.

2006 ANNUAL HOSPITAL QUESTIONNAIRE PERINATAL SERVICES ADDENDUM INSTRUCTIONS

January 1, 2006 through December 31, 2006

PART A: OBSTETRICAL SERVICES UTILIZATION

Note: Total hospital deliveries must equal or exceed total births, and total births must equal or exceed total live births.

1. Delivery Rooms - Traditional delivery rooms in settings where stages of the birth (labor, delivery, and recovery) normally occur in separate rooms.

2. Birthing Rooms - Birthing rooms were an earlier design concept of LDR/LDRP rooms for low risk deliveries. Many existing birthing rooms function as LDR rooms, yet some patients are discharged from the hospital directly from the birthing rooms. The beds in birthing rooms are not included in the hospital's maximum evaluated bed capacity.

3. LDR Rooms - Combination labor/delivery/recovery rooms, generally used for non-cesarean births, designed and staffed so that patients and their families may stay in the one room for labor, delivery, and recovery. The average length of stay in an LDR room is 12 hours, after which a patient is transferred to an obstetrical postpartum bed. The beds in LDR rooms are not included in the hospital's maximum evaluated bed capacity.

4. LDRP Rooms - Combination labor/delivery/recovery/postpartum rooms, generally used for non-cesarean births, designed and staffed so that patients and their families may stay in one room for labor, delivery, recovery, and for the postpartum hospital stay. The average length of stay in an LDRP room varies from 12-24 hours to 2-5 days, after which the patient is discharged from the hospital. (If LDRP rooms functioned more like LDR rooms during the report period, please note this on the survey.) The beds in LDRP rooms are included in the hospital's maximum evaluated bed capacity and thus in obstetric beds set up and staffed

5. Cesarean Sections - All deliveries reported with ICD-9-CM procedure code 74.

6. Total Live Births - All live births occurring in the hospital or on its grounds. A live birth is the complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of the pregnancy, which, after such expulsion or extraction, breathes or shows any evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles whether or not the umbilical cord has been cut or the placenta is attached.

7. Total Births - All live births and late fetal deaths occurring in the hospital or on its grounds.

8. Total Hospital Deliveries - All live births, early and late fetal deaths, and induced terminations (regardless of gestation period) occurring within the hospital or on its grounds. (See definitions of fetal deaths and induced terminations below.) Note that, based on this definition, total deliveries must equal or exceed total births.

NOTE: **Fetal deaths** are included in total births and deliveries as described below. A fetal death occurs **prior** to complete expulsion or extraction from the mother of a product of human conception, irrespective of the duration of the pregnancy. The death is indicated by the fact that, after such expulsion or extraction, the fetus does not breathe or show any other evidence of life, such as beating of the heart, pulsation of the umbilical cord, or definite movement of voluntary muscles. Fetal death is subdivided according to the timing and mode:

DEFINITIONS:

Early fetal death (abortion) - The expulsion or extraction from the mother of a fetus or embryo weighing 500 g or less (about 22 weeks gestation). This definition excludes induced terminations of pregnancy. Early fetal deaths should be included only in 'total deliveries' reported.

Late fetal death (stillbirth) - Death prior to expulsion, extraction, or delivery in which the fetal weight is greater than 500 g or, if weight is unknown, the duration of the pregnancy exceeds 22 completed weeks' gestation. When neither birth weight nor gestational age is available, a body length of 25 cm (crown-heel) is considered equivalent to a 500 g weight. Late fetal deaths (stillbirths) should be included in 'total births' and 'total deliveries' reported.

Induced termination of pregnancy - The deliberate interruption of pregnancy - to produce other than a liveborn neonate or to remove a dead fetus - that does not result in a live birth. Induced terminations should be included only in 'total deliveries' reported.

PART B: NEWBORN AND NEONATAL NURSERY SERVICES

Note: The Level of Care provided on the form is the CON-authorized neonatal Level of Care for your facility contained in DHP records. Reported utilization should reflect the Level of Care authorized. If your facility has a Level of Care other than that included on the form, please contact the Division before completing the Perinatal Services Addendum.

If newborn/neonatal services were initiated or discontinued (permanently or temporarily) during the report period, please note the date(s) of such changes in the margin.

Report beds per station, admissions, and inpatient days as requested. Include data for all levels of newborn/neonatal care. Include out-borns if they are housed in a nursery and not in the pediatric unit. Make note of the following instructions.

Nursery Beds by Type - Report all patient care stations (bassinets, radiant warmers, or isolettes) in the newborn and neonatal special care nurseries. Report beds used for short-term resuscitation or for transitional care on the line with newborn nursery beds.

Nursery Admissions by Type - Report the total number of infants of any age, including outborns, admitted to newborn (including resuscitation and transitional care) beds and to neonatal special care nursery beds during the report period. Include only infants housed in the nursery; **do not** include any housed in pediatric units. Count each admission only once per hospital stay. Do not count transfers as admissions. Infants transferred within the hospital between nurseries/levels of care should be counted only in the bed to which first formally admitted. (Newborns initially treated in the hospital's resuscitation or transitional area, but first formally admitted to the hospital's special care nursery should be counted as admissions to the special (intermediate or intensive) care nursery. Infants initially admitted to intermediate care beds for continuing care should be counted as admissions to the special care nursery.) If the number of admissions is not available, report discharges and be sure to make note of the substitution.

Nursery Inpatient Days - Report the number of inpatient days in newborn (including resuscitation and transitional care) beds and in neonatal special care nursery beds during the report period. If the number of inpatient days is not available, report discharge days and be sure to make note of the substitution.

Nursery With-in Hospital Transfers ("to" Nursery Transfers) – Report the number of inpatient transfers from within the hospital to each nursery. Only report transfers from within the hospital. For example, if a baby is transferred from one nursery to another the inpatient admission (see above) should be counted in the "from" nursery only and the transfer should be counted in the "to" nursery only.

PART C: OBSTETRICAL CHARGES AND UTILIZATION BY MOTHER'S RACE/ETHNICITY AND AGE

1. Report the number of Obstetrical admissions and inpatient days by the categories of race or ethnicity indicated as defined by the United States Census Bureau. Report only mothers.
2. Report the number of Obstetrical admissions and inpatient days by age category. Report only mothers.
3. Report the average hospital charge for a completely normal delivery with no complications (such as uncomplicated deliveries consistent with CPT Codes 59400, 59409, and/or 59410). The average charge should only include those charges incurred by the mother during the delivery process.
4. Report the average hospital charge for the delivery of a premature baby.

2006 ANNUAL HOSPITAL QUESTIONNAIRE PSYCHIATRIC & SUBSTANCE ABUSE SERVICES ADDENDUM

INSTRUCTIONS

January 1, 2006 through December 31, 2006

PART A, Question 1

Please complete the table by providing the distribution (allocated use) of CON-authorized beds and the number of beds that are set up and staffed. Please see the following definitions. The program columns are designated with the letters beside each definition below.

Note: Please be sure to complete all fields where applicable. If you report set-up and staffed beds under Column A, for example, you should also report CON-Authorized Beds and complete all utilization fields for Column A.

DEFINITIONS

(A) Acute Psychiatric Adult Program: A program serving people ages 18 and over with psychiatric diagnoses in which the average length of stay is usually 45 days or less. Program emphasis is on medically oriented evaluation, diagnosis, stabilization and other short-term treatment.

(B) Acute Psychiatric Adolescent Program: A program serving people ages 13 through 17 with psychiatric diagnoses in which the average length of stay is usually 120 days or less. Program emphasis is on medically oriented evaluation, diagnosis, stabilization and other short-term treatment.

(C) Acute Psychiatric Child Program: A program serving people ages 12 and under with psychiatric diagnoses in which the average length of stay is usually 120 days or less. Program emphasis is on medically oriented evaluation, diagnosis, stabilization and other short-term treatment.

(D) Acute Substance Abuse Adult Program: A program serving people ages 18 and over with substance abuse diagnoses in which the average length of stay is usually 45 days or less. Program emphasis is on medically oriented evaluation, diagnosis, stabilization and other short-term treatment.

(E) Acute Substance Abuse Adolescent Program: A program serving people ages 13 through 17 with substance abuse diagnoses in which the average length of stay is usually 120 days or less. Program emphasis is on medically oriented evaluation, diagnosis, stabilization and other short-term treatment.

(F) Extended Care Adult Program: A program serving people ages 18 and over with psychiatric and/or substance abuse diagnoses in which the average length of stay is usually 5 months or more **and** the programmatic directions are clearly distinct from acute care. Extended care should emphasize psychosocial and vocational components in its service programming as distinguished from acute care emphasis.

(G) Extended Care Adolescent Program: A program serving people ages 13 to 17 with psychiatric and/or substance abuse diagnoses in which the average length of stay is usually one year or more **and** the programmatic directions are clearly distinct from acute care. Extended care should emphasize psychosocial, vocational/prevocational, and educational components in its service programming as distinguished from acute care emphasis.

(H) Extended Care Children Program: A program serving patients ages 12 and under with psychiatric diagnoses in which the average length of stay is one year or more and the programmatic directions are clearly distinct from short-term acute care.

(I) Combined Program: A situation where services for 2 or more of the programs in A through G are combined into a single program, using the same beds and staff. Report programs as combined **only** if you have been

notified by The Division of Health Planning that each program included in your combined program, and the beds related, have been officially recognized as distinct programs in a combined program. Programs must be organized entities with specific programmatic direction and intent to serve a special population via designated staff in dedicated beds in a licensed hospital and must provide services on a 24-hour, seven-day per week basis. Note that the occasional acceptance of patients of a particular age or disability other than those for whom a program was designed does not imply programmatic direction and intent to serve those populations.

Report only beds set-up and staffed at the end of the report period.

PART A, Question 2

Report utilization data according to the instructions and definitions below.

UTILIZATION MEASURES:

Count all admissions and discharges from the psychiatric/substance abuse service, including intra-hospital transfers to/from other services, but excluding transfers between psychiatric/substance abuse programs. Count only inpatient days and discharge days for those days of care actually provided in the psychiatric/substance abuse service and exclude any days of care provided by other services in the hospital.

General Hospitals -- Include all admissions and discharges from the dedicated beds in the hospital's psychiatric and/or substance abuse program(s) whether the patients were directly admitted to or discharged from the program(s) or were intra-hospital transfers from or to another clinical service in the hospital. Report **only** the inpatient days and discharge days actually attributable to a patient's stay in the psychiatric and/or substance abuse unit; do not include any days of care rendered in other clinical services in the hospital. **Do not** include in the data reported here any admissions, discharges, inpatient days, or discharge days for patients having psychiatric and/or substance abuse diagnoses who were not served in the dedicated psychiatric and/or substance abuse beds reported here (e.g., detox patients served in medical-surgical beds).

All Hospitals -- If you served patients in your program(s) who were of age and/or disability groups other than those for whom your program was designed (i.e., for whom beds are dedicated and for whom separate and distinct programmatic direction and intent to serve exists), include the utilization for these groups in the column(s) for the program(s) in which they were served. [Example: You provide an adult acute psychiatric program but occasionally serve adult acute substance abuse patients in the program. You should report all utilization data in Column A.]

Inpatient Days -- For this Addendum, report all inpatient days in the program(s) during the report period. Also known as a census day or occupied bed day, an inpatient day is defined as the care of one patient during the period between the census-taking hour of two successive calendar days. The day of discharge should not be counted. If a patient is admitted and discharged on the same day, then one inpatient should be counted.

Discharge Days -- For this Addendum, report all days spent in the program(s) for all patients discharged from the program(s) during the report period, even if the patient was admitted from or discharged to another service in the hospital. Sometimes known as discharged patient days or days of care, discharge days are the number of days each patient discharged during the report period spent in the program(s) from the date of admission or readmission to the date of discharge whether the admission date was within the report period or in a prior year.

PART B

1. Report the total number of psychiatric and substance abuse admissions and inpatient days by the Census race and ethnicity categories listed.
2. Report the total number of admissions and inpatient days by patient gender.
3. Report the total number of patients and inpatient days by payment source. Report Peachcare for Kids and Medicaid separately. Note that patients could be present in more than one payment category.

2006 ANNUAL HOSPITAL QUESTIONNAIRE LONG TERM CARE HOSPITAL ADDENDUM

INSTRUCTIONS

January 1, 2006 through December 31, 2006

The Long Term Care Hospital Addendum should be completed for licensed Long Term Care Hospitals or Long Term Acute Care Hospitals. A Long Term Care Hospital (LTCH) is a freestanding hospital or hospital-within-a-hospital providing specialized acute hospital care in beds that are classified by Medicare pursuant to 42 CFR §412.23(e). Generally, LTCHs provide care to medically complex patients who are critically ill, have multi-system complications and/or failure, and require hospitalization averaging 25 days in a facility offering specialized treatment programs and therapeutic intervention. Services must be offered on a 24-hour/7-day a week basis that complies with appropriate HCFA regulations. LTAC beds require a separate license from acute care hospital beds.

Note: Do not include any Nursing Home beds or Swing Beds as Long Term Hospital Beds. The hospital in which the LTCH beds are located is responsible for reporting LTCH utilization (even if the LTCH beds are operated by another entity).

PART A: GENERAL INFORMATION

- 1. Accreditation Information** – Please report as directed if your Long Term Care Hospital is accredited independently from the host hospital.
- 2. Number of Licensed LTCH Beds** – Indicate the number of beds licensed by the Office of Regulatory Services of the Department of Human Resources at Long Term Care Hospital beds as of the last day of the report period.
- 3. & 4. Permit Effective Date and Designation** – Indicate the effective date of the LTCH beds reported as licensed in question 2 and indicate the exact type of hospital indicated on the permit itself (e.g. “Long Term Care Hospital” or “Specialty Hospital – Long Term Care”, etc).
- 5. CON-Authorized Beds** – Indicate the number of LTCH beds that were approved or authorized as of the last day of the report period under the Certificate of Need program by the Department of Community Health.
- 6. Set-Up and Staffed Beds** – Indicate the number of LTCH beds that were set-up and staffed as of the last day of the report period.
- 7. Total LTCH Patient Days** – Report the total number of Long Term Care Hospital services patient days of care for the patients admitted LTCH hospital beds.
- 8. Total LTCH Discharges** – Report the total number of patients who were discharged from LTCH beds during the report period.
- 9. Total LTCH Admissions** - Report the total number of patients who were admitted to LTCH beds during the report period.

PART B: UTILIZATION by RACE, AGE, GENDER, and PAYMENT SOURCE

- 1. LTCH Utilization by Race** – Report LTCH admissions and inpatient days by race/ethnicity according to the indicated categories. Total LTCH admissions and days of care should balance to LTCH admissions and days of care reported elsewhere in the LTCH Addendum. The United States Census Bureau uses the following racial and ethnicity definitions:

American Indian or Alaska Native: A person having origins in any of the original peoples of North and South America (including Central America), and who maintains tribal affiliation or community attachment.
Asian: A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian

subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.

Black or African American: A person having origins in any of the black racial groups of Africa. Terms such as "Haitian" or "Negro" can be used in addition to "Black or African American."

Hispanic or Latino: A person of Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race. The term, "Spanish origin," can be used in addition to "Hispanic or Latino."

Native Hawaiian or Other Pacific Islander: A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.

White: A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.

Multi-Racial: A person having racial origins from two or more of the above definitions.

2. LTCH Utilization by Age – Report LTCH admissions and inpatient days by the age cohorts indicated. Total LTCH admissions and days of care should balance to LTCH admissions and days of care reported elsewhere in the LTCH Addendum.

3. LTCH Utilization by Gender – Report LTCH admissions and inpatient days of care by gender. Total LTCH admissions and days of care should balance to LTCH admissions and days of care reported elsewhere in the LTCH Addendum.

4. LTCH Utilization by Primary Payer – Report LTCH patients and days of care by the patient's primary payer category.