ANNUAL SURVEY OF HOSPITALS TEMPLATE
WHA Information Center

NOTE: Refer to the detailed instructions contained in the Annual Survey Manual.

This is a blank template to use to share the basic questions of the survey with other people in the organization in preparation for gathering all the necessary information to complete the online survey.

All survey data must be entered and submitted through the online secured portal. Each staff member completing a portion of the survey must have their own username and password. Click here for more information on roles and registration.

This information can also be printed from the survey portal.

*Disclaimer-the annual survey manual and the online portal contains the most accurate up-to-date information.

This template does not reference a specific year as all data is submitted through the online portal for the current year.

I. GENERAL INFORMATION

WHA Info Center 3-digit ID ____________ ____________

Hospital Name ______________________________

Address ______________________________ P.O. Box ____________

City, State ______________________________ ZIP Code ____________

FY Beginning Date

___ / ___ / ___
Mo. Day Yr.

FY Ending Date

___ / ___ / ___
Mo. Day Yr.

II. HOSPITAL INFORMATION AND CLASSIFICATION

Organization Information

1 Communications Contact and Reporting Period

A. Identify the main primary contact responsible for communications related to the data.
B. Indicate the beginning of your current fiscal year.
C. Reporting period begin date.
D. Were you in operation 12 full months at the end of your reporting period?
Yes---
No---If no, number of days open during reporting period.

Hospital / Organization Type

2 Indicate the type of organization responsible for establishing policy concerning overall hospital operation.
CHECK ONLY ONE CODE

Government, Nonfederal	Non-government, Not-for-profit	Investor-owned For-profit	Government, Federal
☐ 12 State	☐ 21 Religious organization	☐ 31 Individual	☐ 45 Veterans Affairs
☐ 13 County	☐ 23 Other not-for-profit	☐ 32 Partnership	
☐ 14 City		☐ 33 Corporation	

3 Is the hospital part of a health care system? .... ☐ Yes ☐ No
If YES, give name, city, and state of the system headquarters.

(Name) *(City)* *(State)*

4 Is the hospital a division or subsidiary of a holding company? .... ☐ Yes ☐ No

5 Does the hospital itself operate subsidiary corporations? .... ☐ Yes ☐ No

6 Is the hospital contract managed? .... ☐ Yes ☐ No
If YES, give name, city, and state of organization that manages the hospital.

(Name) *(City)* *(State)*

7 Is the hospital a member of an alliance? .... ☐ Yes ☐ No
If YES, give name, city, and state of the alliance headquarters. **If more than one, list in Section XIV.**

(Name) *(City)* *(State)*

8 Is the hospital a participant in a health care network? .... ☐ Yes ☐ No
If YES, give name, city, and state of the network headquarters. **If more than one, list in Section XIV.**

(Name) *(City)* *(State)*

9 Does the hospital participate in a group purchasing arrangement? .... ☐ Yes ☐ No
If YES, give name, city, and state of the group purchasing organization.

(Name) *(City)* *(State)*

10 Does the hospital own or operate a primary group practice? .... ☐ Yes ☐ No

Service

11 Indicate the ONE category that BEST describes the type of service that the hospital provides to the MAJORITY of admissions.

☐ 10 General medical and surgical ☐ 22 Psychiatric
☐ 15 GMS – Critical Access Hospital ☐ 46 Rehabilitation

☐ 20 GMS – Long-Term Acute Care ☐ 82 Alcohol/Substance Use Disorder

12 Does the hospital restrict admissions primarily to children? ☐ Yes ☐ No

Accreditation (Check all that apply). **Note for "Other," do not specify State of Wisconsin*

13 ☐ The Joint Commission Date of last survey __/__ (mm/yy) ☐ DNV ☐ AOA ☐ Title 18 certified and HFS 124 licensed ☐ DHS 124 licensed ☐ Other (specify) ______________

Certification Status
If more than one provider number, list in Section XIV.

14 Medicare (Title 18) ☐ Yes ☐ No

If YES, **Provider Number** 52 - ____ ____ ____ ____

15 Medicaid (Title 19) ☐ Yes ☐ No

If YES, **Provider Number** ____ ____ - ____ ____ ____ ____ ____ ____

Managed Care Information

Does the hospital have a formal written contract that specifies the obligations of each party with:

16 Health Maintenance Organization *(HMO)*? ☐ Yes ☐ No **If Yes,** how many contracts? ☐

17 Preferred Provider Organization *(PPO)*? ☐ Yes ☐ No **If Yes,** how many contracts? ☐

18 Other managed care or prepaid plan? ☐ Yes ☐ No **If Yes,** how many contracts? ☐

19 Indicate whether any of the following insurance products have been developed by the hospital, health care system, network, or jointly owned with an insurer *(check all that apply)*:

	(1) Hospital	(2) Health Care System	(3) Network	(4) Jointly Owned With Insurer
Health Maintenance Organization	☐	☐	☐	☐
Preferred Provider Organization	☐	☐	☐	☐
Indemnity Fee-for-Service Plan	☐	☐	☐	☐

20 What percentage of the hospital's NET patient revenue is paid on a capitated basis? (If the hospital does not participate in capitated arrangements, **enter "0."**) ______ % (Round; do not use decimals.)

21 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

22 If your hospital has arrangements to care for a specific group of enrollees in exchange for a capitated premium, how many lives are covered? ☐

Criteria to Determine If Nursing Home Data Should Be Submitted

23 Does the hospital own and operate a nursing home facility under HFS 132? .... ☐ Yes ☐ No
If YES, answer the question on line 24.

24 Are the hospital and nursing home governed by a common Board of Directors? .... ☐ Yes ☐ No

25 If answers to both 23 and 24 are YES, check the appropriate box regarding the location of the nursing home facility.

Attached/within hospital ☐ Freestanding on hospital campus ☐ Freestanding off campus ☐

III. SELECTED INPATIENT UNITS

If information for a category is zero, fill in 0. If information for a category is Not Applicable, fill in 0. Do NOT use dashes, NA, N/AV, or M.

Account for all adult and pediatric inpatient beds set-up-and-staffed on the last day of the fiscal year (***excluding weekends or holidays***). Do not include “normal newborn” bassinets. List beds for a line only if a unit is specifically designated for the service area. The number of discharges should include deaths and unit transfers. For each service listed, circle the code number (*see codes 1-5 below*) that best describes the status of the service as of the last day of the fiscal year.

Code	Description
1	**Service is provided in or by the hospital in a DISTINCT AND SEPARATE UNIT. The number of beds and utilization information MUST be provided for inpatient units.**
2	**Service is provided in or by the hospital but NOT IN A DISTINCT AND SEPARATE UNIT.**
3	**Service is provided by the hospital’s Health Care System.**
4	**Service IS NOT MAINTAINED by the hospital but is available, in the hospital or another facility, through a FORMAL CONTRACTUAL arrangement with another hospital or provider, including networks and joint ventures.**
5	**SERVICE NOT AVAILABLE either by the hospital or through a formal contractual arrangement with another hospital or provider.**

Code	Description
O	**Service is provided by the hospital IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING and is billed under.**
B	**Service is provided by the hospital IN BOTH THE MAIN HOSPITAL BUILDING AND IN BUILDINGS OTHER THAN THE MAIN HOSPITAL BUILDING).**

NOTE: If the hospital has beds of more than one type in a mixed unit, all bed and utilization data for all bed types found in that unit should be reported on the line corresponding to the mixed unit. Code the "mixed unit" with a "1," and code each individual bed type line for that unit with a "2."

Example: If "Mixed intensive care" is the main unit for intensive care beds, code it "1" and the types of beds that may be found there "2." All bed and utilization data should be reported on line 40, "Mixed intensive care."

For a unit coded "2," utilization may be reported only if beds, discharges, and inpatient days are all available.

26 Are any patient services provided by the hospital in buildings other than the main hospital bldg .... ☐ Yes ☐ No

If YES, enter address(es) of other buildings:
In addition to circling code numbers 1-5, **circle O or B, if applicable. See Instructions.**

Selected Inpatient Units	Beds-set-up-&-staffed last day of fiscal year	Number of discharges / transfers for fiscal year	Inpatient days for fiscal year	Discharge Days	Circle one for each line	O or B
GENERAL MEDICAL/SURGICAL						
27 Adult Medical / Surgical, Acute (include gynecology)	____	____	____	____	1 2 3 4 5	____
28 Orthopedic	____	____	____	____	1 2 3 4 5	____
29 Rehabilitation and Physical Medicine	____	____	____	____	1 2 3 4 5	____
30 Hospice	____	____	____	____	1 2 3 4 5	____
31 Acute Long–Term Care (Hospital Only)	____	____	____	____	1 2 3 4 5	____
32 All Other Acute (Specify types) [____]	____	____	____	____	1 2 3 4 5	____
33 Pediatrics General Medical/Surgical	____	____	____	____	1 2 3 4 5	____
34 Obstetrics Level of care (1, 2 or 3) [ ] (include LDRP, exclude gynecology)	____	____	____	____	1 2 3 4 5	____
35 Psychiatric Inpatient Care Inpatient Care	____	____	____		1 2 3 4 5	____
36 Alcohol/Substance Use Disorder Inpatient Care	____	____	____	____	1 2 3 4 5	____
ICU/CCU						
37 Medical / Surgical Intensive Care	____	____	____	____	1 2 3 4 5	____
38 Cardiac Intensive Care	____	____	____	____	1 2 3 4 5	____
39 Pediatric Intensive Care	____	____	____	____	1 2 3 4 5	____
40 Burn Care	____	____	____	____	1 2 3 4 5	____
41 Mixed Intensive Care	____	____	____	____	1 ■ 3 4 5	____
42 Step-down *(special care)*	____	____	____	____	1 2 3 4 5	____

	Selected Inpatient Units	Beds-set-up-&-staffed last day of fiscal year	Number of discharges / transfers for fiscal year	Inpatient days for fiscal year	Discharge Days	Circle one for each line	O or B
43	**Neonatal Intensive / Intermediate Care** *(exclude normal newborns)*	______	______	______	______	1 2 3 4 5	______
44	**All Other Intensive Care** [specify type(s)] ______	______	______	______	______	1 2 3 4 5	______
45	**Subacute Care** Inpatient care	______	______	______	______	1 2 3 4 5	______
46	**ALL OTHER INPATIENT UNITS** [specify treatment area(s)] ______	______	______	______	______	1 2 3 4 5	______
47	**TOTAL HOSPITAL FACILITY** (**Exclude** Medicare-certified swing bed inpatient days and Non-Medicare-certified, swing-bed inpatient days).	______ (add lines 27-46)	______ (add lines 27-46)	______ (add lines 27-46)	______ (add lines 27-46)		
48	**MEDICARE-CERTIFIED SWING UNIT** (Medicare patients only) (Report **average** number of beds used, rounded to whole number)	______ (average # beds used)	______ (discharges and transfers)	______ (inpatient days)	______ (discharge days)	1 2 3 4 5	______
49	**NON- MEDICARE-CERTIFIED SWING UNIT** (Non-Medicare patients only) (Report **average** number of beds used, rounded to whole number)	______ (average # beds used)	______ (discharges and transfers)	______ (inpatient days)	______ (discharge days)	1 2 3 4 5	______
50	**Newborn Nursery** (Bassinets and utilization should be reported on lines 155-157)					1 2 3 4 5	______

IV. SELECTED ANCILLARY AND OTHER SERVICES

For each service, circle the code number that best describes the status of the service as of the last day of the fiscal year, except weekends and holidays.

#	Service	Circle One	O or B
51	AIDS/HIV – Specialized Outpatient Program for AIDS/HIV	1 2 3 4 5	________
52	Alcohol/Substance Use Disorder Outpatient Services *(psych/social)*	1 2 3 4 5	________
	Ambulance/Transportation Services- Non-emergency		
53	- **Non-emergency** inter-facility transports by ground ambulance	1 2 3 4 5	________
54	- **Non-emergency** inter-facility transports by air ambulance	1 2 3 4 5	________
55	Arthritis Treatment Center	1 2 3 4 5	________
56	Assisted Living	1 2 3 4 5	________
57	Volunteer (Auxiliary) Services Department	1 2 3 4 5	________
58	Bariatric Services: Bariatric Weight	1 2 3 4 5	________
59	Birthing Room/Labor, Delivery, Recovery, Post-partum Room (LDR or LDRP room)	1 2 3 4 5	________
	Cardiac services		
60	- Cardiac Angioplasty *(percutaneous transluminal)*	1 2 3 4 5	________
61	- Cardiac Catheterization Laboratory	1 2 3 4 5	________
62	- Cardiac Rehabilitation Program	1 2 3 4 5	________
63	- Non-invasive Cardiac Assessment Services	1 2 3 4 5	________
64	- Open-heart Surgery	1 2 3 4 5	________
65	Case Management	1 2 3 4 5	________
66	Violence (Crisis) prevention programs in workplace and community	1 2 3 4 5	________
67	Complementary Services	1 2 3 4 5	________
68	Dental Services	1 2 3 4 5	________
	Dialysis services:		
69	- Hemodialysis	1 2 3 4 5	________
70	- Peritoneal dialysis	1 2 3 4 5	________
	Emergency/urgent care:		
71	- Emergency Department *(general medical and surgical)*	1 2 3 4 5	________
72	- Trauma Center **[Self-designated Level]**	1 2 3 4 5	________
73	- Urgent Care Center	1 2 3 4 5	________
74	Ethics Committee	1 2 3 4 5	________

75	Extracorporeal Shock Wave Lithotripter *(ESWL)* **CHECK ONE** Fixed Mobile	1 2 3 4 5	
	Selected Ancillary and Other Services	**Circle One**	**O or B**
76	Fitness Center	1 2 3 4 5	______
	Food service		
77	- Meals on Wheels	1 2 3 4 5	______
78	- Nutrition Programs	1 2 3 4 5	______
79	Genetic Counseling/Screening	1 2 3 4 5	______
	Geriatric services		
80	- Adult Day Care Program	1 2 3 4 5	______
81	- Alzheimer's Diagnosis/Assessment	1 2 3 4 5	______
82	- Comprehensive Geriatric Assessment	1 2 3 4 5	______
83	- Emergency Response System	1 2 3 4 5	______
84	- Geriatric Acute Care Unit	1 2 3 4 5	______
85	- Geriatric Clinics	1 2 3 4 5	______
86	- Respite Care	1 2 3 4 5	______
87	- Retirement Housing	1 2 3 4 5	______
88	- Senior Membership Program	1 2 3 4 5	______
	Health Promotion		
89	- Community Health Promotion	1 2 3 4 5	______
90	- Patient Education	1 2 3 4 5	______
91	- Worksite Health Promotion	1 2 3 4 5	______
92	Home Health Services	1 2 3 4 5	______
93	Home Hospice Services	1 2 3 4 5	______
	Mammography services		
94	- Diagnostic Mammography	1 2 3 4 5	______
95	- Mammography Screening	1 2 3 4 5	______
96	Occupational Health Services	1 2 3 4 5	______
	Occupational, physical, and/or rehabilitation services		
97	- Audiology	1 2 3 4 5	______
98	- Occupational Therapy	1 2 3 4 5	______
99	- Physical Therapy	1 2 3 4 5	______

	Selected Ancillary and Other Services	**Circle One**	**O or B**
100	- Recreational Therapy	1 2 3 4 5	
101	- Rehabilitation Inpatient Services *(service does not have beds)*	1 2 3 4 5	
102	- Rehabilitation Outpatient Services	1 2 3 4 5	
103	- Respiratory Therapy	1 2 3 4 5	
104	- Speech Pathology / Therapy	1 2 3 4 5	
105	Oncology Services	1 2 3 4 5	
106	- Outpatient services – within the hospital	1 █ 3 4 5	
107	- Outpatient services – on hospital campus, but in freestanding center	1 █ 3 4 5	
108	- Outpatient services – freestanding off hospital campus	1 2 3 4 5	
109	Pain Management Program	1 2 3 4 5	
110	Patient Representative Services	1 2 3 4 5	
	Psychiatric services		
111	- Psychiatric Child / Adolescent Services	1 2 3 4 5	
112	- Psychiatric Consultation – Liaison Services	1 2 3 4 5	
113	- Psychiatric Education Services	1 2 3 4 5	
114	- Psychiatric Emergency Services	1 2 3 4 5	
115	- Psychiatric Geriatric Services	1 2 3 4 5	
116	- Psychiatric Outpatient Services	1 2 3 4 5	
117	- Psychiatric Partial Hospitalization Program	1 2 3 4 5	
118	Radiation Therapy	1 2 3 4 5	
	Radiology, diagnostic		
119	- CT Scanner (*Computed Tomagraphic Scanner)* **Check One:** ☐ **Fixed** ☐ **Mobile** ☐ **Both**	1 2 3 4 5	
120	- Nuclear Medicine Department	1 2 3 4 5	
121	- Magnetic Resonance Imaging (*MRI)* **Check One:** ☐ **Fixed** ☐ **Mobile** ☐ **Both**	1 2 3 4 5	
122	- Positron Emission Tomography Scanner (*PET)*	1 2 3 4 5	
123	- Single Photon Emission Computerized Tomography (*SPECT)*	1 2 3 4 5	

Check One: ☐ **Fixed** ☐ **Mobile** ☐ **Both**

124	- Ultrasound	1 2 3 4 5	______
	Reproductive health		
125	- Fertility Counseling	1 2 3 4 5	______
126	- In Vitro Fertilization	1 2 3 4 5	______
127	Social Work Services	1 2 3 4 5	______
128	Sports Medicine Clinic/Services	1 2 3 4 5	______
129	Surgery, Ambulatory or Outpatient *(day surgery)*	1 2 3 4 5	______
	Telemedicine		
130	Teleradiology or Other Store and Forward Services	1 2 3 4 5	______
131	Tele ICU	1 2 3 4 5	______
132	Tele Stroke	1 2 3 4 5	______
133	Tele Psychiatry	1 2 3 4 5	______
134	E-Visits	1 2 3 4 5	______
135	Remote Patient Monitoring	1 2 3 4 5	______
136	Specialist Consultation		______
	Transplant services		
137	- Bone Marrow Transplant Program	1 2 3 4 5	______
138	- Heart and/or Lung Transplant	1 2 3 4 5	______
139	- Kidney Transplant	1 2 3 4 5	______
140	- Tissue Transplant	1 2 3 4 5	______
141	Women’s Health Center/Services	1 2 3 4 5	______

142 Are additional non-listed **patient** services provided by the hospital? .... ☐ Yes ☐ No
If YES, list and indicate with O or B if provided in other buildings
(If more room is needed, go to Section XIV)

143 If **O** or **B** is used on lines **27-141**, indicate the number of locations and the address(es) and service(s) provided. *(If more room is needed, go to Section XIV.)*

Number of other locations ☐

Street address ______	Street address ______
City ______	City ______
Service ______ Line ____	Service ______ Line ____
Service ______ Line ____	Service ______ Line ____
Service ______ Line ____	Service ______ Line ____

144 Does the hospital have provider-based facilities that are billed using the hospital's Medicare provider number, reported on Line 14? .... ☐ Yes ☐ No

If YES, indicate the number of facilities. ☐

If YES, indicate the street address and city. *(If more than one address, go to Section XII.)*

Street address ______

City ______

V. SELECTED SERVICE UTILIZATION

DO NOT SKIP THIS PAGE. FILL IN ALL LINES.

If information for a category is zero, fill in 0.
If information for a category is Not Applicable, fill in 0.
Do NOT use dashes, N/A, N/AV, or M.

Surgical Operations *(whether major or minor)*

145 Inpatient surgical operations *(not procedures)* .... ________

146 Outpatient surgical operations *(not procedures)* .... ________

147 TOTAL surgical operations *(not procedures)* [line 145 + line 146] .... ________

Outpatient Visits

148 Emergency visits .... ________

-Number of emergency visits that resulted in inpatient admissions (Subset of line 148) [ ]

149 Other visits *(all non-emergency visits, including urgent care, physician referrals and outpatient surgeries)* .... ________

150 Observation visits .... ________

151 TOTAL outpatient visits [Add *Line 148 + Line 149 + Line 150*] .... ________

Non-emergency Ambulance/Transport Services

152 Non-emergency inter-facility transports by ground ambulance .... ________

153 Non-emergency inter-facility transports by air ambulance .... ________

154 TOTAL non-emergency transports by ambulance [*Add Line 152 + Line 153]* .... ________

Newborn Nursery

155 Number of bassinets set-up-and-staffed as of the last day of the fiscal year *(exclude neonatal beds)* .... ________

156 Total births *(exclude fetal deaths)* .... ________

157 Newborn days *(exclude neonatal days)* .... ________

VI. TOTAL FACILITY UTILIZATION AND BEDS

DO NOT USE DASHES, N/A, N/AV, OR M.
IF INFORMATION FOR A CATEGORY IS ZERO, FILL IN 0.
IF INFORMATION FOR A CATEGORY IS NOT APPLICABLE, FILL IN 0.
DO NOT MAKE ALTERATIONS TO SURVEY QUESTIONS

Utilization and Beds

		(1) Hospital	(2) Nursing Home	
158	Admissions *(exclude newborns; include Medicare-certified and Non-Medicare swing admissions)*	________	________	
159	Inpatient days *(exclude newborns; include Medicare-certified and Non-Medicare swing days)*	________	________	Skilled nursing
			________	Intermediate care
			________	Residential / Elderly housing
160	Discharges/Deaths *(exclude newborns; include Medicare-certified and Non-Medicare swing discharges)*	________	________	
161	Census [*The number of inpatients occupying beds at midnight on the last day* (**exclude weekends or holidays**) *of the fiscal year. Exclude newborns; include Medicare-Certified and Non-Medicare swing patients.]*	________	________	

Utilization and Beds

Indicate Beds set-up-and-staffed (**NOT number of licensed beds**) on the last day ***excluding weekends or holidays***) of the hospital's fiscal year quarter *(every 3 months)*.

		(1) Hospital	(2) Nursing Home	
162	1st Quarter	________	________	Skilled nursing
			________	Residential / Elderly housing
163	2nd Quarter	________	________	Skilled nursing
			________	Residential / Elderly housing
164	3rd Quarter	________	________	Skilled nursing
			________	Residential / Elderly housing
165	4th Quarter (Hospital beds must equal line 47, col.1)	________	________	Skilled nursing
			________	Residential / Elderly housing

Utilization and Beds

Medicare / Medicaid Primary Payer Utilization

		(1) Hospital	(2) Nursing Home
166	Total Medicare *(Title 18)* **Inpatient Discharges**	______	______
167	Total Medicare (Title 18) **Outpatient Visits**	______	
168	Total Medicare Inpatient **Days**	______	______
169	Total Medicaid *(Titles 19 & 21)* **Inpatient Discharges**	______	______
170	Total Medicaid (*Titles 19 & 21)* **Outpatient Visits**	______	
171	Total Medicaid Inpatient **Days**	______	______

(Exclude newborns; include Medicare-certified swing bed utilization, . Include T-18 and T-19 HMO utilization.)

VII. MEDICAL STAFF – September 30.

Indicate which of the following physician arrangements the hospital, health care system, and/or network participate in:

		Hospital		Health Care System	Network
172	Independent practice association (IPA)	☐	# physicians: ______	☐	☐
173	Group practice without walls	☐	# physicians: ______	☐	☐
174	Open Physician Hospital Organization (PHO)	☐	# physicians: ______	☐	☐
175	Closed Physician Hospital Organization (PHO)	☐	# physicians: ______	☐	☐
176	Management Service Organization (MSO)	☐	# physicians: ______	☐	☐
177	Integrated Salary Model	☐	# physicians: ______	☐	☐
178	Equity Model	☐	# physicians: ______	☐	☐
179	Foundation	☐	# physicians: ______	☐	☐
180	Accountable Care Organization (ACO)	☐	# physicians: ______	☐	☐
181	Other	☐	# physicians: ______	☐	☐

Selected Specialty

If information for a category is zero, fill in 0.
If information for a category is Not Applicable, fill in 0. Do NOT use dashes, N/A, N/AV, or M.

	Active/Associate Medical Staff	(1) Medical Staff **as of Sept. 30** *(Includes Board Certified)*	(2) Board Certified Staff **As of Sept. 30** *[Not to exceed column (1)]*
	Medical Specialties		
182	General and Family Practice		
183	Internal Medicine *(general)*		
184	Internal Medicine *subspecialties*		
185	Pediatrics *(general)*		
186	Pediatric *subspecialties*		
	Surgical Specialties		
187	General Surgery		
188	Obstetrics/Gynecology		
189	All other surgical *specialties*		
	Other		
190	Anesthesiology		
191	Emergency Medicine		
192	Pathology		
193	Radiology		
194	Addiction Medicine		
195	Psychiatry		
196	All other specialties *(use valid specialties below)*		

Line 197 *- codes for valid specialties- check all codes that apply:*

- ☐ Aerospace Medicine
- ☐ General Preventive Medicine
- ☐ Podiatry
- ☐ Chiropractic Services
- ☐ Nuclear Medicine
- ☐ Physical Med&Rehab (includes Physiatry)
- ☐ Dental
- ☐ Occupational Medicine
- ☐ Public health

		(1)	(2)
198	**TOTAL** Medical Staff	(add lines 182-196)	(add lines 182-196)

VIII. PERSONNEL ON HOSPITAL PAYROLL – September 30 - DATA FOR ONE WEEK ONLY.

Report the number of full-time and part-time personnel, **including trainees**, in the categories specified below. Report part-time hours for each category. All data must be for **the week of September 30, regardless of the hospitals' fiscal year end date.** Treat shared hospital/nursing home staff as part-time and report only hospital hours. **Do not include contracted staff or nursing home** personnel.

DO NOT USE DASHES, N/A, N/AV, OR M.
PLEASE ROUND TO NEAREST WHOLE NUMBER. DO NOT USE DECIMALS.

		FULL TIME	PART TIME	
	Occupational Categories	Total No. of Persons *(35 Hr/Wk or more)*	Total No. of Persons *(less than 35 Hr/Wk)*	Total No. of P-T hours *(week of Sept 30)*
199	Administrators and assistant administrators			
	Physician And Dental Services			
200	Physicians / Dentists			
201	Dental Hygienists			
202	Hospitalists			

203 **Please select the category below that best describes the employment model for your hospitalists.**

- ☐ Independent provider group
- ☐ Employed by a physician group
- ☐ Employed by your hospital
- ☐ Employed by a university or school program
- ☐ Other

		FULL TIME	PART TIME	
204	Intensivists			
205	Medical and dental residents/interns			
	Nursing Services			
206	Registered nurses			
207	Certified nurse midwives			
208	Licensed practical *(vocational)* nurses			
209	Paraprofessionals: Nursing Assistants (CNA)			
210	Medical assistants			
211	Physician assistants			
212	Nurse practitioners			
213	Pharmacists			
214	Pharmacy Technician/Aides			
215	Medical & Clinical Laboratory Technologists			
216	Medical & Clinical Laboratory Technicians			
217	Surgical Technologists & Technicians			
218	Certified registered nurse anesthetists			
219	Clinical Nurse Specialists			
	Therapeutic Services			
220	Respiratory Therapists			
221	Radiologic Technologists			

	Occupational Categories (*continued*)	FULL TIME Total No. of Persons *(35 Hr/Wk or more)*	PART TIME Total No. of Persons *(less than 35 Hr/Wk)*	 Total No. of P-T hours *(week of Sept 30)*
222	Sonographer	______	______	______
223	All other Radiologic Personnel	______	______	______
224	Occupational Therapists	______	______	______
225	Occupational therapy assistants/aides	______	______	______
226	Physical therapists	______	______	______
227	Physical therapy assistants/aides	______	______	______
228	Recreational therapists	______	______	______
229	Health Information Management Administrators/Technicians	______	______	______
230	Dieticians and Nutritionists	______	______	______
	Psychology / Social Work Services			
231	Psychologists	______	______	______
232	Social Workers	______	______	______
	Other Personnel			
233	All other health professional / technical personnel	______	______	______
234	All other personnel	______	______	______
235	**TOTAL** hospital personnel	______ (add lines 199-234)	______ (add lines 199-234)	______ (add lines 199-234)

236 **Workweek**
Indicate the **average or definition of** WORKWEEK (number of hours per week) of the full-time employees engaged in direct patient care (**40, 38, 35**, etc.) **Do not use decimals.**

☐ (Average **full-time** hours per week)

IX. OTHER *(Lines 237-245)*

Check the appropriate box to indicate the answer to each question.

237 Does your hospital's mission statement include a focus on community benefit? ☐ Yes ☐ No

238 Does your hospital have a long-term plan for improving the health status of its community? ☐ Yes ☐ No

239 Does your hospital have resources for its community benefit activities? ☐ Yes ☐ No

240 Does your hospital work with other providers, public agencies, or community representatives to conduct a health status assessment of the community? ☐ Yes ☐ No

241 Does your hospital use health status indicators *(such as rates of health problems or surveys of self-reported health)* for defined populations to design new services or modify existing services? ☐ Yes ☐ No

242 Does your hospital work with other local providers, public agencies, or community representatives to conduct/develop a written health status assessment of the needed capacity for health services in the community? ☐ Yes ☐ No

243 **IF YES,** have you used the assessment to identify unmet health needs, excess capacity, or duplicative services in the community? ☐ Yes ☐ No

244 Does your hospital work with other providers to collect, track, and communicate clinical and health information across cooperating organizations? ☐ Yes ☐ No

245 Does your hospital either by itself or in conjunction with others disseminate reports to the community on the comparative quality and costs of health care services? ☐ Yes ☐ No

X. SERVICE QUALITY / PATIENT SAFETY

246 Please identify the amount of resources allocated to quality and risk management functions. If a position is split between two or more roles, indicate the portion of the FTE dedicated to each function.

	Dedicated FTEs
Quality management & improvement	________
Clinical safety	________
Case management	________
Accreditation	________
Infection control	________
Risk Management	________

247 Does your facility provide 24-hour pharmacy services?

☐ Yes ☐ No

XI. E-HEALTH

Please indicate if you have the following features fully implemented, partially implemented, in the planning process, or not at all with your facility's electronic health record implementation.

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	Feature	Fully Implemented	Partially Implemented	Planning	Not at All
248	Core MPI database with admission/discharge/transfer	☐	☐	☐	☐
249	Lab information system	☐	☐	☐	☐
250	Pharmacy system	☐	☐	☐	☐
251	E-MAR (real-time enterprise medication administration record)	☐	☐	☐	☐
252	Medication dispensing	☐	☐	☐	☐
253	RIS (Radiology information system)	☐	☐	☐	☐
254	Computerized radiography (digital x-ray)	☐	☐	☐	☐
255	PACS (Picture archiving and communication system)	☐	☐	☐	☐
256	Order entry/resulting	☐	☐	☐	☐
257	Inpatient charting	☐	☐	☐	☐
258	Bedside medication verification	☐	☐	☐	☐
259	CPOE (Computerized physician order entry)	☐	☐	☐	☐
260	EHR portal	☐	☐	☐	☐
261	Bulk scanning	☐	☐	☐	☐

	Feature	Fully Implemented	Partially Implemented	Planning	Not at All
262	Surgery management system	☐	☐	☐	☐
263	Interface engine/expertise	☐	☐	☐	☐
264	Physician Practice Management Systems	☐	☐	☐	☐
265	Physician Practice EMR Systems	☐	☐	☐	☐
266	Long Term Care EMR System	☐	☐	☐	☐
267	Home Health EMR System	☐	☐	☐	☐

XII. HEALTH INFORMATION TECHNOLOGY

Expenditures

268 Total Health Information Technology Expenditures - Capital **$**________________

269 Total Health Information Technology Expenditures- Operating **$**________________

270 What type of internet connection comes into your hospital?

- ☐ T1
- ☐ T3
- ☐ A telephone company DSL line (high speed)
- ☐ A fiber-optic connection
- ☐ Other

If Other, please explain:

XIII. SOCIAL DETERMINANTS OF HEALTH (SDOH)

271 Does your facility screen patients for social needs?

Yes, for all patients   Yes, for some patients   No, (skip to question 274)

272 If yes, please indicate which social needs are assessed. (Check all that apply)

- ☐ Housing (instability, quality, financing)
- ☐ Food insecurity or hunger
- ☐ Utility Needs
- ☐ Interpersonal violence
- ☐ Transportation
- ☐ Employment and income
- ☐ Education
- ☐ Social isolation (lack of family and social support)
- ☐ Health behaviors

Other, please describe ____

273 If yes, does your facility record the social needs screening results in your EHR?

Yes   No

274 Does your facility utilize outcome measures (for example, cost of care or readmission rates) to assess the effectiveness of the interventions to address patients' social needs?

Yes No

275 Has your facility been able to gather data indicating that activities used to address the SDOH and patient social needs have resulted in any of the following? (Check all that apply)

	Better health outcomes for patients
	Decreased utilization of hospital or health system services
	Decreased health care costs
	Improved community health status

276 Who in your hospital or health care system is accountable for **meeting** health equity goals (Check all that apply)
a.CEO
b.Designated Senior Executive (Chief Diversity Officer, VP for DEI, etc.)
c.Middle Management
d.Committee or Task Force
e.Division/Department Leaders
f.Employee Resource Group
g.None of the above

277 Who in your hospital or health care system is accountable for **implementing strategies** for health equity goals (Check all that apply)
a.CEO
b.Designated Senior Executive (Chief Diversity Officer, VP for DEI, etc.)
c.Middle Management
d.Committee or Task Force
e.Division/Department Leaders
f.Employee Resource Group
g.None of the above

278 Does your hospital or health care system use DEI (Diversity, Equity and Inclusion) disaggregated data to inform decisions on the following? (Check all that apply) (Disaggregated data refers to the separation of compiled information into smaller units to elucidate underlying trends and patterns.)
a.Patient Outcomes
b.Procurement
c.Supply Chain
d.Training
e.Professional Development
f.None of the above

279 Does your hospital or health care system have a health equity strategic plan for the following? (Check all that apply)
a.Equitable and inclusive organizational policies
b.Systematic and shared accountability for health equity
c.Diverse representation in hospital and health care system leadership
d.Diverse representation in hospital and health care system governance
e.Community engagement
f.Collection and use of segmented data to drive action
g.Culturally appropriate patient care
h.None of the above

XIII. SUPPLEMENTAL INFORMATION

280 *Use this space or an additional sheet if more space is needed to elaborate on any of the information supplied on the survey. Refer to each response by page, section, and line number.*