

MAINE STATE LEGISLATURE

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Hospitals - Public access to statistical information
Health facilities information disclosure Act

2-19-79

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DEPUTY ATTORNEYS GENERAL



STATE OF MAINE
DEPARTMENT OF THE ATTORNEY GENERAL
AUGUSTA, MAINE 04333

February 5, 1979

Honorable Walter W. Hichens
Maine State Senate
State House
Augusta, Maine 04333

RE: Public Access to Statistical Information of a Public Hospital

Dear Senator Hichens:

This responds to your request for an opinion as to whether a public hospital is required by law to provide its statistical information to a private citizen upon request.

There are no statutes which specifically give a private citizen the right to access to statistical information directly from a hospital. However, much of this information is available to the public indirectly through sources other than the hospital.

The Health Facilities Information Disclosure Act, 22 M.R.S.A. §351 et seq., requires hospitals to compile and disclose a considerable amount of data relating to administration of the facilities. Section 353 of the Act establishes the Health Facilities Cost Review Board. Section 358(4) requires the hospitals to submit the following information to the Board.

- A. Financial information including costs of operation, revenues, assets, liabilities, fund balances, other income, rate, charges, units of services and such other financial information as the board deems necessary for the performance of its duties; and
- B. Scope of service information, including bed capacity, by service provided, special services, ancillary services, physician profiles in the aggregate by clinical specialities, and such other scope of service information as the board deems necessary for the performance of its duties.

Section 358(5) requires further that the hospital provide to an "...independent data organization a completed Uniform Hospital Discharge Data Set, or comparable information, for each patient discharged from the facility." With the exception of information relative to identification of individual patients or health care practitioners, this discharge data is available to the Board.

The information in the possession of the Board is available to the public, pursuant to 22 M.R.S.A. §365 which reads as follows:

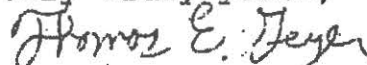
Any information, except privileged medical information, which is filed with the board under this chapter shall be made available to any public or private agencies or other persons upon request, provided that individual patients or health care practitioners are not directly identified. The board shall adopt its own policies pursuant to section 366 and after a public hearing for information made available which may indirectly identify a particular patient or health care practitioner.

The Bureau of Health Planning and Development of the Department of Human Services obtains the foregoing list of information from the Board, using the attached forms. The data is therefore available to the public directly from the Board, as well as from the Department of Human Services [See 1 M.R.S.A. §401 et seq., Freedom of Access].

Another source of information for individual hospital statistics is the Bureau of Health, Division of Hospital Services, an agency within the Department of Human Services. This Bureau is in charge of licensing all hospitals in the State. The application for license form annexed hereto indicates the type of data contained in the Bureau's records. This information, again, is available to the public pursuant to 1 M.R.S.A. §401 et seq., the so-called Freedom of Access Laws.

Finally, the Department of Human Services maintains records reflecting the total numbers of births, deaths, abortions, etc. occurring within the State for a given year. This information, however, is not necessarily broken down on the basis of individual hospitals. These statistics are also open to the public pursuant to 1 M.R.S.A. §401 et seq.

Very truly yours,



Thomas E. Geyer
Assistant Attorney General

TEG:mmm

License No:	_____
Checked By:	_____
Approved:	_____

STATE OF MAINE

DEPARTMENT OF HUMAN SERVICES

TO : Division of Hospital Licensing
 Department of Human Services
 State House, Augusta, Maine 04333

SUBJECT: Application for Renewal of Hospital License for the Period of: _____ to: _____

FROM : _____
 (Name of Hospital) (Street Address)

 (City) (Zip Code) (Telephone Number)

Under the provisions of M.R.S.A. 1964, Title 22, S. 1811-1821, an act relating to licensing hospitals and related institutions in the State of Maine, application is hereby made to the Department of Human Services for a license or renewal of license to maintain and operate a General Hospital, as herein specified.

1. Applicant hospital is owned by: _____

Operated by: _____

Non-Profit: _____ Proprietary: _____

2. Chief Executive Officer: _____
 (Name) (Title)

3. Number of Beds by Level of Care: _____ Location (If other than above) _____

Acute Hospital Beds	_____	_____
Bassinets	_____	_____
Skilled Nursing	_____	_____
Intermediate	_____	_____
Boarding Home	_____	_____

Check those health-care services you propose to render. License will be limited to health-care services and beds and bassinets applied for and approved. The first group of services relates to Daily Hospital Inpatient Services. Give number of beds by category. This total number of beds should agree with the totals on the first page. The second group of services relates to Ancillary Services which can be provided to either inpatients and/or outpatients.

DAILY HOSPITAL INPATIENT SERVICES

	11X Private No. of Beds	12X Semi-private No. of Beds	15X Ward No. of Beds	16X Other No. of Beds
<u>Acute Care</u>				
1. Surgical	_____	_____	_____	
2. OB/GYN	_____	_____	_____	
3. Pediatric	_____	_____	_____	
4. Psychiatric	_____	_____	_____	
5. Medical	_____	_____	_____	
6. Isolation	_____	_____	_____	
7. Detoxification	_____	_____	_____	
8. Alcoholic Rehabilitation	_____	_____	_____	_____
9. Other Acute Hospital Beds	_____	_____	_____	_____
Acute Bed Totals	_____	_____	_____	_____

(These totals combined with intensive care and Coronary care beds should equal acute beds under 3, page 1.)

Skilled Nursing

Intermediate Care

Boarding Home Care

20X
INTENSIVE CARE

BEDS

- 0. General _____
- 1. Surgical _____
- 2. Medical _____
- 3. Pediatric _____
- 4. Psychiatric _____
- 5. Neo Natal (Level II) _____
- 6. Neo Natal (Level III) _____
- 7. Burn Care _____
- 8. Trauma _____
- 9. Other (Specify) _____

21X
CORONARY CARE

BEDS

- 1. Myocardial Infarction _____
- 2. Pulmonary Care _____
- 3. Heart Transplant _____
- 4. Other (Specify) _____

HOSPITAL ANCILLARY SERVICES

<u>25X PHARMACY</u>	<u>Check</u>	<u>45X EMERGENCY ROOM</u>	<u>Check</u>
<u>27X CENTRAL SERVICE</u>	_____	Level III	_____
<u>29X LABORATORY</u>	_____	Level II	_____
1. Clinical	_____	Level I	_____
2. Anatomical Pathology	_____	<u>47X AUDIOLOGY</u>	_____
3. Hematology	_____	<u>50X ORGANIZED OUTPATIENT SERVICES</u>	_____
4. Chemistry	_____	<u>51X ORGANIZED CLINICS</u>	_____
5. Immunology	_____	1. Psychiatric	_____
6. Bacteriology	_____	2. Surgery	_____
7. Urine	_____	3. Admitting	_____
8. Cytology	_____	4. Diabetic	_____
9. Other (Specify)	_____	5. ENT	_____
<u>32X RADIOLOGY-DIAGNOSTIC</u>	_____	6. Eye	_____
1. Angiocardiography	_____	7. Ob/Gyn	_____
2. Computed Tomography Scan-Head	_____	8. Orthopedic	_____
3. Computed Tomography Scan-Total Body	_____	9. Pediatric	_____
4. Mammography	_____	10. Cardiology	_____
5. Angiography	_____	11. Physical Medicine	_____
6. Other (Specify)	_____	12. Urology	_____
<u>33X RADIOLOGY-THERAPEUTIC</u>	_____	13. Cancer	_____
(Radiation Oncology)	_____	14. Ophthalmology	_____
1. Radiation Therapy	_____	15. Other (Specify)	_____
Cobalt Therapy	_____	<u>54X AMBULANCE SERVICE</u>	_____
Radium Therapy	_____	<u>56X MEDICAL SOCIAL SERVICES</u>	_____
<u>34X NUCLEAR MEDICINE</u>	_____	<u>59X HOME HEALTH SERVICE</u>	_____
1. Diagnostic	_____	<u>71X RECOVERY ROOM</u>	_____
2. Therapeutic	_____	<u>72X LABOR AND DELIVERY</u>	_____
<u>36X SURGICAL SERVICES</u>	_____	1. Labor Room	_____
1. General Surgery	_____	2. Delivery Room	_____
2. Organ Transplants	_____	<u>73X EKG</u>	_____
3. Open Heart Surgery	_____	<u>74X EEG</u>	_____
4. Neurosurgery	_____	<u>76X NURSERY</u>	<u>No. of Bassinets</u>
5. Orthopaedic Surgery	_____	1. Newborn (Level I)	_____
6. Day Surgery	_____	2. Premature	_____
7. Other (Specify)	_____	3. Isolation	_____
Laser Surgery (Equip)	_____	Total Bassinets	_____
<u>37X ANESTHESIA</u>	_____	(Should agree with total, Page 1)	_____
1. Anesthesia M.D.	_____	<u>AMBULATORY CARE CENTER</u>	_____
2. Anesthesia C.R.N.A.	_____		
4. Acupuncture	_____		
<u>38X BLOOD BANK</u>	_____		
<u>39X ONCOLOGY SERVICE</u>	_____		
<u>41X RESPIRATORY SERVICES</u>	_____		
1. Inhalation Services	_____		
2. Hyperbaric Oxygen Therapy	_____		
3. Pulmonary Function	_____		
<u>42X PHYSICAL THERAPY</u>	_____		
<u>43X OCCUPATIONAL THERAPY</u>	_____		
<u>44X SPEECH PATHOLOGY</u>	_____		

Check

RENAL DIALYSIS

- 1. Inpatient Hemodialysis
- 2. Inpatient Peritoneal Dialysis
- 3. Outpatient Hemodialysis
- 4. Outpatient Peritoneal Dialysis
- 5. Training Hemodialysis
- 6. Training Peritoneal Dialysis

OTHER SERVICES

- 1. Dental Services
- 2. Electromyography
- 4. Recreational Therapy
- 6. Ultrasound
- 7. Other Therapy (Specify)
- 8. Patient Education/Training
- 9. Podiatric Services

PSYCHIATRIC/PSYCHOLOGICAL SERVICES

- 1. Rehabilitation
- 2. Day Care
- 3. Individual Therapy
- 4. Group Therapy
- 5. Family Therapy
- 6. Bio Feedback
- 7. Testing
- 8. Electric Shock Treatment
- 9. Other (Specify)

List any other hospital facilities at locations other than the above addresses which are under the same ownership and governing authority.

5. Accreditations and Certifications

JCAH: Date of Last JCAH Survey: _____ Accreditation for: 2 yrs. ___ 1yr. ___ None ___

A.O.A.: Date of Last A.O.A. Survey: _____ Accredited for _____ years.

Laboratory Accredited by C.A.P. _____ Date: _____ Number of Years. _____

Blue Cross Participating: _____ Other: _____

Medicare/Medicaid Certified _____

PSRO Delegated _____ Non-Delegated _____

PSRO Non-Participating _____

Partially Delegated by PSRO for: _____ Admissions and Extended Stays _____

Local Care Evaluation _____ Physician Advisor _____

- 6. Has Hospital Charter, Constitution, or Bylaws been amended since last license application? _____ (If "yes", file an amended copy with this application.)
Date on which current hospital charter, constitution, or bylaws adopted by Governing Authority _____
- 7. Have Medical Staff Bylaws been amended since last license application? _____ (If "yes", file an amended copy with this application.) Date on which current medical staff bylaws were approved by hospital governing authority _____
- 8. Use the space below to elaborate on any of the answers given above or to make any pertinent remarks. Refer to each item number to which comments pertain.

I, _____ being duly authorized to assume responsibility for the conduct of the institution herein described, hereby file this application for a license and agree to assume responsibility for the institution, complying with all the current regulations of the Department of Human Services, as authorized by M.R.S.A., 1964, Title 22, s. 1811-1821 and amendments and additions thereto.

DATE: _____

Chief Executive Officer
(Signature)

(Address)

(Address of Chief Executive Officer, if different from above)

FEEES:

\$50.00 FEE FOR A HOSPITAL OF LESS THAN 50 BEDS IN SIZE, \$100.00 FEE FOR A HOSPITAL OF 51 TO 100 BEDS IN SIZE, AND \$200.00 FEE FOR A HOSPITAL LARGER THAN 100 BEDS IN SIZE. MAKE CHECKS OR MONEY ORDERS PAYABLE TO TREASURER OF STATE, AND MAIL TO DEPARTMENT OF HUMAN SERVICES, STATE HOUSE, AUGUSTA, MAINE 04333.

*Similar Data available for all Maine Hospitals from Maine Health Data Service
110 Pine Street
Portland, ME*

FORM HDS-1
FORMERLY HAM-88-1
(1-14-76)

Form Approved
O.M.B. No. 68-R0670

CONFIDENTIAL - All information which would permit identification of an individual or of an establishment will be held confidential, will be used only by persons engaged in and for the purposes of the survey and will not be disclosed or released to other persons or used for any other purpose.

DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE
Public Health Service
Health Resources Administration
National Center for Health Statistics
MEDICAL ABSTRACT - HOSPITAL DISCHARGE SURVEY

I. Patient Identification

1. Hospital number..... _____

2. HDS number _____

3. Medical record number..... _____

4. Date of admission _____
Month Day Year

5. Date of discharge _____
Month Day Year

II. Patient Characteristics

1. Date of birth: _____
Month Day Year

2. Age (complete ONLY if date of birth not given): _____
Units { 1 years
 2 months
 3 days

3. Sex: 1 Male 2 Female

4. Race or color: 1 White 2 Negro 3 Other nonwhite 4 "Nonwhite" 5 Not stated

5. Marital status: 1 Married 2 Single 3 Widowed 4 Divorced 5 Separated 6 Not stated

6. Discharge status: 1 Alive 2 Dead

III. Diagnoses and Operations

1. Final diagnoses

a. Principal diagnosis: _____

b. Other diagnoses: _____

_____ see reverse side

2. Operations: _____

_____ see reverse side

Completed by _____ Date _____

FOR NCHS USE ONLY

Diagnoses _____

Operations _____

Figure 1. Medical Abstract form

ANNUAL SURVEY OF HEALTH FACILITIES: HOSPITALS 1979

PLEASE REFER TO THE INSTRUCTIONS AND DEFINITIONS SHEET

A. PERSON COMPLETING REPORT

If there are questions about your responses to this survey, who should be contacted?

Name _____
(please print)

Tel. No. _____ Ext. _____

B. REPORTING PERIOD (12 month period January 1, 1978 through December 31, 1978 preferred)

Indicate period used: Beginning Date _____ Ending Date _____
Month Day Year Month Day Year

C. FACILITIES AND SERVICES

Check the box identifying a facility or service which is available within your hospital (see the accompanying instructions and definitions sheet).

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> 1. Postoperative Recovery Room <input type="checkbox"/> 2. Open-Heart Surgery Facilities <input type="checkbox"/> 3. Pharmacy w/Full-time Registered Pharmacist <input type="checkbox"/> 4. Pharmacy w/Part-time Registered Pharmacist <input type="checkbox"/> 5. X-Ray Therapy <input type="checkbox"/> 6. Cobalt Therapy <input type="checkbox"/> 7. Radium Therapy <input type="checkbox"/> 8. Chemotherapy <input type="checkbox"/> 9. Diagnostic Radioisotope Facility <input type="checkbox"/> 10. Therapeutic Radioisotope Facility <input type="checkbox"/> 11. Histopathology Laboratory <input type="checkbox"/> 12. Organ Bank <input type="checkbox"/> 13. Blood Bank <input type="checkbox"/> 14. Electroencephalography <input type="checkbox"/> 15. Respiratory (Inhalation) Therapy Department <input type="checkbox"/> 16. Premature Nursery <input type="checkbox"/> 17. Renal Dialysis (inpatient) <input type="checkbox"/> 19. Physical Therapy Department <input type="checkbox"/> 20. Occupational Therapy Department | <ul style="list-style-type: none"> <input type="checkbox"/> 27. Clinical Psychology Services <input type="checkbox"/> 28. Organized Outpatient Department 29. Emergency Department <ul style="list-style-type: none"> <input type="checkbox"/> a. Level III: Twenty-four Hour Emergency Care <input type="checkbox"/> b. Level II: Standby Emergency Care <input type="checkbox"/> c. Level I: Initial Triage and Referral Care <input type="checkbox"/> 30. Social Work Department <input type="checkbox"/> 31. Family Planning Service —Number of Visits _____ <input type="checkbox"/> 32. Genetic Counseling Service <input type="checkbox"/> 33. Abortion Service (outpatient) —Number of Visits _____ <input type="checkbox"/> 34. Alcoholism Services (outpatient) —No. of Visits _____ <input type="checkbox"/> 35. Chemical Dependency Services (outpatient) —Number of Visits _____ <input type="checkbox"/> 36. Home Care Department <input type="checkbox"/> 37. Dental Services <input type="checkbox"/> 38. Podiatric Services <input type="checkbox"/> 39. Speech Pathology Services <input type="checkbox"/> 40. Audiology Services <input type="checkbox"/> 41. Hospital Auxiliary <input type="checkbox"/> 42. Volunteer Services Department |
|---|--|

Check the box identifying any special inpatient unit located within the hospital. Record the unit beds set up and staffed at the end of your reporting period. Admissions and inpatient days are to be recorded for the entire reporting period.

	Beds Set Up and Staffed	Admissions (Inc. Inter-unit Transfers)	Inpatient Days
b. Special Care Units			
<input type="checkbox"/> 1. Cardiac Intensive Care Unit	_____	_____	_____
<input type="checkbox"/> 2. Intensive Care Unit (Mixed)	_____	_____	_____
<input type="checkbox"/> 3. Burn Care Unit	_____	_____	_____
<input type="checkbox"/> 4. Self-Care Unit	_____	_____	_____
<input type="checkbox"/> 5. Rehabilitation Unit	_____	_____	_____
<input type="checkbox"/> 6. Tuberculosis Unit	_____	_____	_____
<input type="checkbox"/> 7. Psychiatric Unit	_____	_____	_____
<input type="checkbox"/> 8. Pediatric Unit	_____	_____	_____
<input type="checkbox"/> 9. Obstetric Unit	_____	_____	_____
<input type="checkbox"/> 10. Alcoholism Unit	_____	_____	_____
<input type="checkbox"/> 11. Chemical Dependency Unit	_____	_____	_____
<input type="checkbox"/> 12. Abortion Unit	_____	_____	_____
<input type="checkbox"/> 13. Other (specify) _____	_____	_____	_____
<input type="checkbox"/> 14. Other (specify) _____	_____	_____	_____
<input type="checkbox"/> 15. Other (specify) _____	_____	_____	_____

Do not complete the following section if SNF, HCF or Boarding Care beds are under construction. Report the number of beds set up and staffed on the last day of your reporting period. Admissions, discharges, inpatient days and discharge days are to be recorded for the entire reporting period.

	Beds Set Up and Staffed	Admissions	Discharges	Inpatient Days	Discharge Days
<input type="checkbox"/> 16. Skilled Nursing Facility	_____	_____	_____	_____	_____
<input type="checkbox"/> 17. Intermediate Care Facility	_____	_____	_____	_____	_____
<input type="checkbox"/> 18. Boarding Care Beds	_____	_____	_____	_____	_____

c. Was there a permanent change or significant temporary change in the number of staffed beds for use during the reporting period?

YES NO 1. Bed Change (+ or -): _____ Date _____ 2. Bed Change (+ or -): _____ Date _____

5. PATIENT CENSUS on the last day of your reporting period (exclude newborns) _____
 6. TOTAL INPATIENT DEATHS (excluding DOA's) for your reporting period _____

E. FINANCIAL DATA (for the reporting period only)

- 1. PAYROLL EXPENSES _____
- 2. NONPAYROLL EXPENSES (Includes Fringe Benefits) _____
- 3. TOTAL EXPENSES (1 + 2) _____

F. EMPLOYEE STATISTICS

Using your last payroll week, please indicate, for each category, the number of full-time and part-time employees. For part-time employees only, also give the total number of hours worked during the week for each category. Do not include courtesy or attending staff, fee for service employees, volunteers, or employees under contract.

INSTRUCTIONS AND DEFINITIONS FOR
ANNUAL SURVEY OF HEALTH FACILITIES: HOSPITALS 1979

A. PERSON COMPLETING REPORT

If the person completing this report has any questions, he or she may call: Nancy Malesky or Brenda Webber - 289-3001.

B. REPORTING PERIOD

Record the beginning and ending dates of the reporting period in a six-digit number; for example, Jan. 1, 1978 should be shown as 01/01/78. Utilization and finances should be presented for days reported only.

C. FACILITIES AND SERVICES

1. **POSTOPERATIVE RECOVERY ROOM.** A separate facility used exclusively to monitor patients recovering from anesthesia or to observe patients for post-surgical return to physiological stability. If these services are provided in an intensive care unit, report only intensive care unit (see number D4B(a) below).
2. **OPEN-HEART SURGERY FACILITIES.** The equipment and staff necessary to perform open-heart surgery.
3. **PHARMACY W/FT REGISTERED PHARMACIST.** Supervised by a full-time registered pharmacist who is employed by the hospital.
4. **PHARMACY W/PT REGISTERED PHARMACIST.** Supervised by a part-time registered pharmacist who is employed by the hospital (NOTE: If you have both a full-time and a part-time registered pharmacist, check facility 3 only).
5. **X-RAY THERAPY.** The treatment of disease by roentgen rays or other radiant energy, with exception of radium, cobalt, or radioisotopes.
6. **COBALT THERAPY.** The use of the metal cobalt and the specialized equipment required for deep therapy treatment of cancer and other diseases.
7. **RADIUM THERAPY.** The use of the metal radium for the treatment of an abnormal condition or disease.
8. **CHEMOTHERAPY.** Treatment of disease by use of drugs and chemicals.
9. **DIAGNOSTIC RADIOISOTOPE FACILITY.** The use of radioactive isotopes as tracers or indicators to detect an abnormal condition or disease.
10. **THERAPEUTIC RADIOISOTOPE FACILITY.** The use of radioactive isotopes for the treatment of an abnormal condition or disease.
11. **HISTOPATHOLOGY LABORATORY.** A laboratory in which tissue specimens are examined by a qualified pathologist.
12. **ORGAN BANK.** A separate repository of the hospital, established for the preservation of such organs as eyes, spleen, liver, vessels, bones, and so forth.
13. **BLOOD BANK.** A medical facility with responsibility for each of the following: blood procurement, drawing, processing, and distribution.
14. **ELECTROENCEPHALOGRAPHY.** A recording of electric currents generated in the brain, by means of electrodes applied to the scalp or brain itself.
15. **RESPIRATORY THERAPY DEPARTMENT.** A separately organized department providing respiratory therapy services to patients.
16. **PREMATURE NURSERY.** A separate facility used exclusively for the care of infants whose birth weight is 2500 grams (5.512 lbs.) or less.
17. **HEMODIALYSIS (INPATIENT).** Provision of equipment and personnel for the treatment of renal insufficiency, on an inpatient basis.
18. **HEMODIALYSIS (OUTPATIENT).** Provision of equipment and personnel for the treatment of renal insufficiency, on an outpatient basis.
19. **PHYSICAL THERAPY DEPARTMENT.** Facilities for the provision of physical therapy services prescribed by physicians and administered by, or under the direction of, a qualified physical therapist.
20. **OCCUPATIONAL THERAPY DEPARTMENT.** Facilities for the provision of occupational therapy services prescribed by physicians and administered by, or under the direction of, a qualified occupational therapist.
21. **REHABILITATION OUTPATIENT SERVICES.** The provision of coordinated multidisciplinary physical restorative services to ambulatory patients under the direction of a physician knowledgeable and experienced in rehabilitation medicine.
22. **PSYCHIATRIC OUTPATIENT SERVICES.** Organized hospital facilities and services for the medical care (including diagnosis and treatment) of psychiatric outpatients.
23. **PSYCHIATRIC PARTIAL HOSPITALIZATION PROGRAM.** Organized hospital facilities and services for day care and/or night care of psychiatric patients who do not require 24-hour-a-day inpatient care.
24. **PSYCHIATRIC EMERGENCY SERVICES.** Organized hospital facilities and services for emergency outpatient care of psychiatric patients whose conditions are considered to require immediate care. Staff must be available 24 hours a day.
25. **PSYCHIATRIC FOSTER AND/OR HOME CARE.** Planned post-discharge psychiatric observation and care in the patient's place of residence or in an approved foster home.
26. **PSYCHIATRIC CONSULTATION AND EDUCATION SERVICES.** Provision of interpretive psychiatric consultation and education 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.
27. **CLINICAL PSYCHOLOGY SERVICES.** One or more clinical psychologist(s) who provide diagnostic or therapeutic services to inpatients or outpatients. This may be on a full-time regularly scheduled or on an intermittent basis.
28. **ORGANIZED OUTPATIENT DEPARTMENT.** Regularly scheduled organized services or specialty clinics to provide non-emergency services on an outpatient basis.
29. **EMERGENCY DEPARTMENT.**
 - a. **LEVEL III: Twenty-Four Hour Emergency Care Facility:** Hospital facilities in this category are able to handle virtually all emergency conditions definitively except for those requiring very special procedures or facilities such as cardiopulmonary bypass or renal dialysis. Such facilities will very likely receive a significant number of patients on referral from other facilities in their area and will only rarely find it necessary to refer patients from their facility to another.

UNIT BEDS AND INPATIENT STATISTICS.

All hospitals should complete this section. Hospitals that are units of non-hospital institutions (such as universities and correctional institutions) should report for the hospital unit only.

Licensed Beds—Report the total number of adult and pediatric beds for which your Facility was licensed on the last day of your reporting period. Exclude SNF, ICF, and BC beds. Exclude bassinets.

Beds Set Up and Staffed—Report the number of adult and pediatric beds regularly available at the end of the reporting period. Report only operating beds, not constructed bed capacity. Include all bed facilities that are set up and staffed for use by inpatients who have no other bed facilities assigned to or reserved for them, such as isolation units, quiet rooms and reception and observation units. Exclude newborn bassinets and bed facilities for patients receiving special procedures for a portion of their stay who have other bed facilities assigned to or reserved for them. Exclude, for example, labor room, post-anesthesia or post-operative recovery room beds, psychiatric holding beds and beds that are used only as holding facilities for patients prior to their transfer to another hospital.

Admissions—Include the number of adult and pediatric admissions only (exclude births). This figure should include all patients admitted during the reporting period.

Discharges—Report the number of adults and pediatric discharges only (include deaths, exclude newborns). This figure should include all patients discharged during the reporting period.

Inpatient Days—Report the number of adult and pediatric days of care rendered during the entire reporting period. Do not include days of care rendered for infants born in the hospital, but do include those for their mothers. An inpatient day of care (also known as "census day" or "occupied bed day") is a period of service between the census taking hours on two successive calendar days, the day of discharge being counted only when the patient was admitted the same day.

- b. 1-15. Special Care Units. Check the box identifying a special care unit located within the hospital (see definitions below) and supply for each the number of beds set up and staffed at the end of the reporting period, and admissions and inpatient days for the entire reporting period. Report a unit only when a set number of beds have been permanently assigned and maintained for a specific service. Do not count a bed, discharge, or inpatient day in more than one category. NOTE: Includes transfers between special care units in the admissions count for each unit and report the inpatient days only for the time spent in each special care unit.

Special Care Unit Definitions

- 1. **CARDIAC INTENSIVE CARE UNIT.** A special unit staffed and equipped solely for the intensive care of cardiac patients.
- 2. **INTENSIVE CARE UNIT (MIXED).** A special unit in which patients are concentrated, by reasons of serious illness, without regard to diagnosis. Special life-saving techniques and equipment are immediately available, and patients are under continuous observation by nursing staff specially trained and selected for the care of this type of patient.
- 3. **BURN CARE UNIT.** A special unit staffed and equipped solely for the treatment of severely burned patients.
- 4. **SELF-CARE UNIT.** A unit designed for ambulatory patients who need minimal nursing care but who must remain hospitalized.
- 5. **REHABILITATION UNIT.** A unit that provides coordinated multidisciplinary physical restorative services under the direction of a physician knowledgeable and experienced in rehabilitation medicine.
- 6. **TUBERCULOSIS UNIT.** A unit that provides medical and/or rehabilitative treatment services to inpatients for whom the primary diagnosis is tuberculosis or other respiratory disease.
- 7. **PSYCHIATRIC UNIT.** A specific section, ward, wing, floor or building devoted primarily to the care of psychiatric inpatients.
- 8. **PEDIATRIC UNIT.** A unit with organized facilities and services for the development and care of infants and children, with the treatment of their diseases.
- 9. **OBSTETRIC UNIT.** A unit with organized facilities and services pertaining to pregnancy and delivery.
- 10. **ALCOHOLISM UNIT.** A unit that provides medical care and/or rehabilitative treatment services to inpatients for whom the primary diagnosis is alcoholism.
- 11. **CHEMICAL DEPENDENCY UNIT.** A unit that provides medical care and/or rehabilitative treatment services to inpatients for whom the primary diagnosis is chemical dependency other than alcoholism.
- 12. **ABORTION UNIT.** A unit that provides pregnancy termination services to inpatients.
- 13-15. **OTHER.** If your Facility has specific bed units which are not listed above, please provide data on these "other" units. Do not include SNF, ICF, or BC unit.
- 16-18. **SNF, ICF AND BC BEDS.** Report beds set up and staffed, admissions, discharges and inpatient days according to the above definitions. In addition, report the total number of patient days of care rendered to patients discharged during the reporting period (discharge days). Count all days of care rendered to patients who were discharged during the reporting period, regardless of when they entered the hospital. Do not report discharge days for patients transferred between short-term and long-term units except for those patients discharged from the long-term care unit following transfer. In this case, report discharge days according to the days of care rendered in the long-term unit.

- c. A significant temporary change occurs when beds are temporarily out of use and not included in the bed count. If yes, give beds added or withdrawn (show increase by + and decrease by -) and dates of change. If more than two changes occurred during the reporting period, please report all changes on a separate piece of paper.

E. FINANCIAL DATA

- 2. Non-payroll Expenses. Fringe benefits are employer paid benefits—i.e., social security, group insurance and retirement benefits.

F. EMPLOYEE STATISTICS

Complete this section according to the instructions given on the survey form. Report all full-time and part-time personnel in columns A and B who were on the hospital payroll as of the last payroll week in your reporting period. In Column C, report the total part-time hours worked by all the