



INSTRUCTIONS FOR COMPLETING

ANNUAL UTILIZATION REPORT OF HOSPITALS

REPORT PERIOD
JANUARY 1, 2018 THROUGH DECEMBER 31, 2018

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Annual Utilization Report of Hospitals
For
Report Periods Ended in 2018

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INSTRUCTIONS for ANNUAL UTILIZATION REPORT of HOSPITALS - 2018

These are the instructions for completing the 2018 Annual Utilization Report of Hospitals. Additionally, there is a glossary of the terms included in the report.

Please contact the Office of Statewide Health Planning and Development (OSHPD) Technical Support at (916) 326-3854, or utilization@oshpd.ca.gov for any questions or for further clarification.

GENERAL INSTRUCTIONS

1. Section 127285 of the Health and Safety Code requires every hospital location to file with OSHPD an Annual Utilization Report that contains utilization data for its licensed services. Multiple hospital locations that operate under a consolidated license must submit a separate report for each location. Failure to file a timely report may result in a suspended license by the Department of Health Services (CDPH) until the report is completed and filed with OSHPD.
2. The standard report period for Annual Utilization Reports covers the period from January 1 to December 31, unless there has been a change in licensure (ownership) during the calendar year. In this case, the former licensee is responsible for submitting a final report that covers from January 1 to the last date of licensure, while the new licensee is responsible for submitting an initial report that covers from the effective date of licensure to December 31.



Note: Hospitals are encouraged to request permission to submit a combined 12-month report if there has been a change in licensure during the calendar year. The former and current licensees need to agree which licensee will be responsible for submitting the report. Please send your request to file a combined report by e-mail to utilization@oshpd.ca.gov, or contact OSHPD Technical Support for instructions.

If a hospital opens or resumes operations during the year, the utilization report must cover from effective date of licensure to December 31. If a hospital closes or suspends operations during the year, the utilization report must cover from January 1 to the date of closure or suspension.

3. All hospitals are required to submit their Annual Utilization Reports using OSHPD's System for Integrated Electronic Reporting and Auditing (SIERA) for calendar year 2018 and thereafter. SIERA can be used with Google Chrome, Microsoft Edge and Internet Explorer, Apple Safari, and Mozilla Firefox. Other browsers can be used, but they may not provide complete functionality in SIERA. Please visit SIERA at <https://siera.oshpd.ca.gov/>.
4. **Do not submit the hardcopy report to OSHPD.** Only facilities with prior formal written permission for modification of submission may use a different submission format.

5. Annual Utilization Reports are due on February 15 if the report is for a full 12-month report period. If the hospital closes before December 31, the report is due 14 days from the date of notification from OSHPD. To start a report, click on “Submit” for the report year under the facility name and information.

Note: If February 15 falls on a weekend or holiday, the due date will be the first working day after the weekend or holiday.

6. Enter all amounts as whole numbers. Enter financial data to the nearest dollar. Do not use decimals, commas, dollar signs, spaces or special characters.
7. SIERA Utilization will calculate totals for a report page or the entire report by clicking on the “Calculate” button on the bottom of the page.
8. When you have validated the report and eliminated all of the fatal errors and explained all of the warning errors in the Edits on the bottom of the report, you are ready to submit the report to OSHPD. Click on the “Submit” button at the bottom of the report. A Certify Report page will appear that will ask you to certify the accuracy of the report. If you agree with the terms, click on checkbox and “Certify” button. Be aware that if you accept certification that you are certifying **under penalty of perjury** that the information supplied is, to the best of your knowledge, accurate, truthful, and complete. If the report is accepted, the status will show as “Submitted”. You can print this screen for your records. If it is not valid, the SIERA Utilization application will send you back to the report and show any remaining errors. Repeat until the report has been submitted.
9. When the report has been submitted, you can view your report in the SIERA Utilization system. Log into SIERA Utilization, on the SIERA Utilization Home page will display your facility’s reports. If you have multiple facilities, you may filter for the OSHPD ID number or name of your facility, then select “Filter”. The report will be listed with a status of “Submitted” and any reports that have not been submitted will display a status of “Pending” or “Delinquent” if passed the due date.
10. To view the original report, click on the “View” link under the Original Submission column. If you need to make changes to the report, select “Revise/View” and you will access the originally submitted report. Make necessary changes and save and re-validate before submitting the report again. (While the report is being revised it will have an “In Process” icon () next to the report year. Hovering over the icon () will display the user of last saved report. To continue with the revision, click on “Revise/View” for the report year and the last saved report will be displayed and ready for submission. When re-submitted, the status will change to “Revised”. You can revise the report as many times as needed by following the same steps.

REPORT PAGE 1 – GENERAL INFORMATION

This report page contains basic information about the hospital and parent corporation, if any, and the person completing the report.

1. **Lines 1 - 5: Facility Name and Address**

The hospital information for lines 1 through 5 is automatically entered from OSHPD's Licensed Facility Information System (LFIS) based on data from the Department of Health Services (CDPH) Licensing and Certification Division. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

2. **Lines 6 - 8: Facility Telephone Number, Administrator Name, and E-mail Address**

Enter the facility's main phone number on line 6 and the administrator's name on line 7. Enter the administrator's e-mail address on line 8 if one is available. The administrator's e-mail address will not be made available to the public.

3. **Line 9: Operation Status**

On line 9, select "Yes" or "No" from the drop down menu to indicate whether or not the hospital was in operation at any time from January 1 through December 31. If you selected "No" because the facility was not in operation during the year, you do not need to complete the rest of the report. Go to the end of the report and select the "submit" button to submit the report to OSHPD.

4. **Lines 10 - 11: Dates of Operation**

If you selected "Yes" on line 9 because the hospital was in operation during the year, enter the beginning and ending dates of operation on lines 10 and 11, respectively.

Example – A hospital began operation on April 15 and continued operation for the rest of the year. Line 10 would be 04/15/2018 and line 11 would be 12/31/2018.

5. **Lines 12 – 16: Parent Corporation Information**

If the hospital is a subsidiary or division of another corporation, enter the parent corporation's name, address and phone number on lines 12 through 16. If the hospital is not a subsidiary or division of another corporation, leave these lines blank.

6. **Lines 17 – 20: Person Completing the Report (Report Contact Person)**

The contact information on lines 17 through 20 will be filled in automatically based on the report preparer's registration information. The e-mail address on line 20 will not be made available to the public.

7. **Line 30: Submitted By and Submitted Date and Time**

When the report is submitted, the SIERA Utilization application will supply the name of the person who submits the report, the date, and the time of submission on line 30 of the final, submitted version of the report. Before the report is submitted line 30 will read, "Not submitted yet".

REPORT PAGE 2 – HOSPITAL DESCRIPTION

This report page includes information on the license category (type), licensee type of control and principal service type.

1. **Line 1: License Category (Type)**

The hospital's license category for line 1 is automatically completed by OSHPD based on data from CDPH, Licensing and Certification Division. License categories include General Acute Care, Acute Psychiatric, Psychiatric Health Facility, and Chemical Dependency Recovery Hospital. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

2. **Line 5: Licensee Type of Control**

Select from the drop down menu the Licensee Type of Control that best describes the hospital's type of ownership, i.e. the type of organization that owns the license of your hospital.

3. **Line 25: Principal Service Type**

Select from the drop down menu the Principal Service Type that best describes the type of service provided to the majority of the hospital's patients. Use the percentage of patient (census) days from Report Page 3, Lines 1 through 25 to determine which service type is most appropriate. The Principal Service Type usually relates either to the majority of reported Patient Days or to the mix of reported Patient Days.

REPORT PAGE 3 – INPATIENT SERVICES

In addition to the Inpatient Bed Utilization table, this report page provides information about the Chemical Dependency Recovery Services, Newborn Nursery, Skilled Nursing swing beds, Acute Psychiatric Services, Short Doyle contract services, and the hospital's inpatient hospice program, if any.

1. Lines 1 through 9 and 16 through 20: Inpatient Bed Utilization

Column 1: Licensed Beds - The number of licensed beds in column 1 is automatically completed by OSHPD based on data from CDPH, Licensing and Certification Division. Review the number of beds for each bed classification, which includes beds placed in suspense. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

There are six licensed bed classifications (line 15 and lines 16 through 20): General Acute Care, Chemical Dependency Recovery Hospital, Acute Psychiatric, Skilled Nursing, Intermediate Care, and Intermediate Care/Developmentally Disabled.

There are nine bed designations within the General Acute Care Classification (lines 1 through 9): Medical/Surgical, Perinatal, Pediatric, Intensive Care, Coronary Care, Acute Respiratory Care, Burn, Intensive Care Newborn Nursery, and Rehabilitation Care.

Note: Hospitals may use 100% of the licensed Medical/Surgical beds between the GAC bed designations.

Column 2: Licensed Bed Days - The number of licensed bed days in column 2 is automatically calculated by OSHPD using data from CDPH, Licensing and Certification Division. Licensed bed days are calculated for each bed classification and each Acute Care bed designation based on the number of licensed beds and the dates of licensure during the reporting period. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

Column 3: Hospital Discharges – Enter on lines 1 through 9, and on lines 16 through 20 the number of discharges from the hospital (including deaths) for each licensed bed designation and classification. Include patients who were discharged from one bed classification and formally admitted to another bed classification. **Do not include bed designation transfers that occur within General Acute Care or normal nursery discharges.**

Column 4: Intra-Hospital Transfers – Enter on lines 4 through 8 the number of intra-hospital transfers from these Critical Care bed designations to a bed designation of a lower level, usually a Medical/Surgical bed within General Acute Care prior to being discharged from the hospital. These data are needed to accurately estimate the average length of stay in critical care units.

Column 5: Patient (Census) Days – Enter on lines 1 through 9, and on lines 16 through 20, the number (cumulative count) of patient (census) days for each licensed bed designation and classification for the calendar year. If admission and discharge occur on the same day, this counts as one patient day. Do not include Observation Care days or normal Newborn Nursery days in this table.

ALOS Current Year – The SIERA Utilization application will complete the Average Length of Stay (ALOS) in this column with the result of dividing the Patient (Census) Days (column 5) by the Hospital Discharges (column 3) for lines 1 through 3 and 9 through 25. For lines 4 through 8, the application will divide the Patient (Census) Days (column 5) by the sum of the Hospital Discharges (column 3) and the Intra-Hospital Transfers (column 4) and enter the resulting Average Length of Stay in this column. This application will complete the ALOS data when you click on either “Click to Total” or “Validate”.

ALOS Prior Year – The SIERA Utilization application will access the hospital’s Annual Utilization Report for the prior year and will perform the calculation of the Average Length of Stay (ALOS) as described for column 6 and will enter the result in column 7.

Note: *Data in “ALOS” columns will not appear in any state data files. It is provided as an aid in reporting accurate information. If the average length of stay does not look reasonable, there could be an error in discharges, intra-hospital transfers, or patient (census) days.*

2. **Lines 15 and 25: Total Inpatient Bed Utilization**

The SIERA Utilization application will complete the General Acute Care (GAC) sub-total on line 15 with the sum of lines 1 through 9; and the totals on line 25 with the sum of lines 15 through 20 for columns 1, 2, 3 and 5. The application will not calculate totals in column 4.

3. **Line 30 and 31: Chemical Dependency Recovery Services in Licensed GAC and Acute Psychiatric Beds**

Column 1: Licensed Beds – The number of licensed GAC and Acute Psychiatric beds approved for providing Chemical Dependency Recovery Services (CDRS) is automatically completed on lines 30 and 31 by OSHPD based on data from CDPH, Licensing and Certification Division. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

Column 3: Hospital Discharges – Enter on lines 30 and 31 the respective numbers of Chemical Dependency Recovery Service discharges from the beds in these two licensed bed classifications.

Column 5: Patient (Census) Days – Enter on lines 30 and 31 the respective number of Chemical Dependency Recovery Service patient (census) days for the beds in these two licensed bed classifications.

ALOS Current Year - The SIERA Utilization application will complete the Average Length of Stay (ALOS) in this column with the result of dividing the Patient (Census) Days (column 5) by the Hospital Discharges (column 3) for lines 30 and 31.

ALOS Prior Year – The SIERA Utilization application will access the hospital's Annual Utilization Report for the prior year and will complete the Average Length of Stay (ALOS) in this column with the result of dividing the Patient (Census) Days (column 5) by the Hospital Discharges (column 3) using the prior year data.

Note: The CDRS data reported on lines 30 and 31 are subsets of the GAC and Acute Psychiatric data reported above on lines 15 and 17, respectively.

Note: Data in “ALOS” columns will not appear in any state data files. It is provided as an aid in reporting accurate information. If the average length of stay does not look reasonable, there could be an error in either discharges or patient (census) days.

4. **Line 35: Newborn Nursery Information**

Column 1: Nursery Bassinets - Enter on line 35 the number of bassinets in use in the (Normal) Newborn Nursery. Nursery bassinets are not considered licensed beds. Do not include bassinets located in an Alternate Birthing Center.

Column 3: Nursery Infants – Enter on line 35 the number of newborns discharged from the Newborn Nursery. Include newborns that were discharged from the Newborn Nursery and previously admitted as inpatients to a hospital's Intensive Care Newborn Nursery (Neonatal Intensive Care Unit.) Do not include newborns discharged from an Alternate Birthing Center.

Column 5: Nursery Days – Enter on line 35 the number of nursery days for the Newborn Nursery. Do not include patient days for newborns that have been formally admitted as hospital inpatients, or nursery days for newborns located in an Alternate Birthing Center.

5. **Line 40: Skilled Nursing Swing Beds**

The number of licensed GAC beds approved for skilled nursing care (swing beds) is automatically completed on line 40 by OSHPD based on data from CDPH, Licensing and Certification Division. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

Note: Complete lines 43 through 70 only if your hospital has licensed Acute Psychiatric or PHF beds. Include Chemical Dependency Recovery Services provided in licensed Acute Psychiatric beds. All others go to line 71.

6. **Lines 43 and 44: Acute Psychiatric Patients by Unit on December 31**

Enter the number of psychiatric patients in locked units and in open units on lines 43 and 44, respectively, as of December 31. See Glossary for definition of “locked” and “open” units.

7. **Line 45: Acute Psychiatric Total (By Unit)**
The SIERA Utilization application will complete the Acute Psychiatric Total in column 1, line 45 with the sum of lines 43 and 44.
 8. **Lines 46 through 49: Acute Psychiatric Patients by Age on December 31**
Enter on lines 46, 47, and 49 the number of acute psychiatric patients for each age category as of December 31.
 9. **Line 50: Acute Psychiatric Total (By Age)**
The SIERA Utilization application will complete the Acute Psychiatric Total in column 1, line 50 with the sum of lines 46 through 49.
 10. **Lines 51 through 64: Acute Psychiatric Patients by Primary Payer on December 31**
Enter on lines 51 through 64 the number of acute psychiatric patients by payer category as of December 31. See Glossary for a definition of each payer category.
 11. **Line 65: Acute Psychiatric Total (By Primary Payer)**
The SIERA Utilization application will complete the Acute Psychiatric Total in column 1, line 65 with the sum of lines 51 through 64.
- Note: The SIERA Utilization application will not allow you to submit your report unless the total acute psychiatric patients on lines 45, 50, and 65 agree.**
12. **Line 70: Short Doyle Contract Services**
On line 70, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital provided any psychiatric care under a Short-Doyle contract. You need to select “yes” if patients are reported on line 58.
 13. **Line 71: Inpatient Hospice Program**
On line 71, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital offered an inpatient hospice program during the year.
 14. **Lines 72 through 74: Inpatient Hospice Program Bed Classifications**
If the hospital offered an inpatient hospice program, check (“✓”) on each of the bed classifications that were used for the hospice program.
 15. **Line 80: Inpatient Palliative Care Program**
On line 80, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital offered an inpatient palliative care program during the year.
 16. **Lines 81 through 87: Inpatient Palliative Care Team**
Enter on lines 81 through 87 the number palliative care team members by type as of December 31.
 17. **Line 90: Outpatient Palliative Care Services**
On line 90, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital offered an outpatient palliative care services during the year.

REPORT PAGE 4 – EMERGENCY DEPARTMENT SERVICES

This report page includes information regarding Emergency Medical Services (EMS) provided by the hospital: trauma center designation, Emergency Department level, types of services available, and the number of visits by severity. It also includes information regarding the number of emergency medical treatment stations, scheduled non-emergency visits, emergency visits where the patient leaves before receiving any treatment, and emergency department closures resulting in ambulance diversions.

1. **Line 1: EMSA Trauma Center Designation**

The hospital's Trauma Center Designation level is automatically completed by OSHPD based on data from the Emergency Medical Services Authority (EMSA.) There are four trauma center designations established by EMSA (column 1), with Level I being the highest. For Pediatric (column 2), only Levels I and II are applicable. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

2. **Line 2: Licensed Emergency Department Level**

The hospital's licensed Emergency Medical Service (EMS) level at the beginning (column 1) and ending (column 2) of the reporting period is automatically completed by OSHPD based on data from CDPH, Licensing and Certification Division. There are three licensed EMS levels: Standby, Basic and Comprehensive. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

3. **Lines 11 through 17: Services Available on Premises**

Column 1: 24 Hour

On lines 11 through 17, check ("✓") those services for which licensed medical personnel are at the facility 24 hours a day.

Column 2: On-Call

On lines 11 through 17, check ("✓") those services for which licensed medical personnel are not necessarily at the facility but are available on an on-call basis.

Note: Check ("✓") only one column for each line.

4. **Lines 21 through 25: Emergency Department Services**

Column 1: EDS Visits Not Resulting in Admission

On lines 21 through 25, enter the total number of EDS visits by each type of visit, as defined by Common Procedural Terminology (CPT) codes 99281 through 99285. This applies to outpatient EDS visits **not** resulting in an inpatient admission. Enter the total on line 30. Do not include patients who registered at the Emergency Department but left without being seen, employee physicals, and scheduled clinic-type visits. See the Glossary for definitions of each Emergency Department Service type.

Note: Critical care services code 99291 is to be reported on line 25 with code 99285, if they are performed in the Emergency Room and not in Pediatric, Intensive Care, Coronary Care, or Acute Respiratory Care.

Column 2: Visits Resulting in Inpatient Admissions (optional for lines 21-25)
On lines 21 through 25, enter the number of EMS visits that resulted in the formal admission of an inpatient. Enter the total on line 30. If detail data is not available you may skip lines 21-25, column 2 and **enter the total on line 30**.

5. **Line 30: Total**

Column 1: Enter the total Emergency Department visits not resulted in admission to the hospital. This should be the sum of lines 21 through 25.

Column 2: Enter the total Emergency Department visits resulted in admissions to the hospital.

Column 3: Total ED Traffic

The SIERA Utilization application will complete total Emergency Department traffic with the sum of column 1 and column 2.

6. **Line 35: Emergency Medical Treatment Stations on December 31**

Enter on line 35 the total number of emergency medical treatment stations as of December 31. An emergency medical treatment station is a specific place within the emergency department adequate to treat one patient at a time. Do not count holding or observation beds.

7. **Line 40: Non-Emergency (Clinic) Visits Seen in Emergency Department**

Enter on line 40 the number of scheduled, non-emergency visits to the Emergency Department. This statistic typically applies to smaller hospitals that use the Emergency Department to provide outpatient clinic services.

There are times when everything else is closed at a hospital and patients come to the ED for clinic type visits such as a sore throat. The ED sees these patients as there is nowhere else to send them. The ED should record these encounters as a minor EMS visit type.

The purpose of report page 4 of the Annual Utilization Report of Hospitals is to present a picture of the medical services delivered in the hospital's emergency department. If a patient is seen in one of the emergency department's treatment stations **and** the procedure code assigned is one of the Emergency Department Services codes (i.e. CPT codes 99281 - 99285) then the encounter would be recorded as a "visit" on the "Emergency Department Services" table (report page 4, lines 21 - 25, column 1).

8. **Line 45: Emergency Registrations, But Patient Leaves Without Being Seen**
Enter on line 45 the number of ED patients that were triaged and registered, but left without being treated by a physician. If available, include the number of ED patients that left without being triaged or registered, and those patients that were triaged and left before registration.

How is the hospital to report patients who came to the ED, being triaged by a nurse or MD, and then sent to a clinic located somewhere else on the hospital campus or to a clinic off the hospital premises?

Again the purpose of report page 4 of the Annual Utilization Report of Hospitals is to capture data on the medical services delivered in the Emergency Department. Those patients who are not **treated** but are referred elsewhere (either to another department of the hospital or to another medical facility) would be recorded in the "Emergency Registrations, But Patient Leaves Without Being Seen" table (report page 4, line 45, column 1).

9. **Line 50: Emergency Department Ambulance Diversion Hours**
On line 50, select "Yes" or "No" from the drop down menu to indicate whether ambulance diversion occurred at your hospital during the year. A "Yes" means your hospital's Emergency Department (ED) was completely unavailable to all ambulance patients for a given period during the reporting year. The "full diversion" resulted in ALL PATIENTS being re-routed to other hospital during those hours. This is a count of hours and not the number of ambulances being diverted.

Note: There are times when specific types of patients must be diverted due to equipment failure, lack of specialized staff or some other reason. However, during that same time frame, if other patients who do not require these specific equipment or specialized staff are treated by the ED, then the ED would not be considered "on diversion" for this period.

10. **Lines 51 through 62: Number of Ambulance Diversion Hours Occurred at Emergency Department**
If you answered "Yes" on line 50, enter on lines 51 through 62 the number of hours the emergency department was closed to ambulances during each month of the year.
11. **Line 65: Total Hours**
The SIERA Utilization application will complete total ambulance diversion hours on line 65 with the sum of lines 51 through 62.

REPORT PAGE 5 – SURGERY AND RELATED SERVICES

This report page shows information about surgeries and related procedures such as live births, Alternate Birthing Center information, and information related to cardiology and cardiovascular surgery services.

1. Lines 1 and 2: Surgical Services

Column 1: Surgical Operations

Enter on lines 1 and 2 the number of inpatient and outpatient surgical operations, respectively. Multiple procedures performed during the same operation count as one surgical operation. Report only those surgical operations performed in a surgical suite. A surgical operation is also referred to as a “patient scheduling.”

Column 2: Operating Room Minutes

Enter on lines 1 and 2 the number of operating room minutes related to the surgeries reported in column 1. If general anesthesia is administered, count time interval from the start of anesthesia to the end of anesthesia. If general anesthesia is not administered, count time interval from the start to the end of the surgery. Do not include post-operative time spent in the recovery room.

Average Minutes per Surgery – The SIERA Utilization application will complete this column with the result of dividing the Operating Room Minutes (column 2) by the number of Surgical Operations (column 1). This data will not appear on any state data files, but is provided as an aid in reporting accurate surgical operations and operating room minutes.

2. Lines 7 through 9: Operating Rooms on December 31

Enter on lines 7 through 9 the number of operating rooms in service on December 31 by type: those used for inpatients only, those used for outpatients only, and those used for inpatients and outpatients.

3. Line 10: Total Operating Rooms

The SIERA Utilization application will complete total operating rooms on line 10 with the sum of lines 7 through 9.

4. Line 15: Ambulatory Surgical Program

On line 15, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital had an organized ambulatory surgical program during the year.

5. Lines 20 through 22: Live Births

Line 20: Enter on line 20, the total number of live births. Count all live births, including LDR (labor, delivery, recovery), LDRP (labor, delivery, recovery, post-partum), and C-Section deliveries. For multiple births, count each newborn as a separate live birth. Note that a live birth is not necessarily a viable birth.

Note: Total live births on line 20 should approximate but not necessarily equal to the number of Perinatal discharges shown in Report Page 3, line 2, column 3, plus LDR and LDRP births shown in Report Page 3, line 36. Note that a live birth does not always result in a viable birth.

Line 21: Enter on line 21, the total number of live births with a birth weight of less than 2,500 grams (5 pounds, 8 ounces.)

Line 22: Enter on line 22, the total number of live births with a birth weight of less than 1,500 grams (3 pounds, 5 ounces.)

6. **Lines 31 through 33: Alternate Birthing (Outpatient) Center Information**

Line 31: On line 31, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital had an approved (by CDPH, Licensing and Certification Division) alternate birthing program. If “Yes”, complete lines 32 and 33. If “No”, leave lines 32 and 33 blank and go to line 36.

Lines 32 and 33: On lines 32 and 33, check (“✓”) if your alternate setting was approved as LDR or LDRP, respectively. The primary difference is that LDR uses unlicensed beds and LDRP uses licensed perinatal beds.

7. **Lines 36 and 37: Other Live Birth Data**

Line 36: On line 36, enter the total number of live births reported on line 20 that occurred in your alternate birth (outpatient) setting. Do not count C-Section deliveries.

Line 37: On line 37, enter the total number of live births reported on line 20 that were C-Section deliveries. Include C-Section deliveries performed in the perinatal service, an operating room, or any other location within the hospital.

8. **Line 41: Licensed Cardiology and Cardiovascular Surgery Services**

The license category for line 41 is automatically completed by OSHPD based on data from CDPH, Licensing and Certification Division. If you find any discrepancies in this information, please notify us by e-mail at utilization@oshpd.ca.gov or call (916) 326-3854.

Note: If the hospital is licensed for Cardiovascular Surgery Services, complete lines 42 through 84. If the hospital is licensed for Cardiac Catheterization only, complete lines 55 through 84. If the hospital is not licensed for either Cardiovascular Surgery Services or Cardiac Catheterization, go to Report Page 6.

9. **Line 42: Licensed Cardiovascular Operating Rooms**

On line 42, enter the total number of operating rooms that were used to perform cardiovascular surgeries on December 31.

10. **Line 43 and 44: Cardiovascular Surgical Operations (visits with and without the Heart/Lung Machine)**

Column 1: Cardio-Pulmonary Bypass Used

Enter in column 1 the total number of pediatric and adult cardiovascular visits for surgical operations performed with the use of a cardio-pulmonary bypass.

Column 2: Cardio-Pulmonary Bypass Not Used

Enter in column 2 the total number of pediatric and adult cardiovascular visits for surgical operations performed without the use of a cardio-pulmonary bypass.

Note: Cardio-Pulmonary Bypass is also referred to as Extracorporeal Bypass or “on-the-pump” (heart/lung machine.)

11. **Line 45: Total Cardiovascular Surgical Operations**

The SIERA Utilization application will complete the total cardiovascular surgical operations on line 45 with the sum of lines 43 and 44 for columns 1 and 2.

12. **Line 50: Coronary Artery Bypass Graft (CABG) Surgeries**

Enter on line 50 the total number of Coronary Artery Bypass Graft (CABG) Surgeries performed. This is one type of cardiovascular surgery reported on line 45, which means line 50 should be less than line 45.

13. **Line 55: Cardiac Catheterization Lab Rooms**

Enter on line 55 the total number of rooms equipped to perform cardiac catheterizations on December 31.

14. **Lines 56 through 59: Cardiac Catheterization Laboratory Visits**

Cardiac catheterization visits are recorded when a patient is in the cardiac catheterization laboratory and is having some type of procedure performed. Only procedures related to the cardiac area are to be reported. The lab may be used to perform catheterizations and procedures on other parts of the body but these procedures are not captured on the current report. The catheterization procedure could be performed either for the purpose of diagnosis or an interventional procedure (i.e. treatment). In some cases both are done in sequence. The visits are classified by patient age (pediatric or adult), patient classification (inpatient or outpatient) and procedure type (diagnostic or therapeutic). They are recorded on the Cardiac Catheterization Visits table in Report Page 5 of the report.

Column 1: Diagnostic

Enter in column 1 the number of pediatric and adult, inpatient and outpatient cardiac catheterization visits for the purpose of diagnosing an illness or condition.

Column 2: Therapeutic

Enter in column 2 the number of pediatric and adult, inpatient and outpatient cardiac catheterization visits for the purpose of treating an illness or condition.

Note: If a diagnostic test is immediately followed by an interventional procedure on the same patient both procedures are to be counted. The rationale for this is that diagnostic procedures typically take from 45 – 60 minutes of physician and staff time, certain supplies and use of special equipment. The interventional procedure will require anywhere from 45 to 90 additional minutes of physician and staff time (and in some cases even longer), the cost of additional supplies and the use of special equipment.

When the procedures are done in sequence there are some savings. The patient is already on the table in the sequential scenario eliminating the two “set up” times of approximately 30 minutes if the procedures were performed separately. There are also some savings on supplies when the procedures are performed in sequence. However, these costs are minimal compared to the physician and staff time and the fact is that two separate cardiac procedures were actually performed. Not counting one of them simply because they were done in sequence would give a distorted picture of the cardiac catheterization lab’s actual utilization.

15. Line 60: Total Cardiac Catheterization Visits

The SIERA Utilization application will complete the total diagnostic and therapeutic visits on line 60 with the sum of lines 56 through 59.

Note: Do not include any of the following as cardiac catheterization visits:

Defibrillation

Cardioversion

Pericardiocentesis

Temporary Pacemaker Insertion

Percutaneous Transluminal Balloon Valvuloplasty (PTBV) is very rarely done in these times. Those that are done are generally on pediatric patients.

AICD procedures are frequently done in the cath lab and are very similar to permanent pacemaker implants.

16. Lines 65 through 83: Distribution of Procedures Performed in Catheterization Laboratory

If you reported Cardiac Catheterization Visits in on lines 56 through 59, enter on lines 65 through 83 the total number of procedures performed in the catheterization laboratory.

Multiple Procedures -

The Distribution of Cardiac Catheterizations Table (Report Page 5) is designed to capture all of the procedures done in the lab. Thus, if two or more distinct procedures are performed on the same visit count all procedures.

For example a patient received an atherectomy followed by a PCI, both procedures would be recorded (the atherectomy on Line 73 and the PCI on Line 71 or 72).

17. Line 84: Total Catheterization Procedures

The ALIRTS application will complete the total catheterization procedures on line 84 with the sum of lines 65 through 83.

REPORT PAGE 6: MAJOR CAPITAL EXPENDITURES

This report page satisfies Section 127285 (3) of the Health and Safety Code, which requires each hospital to report “acquisitions of diagnostic or therapeutic equipment during the reporting period with a value in excess of five hundred thousand dollars (\$500,000.)” It also satisfies Section 127285 (4) of the Health and Safety Code, which requires each hospital to report the “commencement of projects during the reporting period that require a capital expenditure for the facility or clinic in excess of one million dollars (\$1,000,000.)”

1. Line 1: Diagnostic and Therapeutic Equipment Costing Over \$500,000

On line 1, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital acquired any diagnostic or therapeutic equipment during the year with a cost or fair market value in excess of \$500,000. If you select “Yes”, complete lines 2 through 11, as necessary, to report the details of these acquisitions.

2. Lines 2 through 11: Diagnostic and Therapeutic Equipment Detail

Column 1: Description of Equipment

In column 1, enter a description of the acquired equipment.

Column 2: Value

In column 2, enter the value of the acquired equipment. Enter the cost of purchased equipment, the total value of a capital lease or fair market value of equipment leased on a month-to-month basis, or the fair market value of donated equipment. Need to report to the nearest dollar.

Column 3: Date of Acquisition

In column 3, enter the date the equipment was acquired. The date format is “MM/DD/YYYY”.

Column 4: Means of Acquisition

In column 4, select “Purchase”, “Lease”, “Donation”, or “Other” from the drop down menu to indicate the means of acquisition.

3. Line 25: Building Projects Commenced During the Period Costing over \$1,000,000

On line 25, select “Yes” or “No” from the drop down menu to indicate whether or not the hospital commenced any building projects during the year that will require an aggregate capital expenditure exceeding \$1,000,000. If “Yes”, complete lines 26 through 30, as necessary, to describe the building project(s.)

Note: The commencement of a building project is considered to be in the reporting period in which OSHPD issues a project number for that project.

4. **Lines 26 through 30: Detail of Capital Expenditures**

Column 1: Description of Project

In column 1, enter a description of each building project started during the reporting period.

Column 2: Projected Total Capital Expenditure

In column 2, enter the projected total expenditure required to complete each building project started during the reporting period. Need to report to the nearest dollar.

Column 3: OSHPD Project No.

In column 3, enter the project number that was issued by Facilities Development Division, OSHPD, for each building project commenced during the reporting period. Report the primary eight digit project number but do not report any sub numbers after the primary number. See Glossary for details.

Note: If the reported project does not require an OSHPD project number, please enter "N/A" in column 3.

Note: If there are more than five projects to be reported, you may report several on each line. Enter a summary description in column 1, and report all associated OSHPD project numbers in column 3.

GLOSSARY

ANNUAL UTILIZATION REPORT OF HOSPITALS

Acute Psychiatric

This includes medical care, nursing and auxiliary professional services and intensive supervision of the mentally ill, mentally disordered or other mentally incompetent persons.

Locked Unit

A unit designed for the more chronically ill psychiatric patients where access into and out of the unit is obtained only by unlocking the unit's outside doors.

Open Unit

A unit designed for patients with less severe psychiatric conditions where there are no restrictions to access into and out of the unit.

Acute Respiratory Care

This is the provision of acute inpatient care to patients with severe respiratory conditions who require a more intensive treatment than usual medical/surgical acute nursing care. **The patient-to-RN ratio is not to exceed 2:1.**

Ambulatory Surgical Program

A program in which the hospital is equipped and staffed and has written policies and procedures to handle surgical cases on an out-patient basis, such as cataracts, herniorrhaphy, and meniscectomy, that do not require overnight hospitalization.

Angiography – Non-Coronary

This is for the x-ray visualization of the internal anatomy of blood vessels, other than coronary vessels, after the intravascular introduction of radiopaque contrast medium.

Atherectomy

Coronary atherectomy removes plaque from the arteries supplying blood to the heart muscle. It uses a laser catheter, or a high speed, rotating shaver ("burr" device on the end of a catheter.) The catheter is inserted into the body and advanced through an artery to the area of narrowing. Other devices are directional coronary atherectomy (DCA), catheters that shave off the plaque and capture it within the catheter, or laser catheters that vaporize the plaque. Balloon angioplasty or stenting may be used after an atherectomy.

Automatic Implantable Cardiac Defibrillator (AICD) or Implantable Cardioverter Defibrillator (ICD)

The device is implanted in the patient similar to a permanent pacemaker. It is automatically detects fast and potentially lethal heart rhythms. The AICD/ICD can deliver several kinds of rapid and effective electrical treatments designed to promptly terminate these rhythms. In essence, the automatic treatments consist of either rapidly pacing the heart (briefly) or delivering small internal electric shocks directly to the heart, or a sequential combination of both.

Average Daily Census (ADC)

This represents the average number of inpatients, excluding nursery patients, receiving care each day during the reporting period. It is derived by dividing the number of patient (census) days for the reporting period by the number of days in the reporting period.

Average Length of Stay (ALOS)

The estimated average number of days of service rendered to each inpatient discharged during a given period. To calculate, divide the total number of patient (census) days for the reporting period by the total patients discharged during the reporting period. Note – This is a fairly accurate estimate for acute bed types. However, it is an inaccurate estimate for Long-Term Care beds (SNF, ICF, ICF/DD), as it does not include the patient days generated during prior years for the patients discharged during the reporting period. (LTC **Discharge** Days must be used as the numerator to calculate LTC ALOS (available from OSHPD's Discharge Data)

Bed Classification

This denotes the “major” licensed bed category scheme used by CDPH, Licensing and Certification Division. The CDPH Bed Classifications are:

- General Acute Care
- Acute Psychiatric
- Chemical Dependency Recovery Hospital
- Skilled Nursing
- Intermediate Care
- Intermediate Care/Developmentally Disabled

Bed Designation (General Acute Care)

The scheme used to sub-categorize General Acute Care beds, by CDPH, Licensing and Certification Division.

The GAC bed designations used by CDPH are:

- Undesignated General Acute*
- Perinatal – for maternity services, including patients who do not deliver (false labor) but excludes all newborns and gynecological patients.

- Pediatric – for patients under 14 years of age.
- Intensive Care – for the treatment and continuous monitoring of patients with life threatening conditions.
- Coronary Care – for the specialized medical and nursing treatment to patients being suspected of, or having significant coronary artery disease or heart failure.
- Acute Respiratory Care – for the specialized medical and nursing care by specially trained nursing and supportive personnel to patients with acute respiratory problems.
- Burn Center – for the specialized medical and nursing care by specially trained medical and supportive personnel to severely burned patients.
- Intensive Care Newborn Nursery – for comprehensive and intensive care for all contingencies of the newborn infants.
- Rehabilitation Center – for physical, occupational and speech therapy specifically.

*Note – although licensed as “Undesignated General Acute Care,” these beds are commonly referred to as Medical/Surgical, or Med/Surg beds.

Burn Center

The provision of care to severely burned patients requiring a more intensive treatment than usual medical/surgical acute nursing care. Severely burned patients have second degree burns over more than 25% of the total body surface, or third degree burns over more than 10% of the total body surface, or any severe burn to the hands, face, eyes, ears or feet. **The patient-to-RN ratio is not to exceed 2:1.**

CPT 200X Codes (Current Procedural Terminology)

Current Procedural Terminology is a listing of descriptive terms and identifying codes for reporting medical services and procedures performed by physicians. The purpose of the terminology is to provide a uniform language that will accurately describe medical, surgical, and diagnostic services, and will thereby provide an effective means for reliable nationwide communication among physicians, patients, and third parties. It is published by the American Medical Association.

Cardiac Catheterization

Diagnostic: The intravascular insertion of a catheter into the root of the aorta and the heart for the primary definition and diagnosis of arterial lesions or other cardiac conditions.

Therapeutic: The intravascular insertion of a catheter into the coronary arteries or into the heart for treatment purposes, e.g. PIC's, coronary stenting, permanent pacemakers, and thrombolytic agent infusion (e.g., streptokinase), etc.

Cardio-Pulmonary Bypass

This is a process of routing blood from the body to an external heart/lung machine which provides circulation and oxygenates the blood. This is also referred to as Extracorporeal Bypass or “on-the-pump” (heart-lung machine.)

Cardiovascular Surgery

Surgery performed on the heart or major blood vessels entering or leaving the heart. This is also referred to as open heart surgery. It can be performed with or without Cardio-Pulmonary Bypass. (see **Cardio-Pulmonary Bypass**.)

Cardioversion

The restoration of the heart’s normal sinus rhythm by delivery of a synchronized electric shock through two metal paddles placed on the patient’s chest. Cardioversion is used to slow the heart rate or to restore the heart’s normal sinus rhythm when drug therapy is ineffective or in combination with drug therapy.

Chemical Dependency Recovery Hospital Beds

Those beds in a Chemical Dependency Recovery Hospital or a General Acute Care Hospital are classified as Chemical Dependency Recovery Hospital beds by CDPH, Licensing and Certification Division.

Chemical Dependency Recovery Hospital (CDRH)

This is a separately licensed hospital that provides 24-hour inpatient care for persons who have a chemical dependency (alcohol or other drugs.) Care includes patient counseling, group therapy, physical conditioning, family therapy, outpatient services, and dietetic services.

Chemical Dependency Recovery Services (CDRS)

Services provided as a supplemental service in General Acute Care Beds or Acute Psychiatric Beds. The service must be provided in a distinct part of the hospital and is the same as the service provided in hospitals licensed as Chemical Dependency Recovery Hospital.

Consolidated License

This refers to a (parent) General Acute Care Hospital license that includes satellite locations that were formerly separately licensed Facilities. This licensing option became available after Section 1250.8 was added to the Health and Safety Code in 1983. The satellite locations may be other hospital or Long-term Care campuses. For purposes of this report, each location must submit a separate annual utilization report.

Coronary Artery Bypass Graft Surgery (CABG)

This is a surgical procedure that creates new routes around narrowed and blocked arteries, allowing sufficient blood flow to deliver oxygen and nutrients to the heart muscle.

Coronary Care Unit

This involves the delivery of care pertaining to conditions of the heart that is more specialized in nature than those provided to the usual Medical, Surgical, and Pediatric patient. It includes Cardiovascular Care, Myocardial Infarction Care, Heart Transplant Care, Cardio-Pulmonary Care, and Other Coronary Care. **NOTE: Patient-to-RN ratio is not to exceed 2:1.**

County Indigent Programs

The County Indigent Programs category includes indigent patients covered under Welfare and Institution Code Section 17000. Also included are patients paid for in whole or in part by the County Medical Services Program (CMSP), California Health Care for Indigent Program (CHIP or tobacco tax funds), and other funding sources whether or not a bill is rendered. This category also includes indigent patients who are provided care in county hospitals, or in certain non-county hospitals where no county-operated hospital exists, whether or not a bill is rendered. Also included are patients covered under a managed care plan funded by the county. (See **Primary Payer** for a list of the ten payer categories.)

Critical Care

Beds within General Acute Care designated for patients that require more than the usual level of acute care. These designations require a patient-to-RN ratio not to exceed 2:1.

Beds designated as Critical Care are:

- Intensive Care
- Coronary Care
- Acute Respiratory Care
- Burn
- Intensive Care Newborn Nursery

Dates of Operation

This denotes the beginning and ending dates of the period of time during the year for which the facility was licensed to operate. The facility may or may not have patients during this period of time.

Defibrillation

It is the termination of ventricular fibrillation (involuntary recurrent contraction) or severe ventricular tachycardia by delivery of an electrical shock to the patient's precordium.

Discharge

The formal termination and release by the hospital of inpatient hospitalization excluding nursery. Deaths are included in discharges. Transfers between types of care (acute, psychiatric, chemical dependency, skilled nursing, intermediate care) are also considered "discharged and re-admitted".

Distinct Part Facility

This refers to a satellite location (campus) on a (parent) General Acute Care Hospital license. Each Distinct Part Facility was a formerly separately licensed facility. The satellite locations include either a hospital or Long-term Care campuses. For purpose of this report, the data for each Distinct Part Facility must be included in the parent's annual utilization report.

Distinct Part Service

This is a service on a General Acute Care Hospital campus comprised of beds from the Licensed Bed Classifications lower than the facility's Licensed Bed Category. For example, a General Acute Care Hospital can have licensed Acute Psychiatric, Chemical Dependency Recovery Hospital and/or Long-term Care services on campus. The data for Distinct Part Services must be included in the hospital's annual utilization report.

Emergency Department Services (EDS)

Hospital services providing immediate initial evaluation and treatment of acutely ill or injured patients on an unscheduled 24-hour basis, and licensed by CDPH, Licensing and Certification.

Licensed EDS Levels are:

- Standby - A level of emergency medical care in a hospital where an EDS physician is at minimum, on-call. (See Title 22, Division 5, Sections 70651-70657, California Code of Regulations, for details.)
- Basic - A level of emergency medical care in a hospital where an EDS physician is on staff 24 hours a day, year-around. (See Title 22, Division 5, Sections 70413-70419, California Code of Regulations, for details.)
- Comprehensive - A level of emergency medical care in a hospital where an EDS physician is on staff 24 hours a day, year-around. Other physician specialties required for this level, 24 hours a day year-around, includes thoracic surgeon, neurosurgeon, orthopedic surgeon, and pediatrician. The hospital must also

have a Burn Center, and provides Acute Dialysis, and Cardiovascular surgery services. (See Title 22, Division 5, Sections 70453-70459, California Code of Regulations, for details.)

EDS Visit Type (CPT Code)

Types of visits to the Emergency Department as indicated in *Current Procedural Terminology*.

- Minor (CPT Code 99281) – An Emergency Department visit which requires a problem focused history/examination, and straightforward medical decision making. Usually, the problems are self-limited or minor.

Example: Emergency Department visit for a patient for removal of sutures from a well-healed, uncomplicated laceration.

- Low/Moderate (CPT Code 99282) – An Emergency Department visit that requires an expanded problem focused history/examination, and medical decision-making of low complexity. Usually, the presenting problems are of low to moderate severity.

Example: Emergency Department visit for a patient with a minor traumatic injury of an extremity with localized pain, swelling, and bruising.

- Moderate (CPT Code 99283) - An Emergency Department visit that requires an expanded problem-focused history/examination, and medical decision-making of moderate complexity. Usually, the presenting problems are of moderate severity.

Example: Emergency Department visit for a patient with an inversion ankle injury, who is unable to bear weight on the injured foot and ankle.

- Severe without threat (CPT Code 99284) - An Emergency Department visit that requires a detailed history/examination, and medical decision-making of moderate complexity. Usually, the presenting problems are of high severity, and require urgent evaluation by the physician but do not pose an immediate threat to life or physiologic function.

Example: Emergency Department visit for an elderly female who has fallen and is now complaining of pain in her right hip and is unable to walk.

- Severe with threat (CPT Code 99285) – An Emergency Department visit which requires a comprehensive history/examination, and medical decision-making of high complexity. Usually, the presenting problems are of high severity and pose an immediate significant threat to life or physiologic function.

Example: Emergency Department visit for a patient exhibiting active, upper gastrointestinal bleeding.

Emergency Medical Treatment Station

This is a specific place within the Emergency Department adequate to treat one patient at a time. Holding or observation beds are not included.

EMS Trauma Center

A licensed hospital designated as such by a local Emergency Medical Services Agency and includes personnel, services and equipment necessary for the care of trauma patients. General requirements include a trauma program medical director, a trauma nurse coordinator, a basic emergency department (minimum), multidisciplinary trauma team, and specified service capabilities required under Title 22, Division 9, Chapter 7 – Trauma Care Systems.

EMSA Trauma Center Designations

- Level I and II: Level I and II trauma centers have similar personnel, services, and resource requirements with the greatest difference being that Level I is for research and teaching facilities.
- Level I and II Pediatric: Level I and II Pediatric trauma centers focus specifically on pediatric trauma patients. Level I facilities require some additional pediatric specialties and are research and teaching facilities.
- Level III and IV: Level III and IV trauma centers generally provide initial stabilization of trauma patients with the greatest difference being surgical capabilities at the Level III facilities.

Facility Name

This is the name under which the facility is doing business (DBA name). This name may be an abbreviation of and may differ from the facility's legal name. It is listed on the license as the name of the facility being operated by the licensee.

General Acute Care (GAC) Beds

Beds licensed and designated by CDPH, Licensing and Certification Division as Medical/Surgical, Pediatric, Perinatal, Acute Rehabilitation Center, Burn Center, ICU, CCU, Acute Respiratory, or ICNN Beds. See also "Bed Classification".

Inpatient

This denotes a person who is formally admitted by a physician and is provided with room, board, and continuous general nursing service in an area of the hospital where patients stay overnight.

Inpatient Hospice Program

A hospice program is a centrally administered program of palliative and supportive services that provides physical, psychological, social and spiritual care for dying persons and their families, focusing on pain and symptom control for the patient.

Inpatient Palliative Care Program

An interdisciplinary team that sees patients, identifies needs, makes treatment recommendations, facilitates patient and/or family decision making, and/or directly provides palliative care for patients with serious illness and their families.

Intensive Care Newborn Nursery (ICNN)

It is a place that provides comprehensive and intensive care for all contingencies of the newborn infant. Infant transport services are an indispensable part of an Intensive Care Newborn Nursery. **NOTE: Infant-to-RN ratio is not to exceed 2:1.**

Intensive Care Unit

This involves the delivery of care for the treatment and continuous monitoring of patients with life threatening conditions. **NOTE: Patient-to-RN ratio is not to exceed 2:1.**

Intermediate Care (IC)

Long-term Care Services to a patient whose condition does not require the degree of care provided by a General Hospital or Skilled Nursing Facility.

Intermediate Care Hospital/Developmentally Disabled IC/DD (or ICF/DD):

A bed classification and/or hospital classification for providing a special treatment program for persons who are developmentally disabled.

Intra-Aortic Balloon Pump

A procedure where a balloon is threaded into the aorta on the end of a catheter attached to the pump. The balloon inflates when the heart muscle relaxes, and deflates just before the heart muscle pumps. This increases blood flow to the heart muscle and relieves some of the heart's workload.

Intra-Hospital Transfer

An Intra-Hospital Transfer is the formal transfer of a patient from one general acute care service to another. Such a transfer occurs during a patient's single hospitalization. (The hospital annual utilization report shows only intra-hospital transfers from critical care units.)

Labor, Delivery, and Recovery (LDR):

This is an outpatient program formally approved as ABC (Alternative Birthing Center) for low risk mothers, by CDPH, Licensing and Certification Division. It is in a home-like setting with equipment and supplies for uncomplicated deliveries with stays of less than 24 hours. Beds in an Alternative Birthing Center are not required to be licensed.

Labor, Delivery, Recovery, and Post-Partum (LDRP):

This is a program for all mothers for complicated deliveries, in a home-like setting with equipment and supplies, with stays which can exceed 24 hours. This program has been approved by CDPH, Licensing and Certification Division and provided in licensed perinatal beds.

License Category

The license category describes the licenses issued to acute hospitals by CDPH, Licensing and Certification Division. It represents the highest level of bed classification in the hospital. It does not necessarily represent the principle type of service offered to patients. The license categories are; General Acute Care Hospital, Acute Psychiatric Hospital, Psychiatric Health Facility, or Chemical Dependency Recovery Hospital.

Licensed Beds

Licensed beds for the purpose of this report are the number of beds licensed by CDPH, Licensing and Certification Division on the last day of the reporting period. This includes beds placed in suspense.

Licensed Bed Days

It is the result of the number of licensed beds multiplied by the number of days in the reporting period. This calculation reflects changes in the actual bed capacity during the year and is used to calculate occupancy rates. $\text{Patient (Census) Days/Licensed Bed Days} = \text{Occupancy Rate}$.

Licensee Type of Control

This denotes the type of ownership and/or legal organization of a hospital licensee. The following nine types of control are reported:

- City and/or County
- District
- Non-Profit Corporation (incl. Church-Related)
- University of California
- State
- Investor – Individual
- Investor – Partnership

- Investor – Limited Liability Company
- Investor – Corporation

Live Birth

The birth of an infant, irrespective of the duration of gestation, that exhibits any sign of life, such as respiration, heartbeat, umbilical pulsations, or movement of voluntary muscles. A live birth is not necessarily a viable birth.

Long-term Care (LTC):

Long-term care refers to Skilled Nursing, Intermediate Care and Intermediate Care/Developmentally Disabled.

Managed Care

Managed care patients are patients enrolled in a managed care health plan to receive health care from providers on a pre-negotiated or per diem basis, usually involving utilization review. This includes Health Maintenance Organizations (HMO), Health Maintenance Organizations with Point-of-Service option (POS), Preferred Provider Organizations (PPO), Exclusive Provider Organizations (EPO), Exclusive Provider Organizations with Point-of-Service option, etc. (Also see **Primary Payer** for related information.)

Medical/Surgical (M/S):

Licensed as “Unspecified General Acute Care”, i.e., GAC beds not designated as Perinatal, Pediatric, ICU, CCU, Acute Respiratory, Burn Center, ICNN, or Acute Rehabilitation.

Medi-Cal – Managed Care

The Medi-Cal – Managed Care payer category includes patients covered by a managed care health plan funded by Medi-Cal. (See **Primary Payer** for a list of the ten payer categories. See also **Managed Care**.)

Medi-Cal – Traditional

The Medi-Cal-Traditional payer category includes patients who are qualified as needy under state laws and are enrolled in Medi-Cal. (See **Primary Payer** for a list of the ten payer categories)

Medicare – Managed Care

The Medicare - Managed Care payer category includes patients who are covered by a managed care health plan funded by Medicare. (See **Primary Payer** for a list of the ten payer categories. See also **Managed Care**.)

Medicare – Traditional

The Medicare - Traditional payer category includes patients covered under the Social Security Amendments of 1965. These patients are primarily the aged and needy.

Newborn Nursery

It is a hospital service providing daily nursing care for normal newborn infants, premature infants not requiring extraordinary care, and boarder babies. Capacity is determined by the number of bassinets in the unit reporting this type of newborn. These nursery bassinets are not included in the count of licensed beds.

Occupancy Rate

This is a measurement of bed utilization for the reporting period. To calculate, divide the reported patient days by the respective licensed bed days.

Operating Rooms

The number of operating rooms located at the hospital and any discrete operating rooms existing at Satellite Ambulatory Surgery Centers. Operating rooms located at the hospital may be exclusively for inpatients or outpatients, or may be combined inpatient/outpatient operating rooms.

Operating Room Minutes

The number of operating room minutes is the difference between starting time (beginning of anesthesia) and ending time (end of anesthesia.) If anesthesia is not administered, starting and ending times are defined as the beginning and end, respectively, of surgery. If the patient is to remain under general anesthesia after leaving the operating room, ending time occurs when the patient leaves the operating room.

OSHPD Facility Number

This is a nine-digit facility identification number assigned by OSHPD for reporting purposes. The first three digits indicate the type of facility, the next two digits indicate the county in which the facility operates, and the last four digits are assigned to identify the facility.

Other Indigent

The Other Indigent payer category includes indigent patients who are being provided charity care by the hospital and U.C. teaching hospital. These patients are provided care with the Support for Clinical Teaching funds. This category excludes those who are recorded in the County Indigent Programs category. (See **Primary Payer** for a list of the ten payer categories.)

Other Payers

The Other Payers payer category includes all patients who do not belong in the other payer categories, such as those designated as self-pay. (See **Primary Payer** for a list of the ten payer categories.)

Other Third Parties – Managed Care

The Other Third Parties - Managed Care category includes patients covered by managed care plans other than those funded by Medicare, Medi-Cal, or a county. Patients enrolled in the Healthy Families program are reported here. (See **Payer Categories** for a list of the ten payer categories. See also **Managed Care**.)

Other Third Parties – Traditional

The Other Third Parties - Traditional category includes all other forms of health coverage excluding managed care plans. Examples include TRICARE, IRCA/SLIAG, California Children's Services, indemnity plans, fee-for-service plans, and Workers' Compensation. (See **Payer Categories** for a list of the ten payer categories)

Outpatient

An outpatient is a patient who appears in the hospital for ambulatory services or is referred to the hospital for ancillary services. In both instances, the patient is typically treated and released on the same day, and is not formally admitted as an inpatient, even though occasional overnight stays may occur. Included are outpatient Emergency Room Visits, outpatient Clinic Visits, Referred (ancillary service) Visits, Home Health Care Visits, and day care days, where the outpatient is treated and released on the same day. Also included are outpatient chemical dependency visits, hospice outpatient visits, and adult day health care visits.

Parent Corporation

This denotes a corporation that owns a number of facilities and holds the license to operate this facility.

Patient (Census) Days:

This is the sum of all inpatient daily census counts (excluding nursery) for each day of the reporting period (i.e. cumulative patient census.) The reporting period is the calendar year unless the hospital was not in operation all year.

Pediatric Service

The provision of nursing care to Pediatric patients (usually children less than 14 years old), including neonatal patients who require services not available or appropriately given in the newborn nursery.

Percutaneous Coronary Intervention (PCI):

This procedure relieves narrowing and obstruction of the arteries to the muscle of the heart (coronary arteries). This allows more blood and oxygen to be delivered to the heart muscle. Percutaneous coronary intervention is accomplished with a small balloon catheter inserted into an artery in the groin or arm, and advanced to the narrowing in the coronary artery. The balloon is then inflated to enlarge the narrowing in the artery. It can be done with or without a stent. When successful, percutaneous coronary intervention can relieve chest pain or angina, improve the prognosis of individuals with unstable angina, and minimize or stop a heart attack without having the patient undergo open heart coronary artery bypass graft (CABG) surgery.

Percutaneous Transluminal Balloon Valvuloplasty (PTBV):

This procedure involves a catheter with a balloon that is threaded in the femoral vein (leg) up into the heart and across the pulmonary valve located in the heart. The pulmonary valve is usually tight with stricture or stenosis. The balloon is then inflated by hand pressure. The process (inflation and deflation) may be repeated several times in order to increase the diameter of the valve. This procedure is rarely done in these times. Those that are done are generally on pediatric patients.

Percutaneous Transluminal Coronary Angioplasty (PTCA):

This is now referred to as percutaneous coronary intervention (PCI), as this term includes the use of balloons, stents, and atherectomy devices.

Pericardiocentesis

It is a procedure for drawing fluid in the pericardial space between the serous membranes by surgical puncture and aspiration of the pericardial sac.

Perinatal Unit

Hospital unit that consists of licensed perinatal beds for the provision of care during pregnancy, labor, delivery, postpartum, and neonatal periods. This includes labor rooms, delivery rooms, and a newborn nursery. It is commonly called “maternity” or “obstetrical”.

Permanent Pacemaker Implantation (PPI)

This is a type of therapeutic cardiac catheterization. The pacemaker is surgically implanted in the body, usually in the shoulder area. A small incision is made, a ‘pocket’ is created to contain the pulse generator and the wire(s) are inserted into a large vein and advanced to the heart. Removal of the pacemaker would require a surgical procedure.

Primary Payer

The third-party or individual who is responsible for the predominate portion of a patient's bill. The Office has established 10 payer categories: Medicare - Traditional, Medicare - Managed Care, Medi-Cal - Traditional, Medi-Cal - Managed Care, County Indigent Programs - Traditional, County Indigent Programs - Managed Care, Other Third Parties - Traditional, Other Third Parties - Managed Care, Other Indigent, and Other Payers (see definition of each payer category for more detail.)

Principal Service Type

The self-selected category that best describes the type of service provided to the majority of patients, according to the hospital. The category selected should be consistent with the majority or, or mix of, reported patient (census) days.

- General Medical/Surgical
- Long-term Care (Skilled Nursing or SN; Intermediate Care or IC)
- Psychiatric
- Chemical Dependency (Alcohol / Drug)
- Pediatric
- Physical Rehabilitation
- Orthopedic or Pediatric Orthopedic
- Developmentally Disabled
- Other

Project Number

A number issued to the facility by Facilities Development Division, OSHPD, to identify construction projects.

The project number for building projects costing \$1,000,000 or more consists of an 8 digit alpha-numeric number in the following format:

First digit:	The letters S, H, or I, indicating the type of equipment.
Second digit:	The letters S or L, indicating the issuing office (Sacramento or Los Angeles.)
Third and Fourth digits:	Two numbers indicating the year the project number was issued. For this report the third and fourth digits will be "02".
Fifth through eighth digits:	Four numbers indicating the sequence, starting with 0001 and continuing as far as necessary.

Example: HL020123

Psychiatric Health Facility (PHF)

A hospital licensed by the Department of Health Care Services that provides 24-hour inpatient care for the mentally disordered or incompetent patients. Such care shall include, but not be limited to the following basic services: psychiatry, clinical psychology, psychiatric nursing, social work, rehabilitation, drug administration and appropriate food services.

Radiofrequency Catheter Ablation

This is a technique being used to eliminate abnormal conduction signal sites. Typically it is used for arrhythmias such as supraventricular tachycardia (SVT), atrial fibrillation (AF) and ventricular tachycardia (VT). A catheter is inserted through the skin and threaded through the blood vessels to the site of abnormal cardiac rhythm source. Heat is delivered to the site and controlled by a radiofrequency generator with the effect of eliminating the point of abnormal cardiac rhythm activity.

Rehabilitation Center

It is the licensed general acute care bed designation in which provision of 24-hour rehabilitation care to patients needing physical or corrective treatment of bodily conditions. Patients in the Rehabilitation Center receive a minimum of four hours a day of physical therapy, occupational therapy, speech therapy and/or social services.

Short-Doyle

The Short-Doyle Act, implemented in 1957, was designed to organize and finance community mental health services for persons with mental illness through locally administered and locally controlled community health programs.

In 1972, Short-Doyle community mental health services were added to the scope of benefits of the Medi-Cal program. The Short-Doyle/Medi-Cal (SD/MC) program provides cost-based reimbursement for a broad range of mental health services including rehabilitative services, and a limited range of services for treatment of substance abuse. These mental health services are provided by the county or through a contract with the county.

Skilled Nursing

Twenty-four-hour licensed nursing care provided to patients who require convalescent and/or restorative services at a level less intensive than Medical, Surgical, and Pediatric acute care and Sub-Acute care requirements.

Skilled Nursing Swing Beds

Beds licensed for general acute care that may be used, with the approval of CDPH, Licensing and Certification Division, as Skilled Nursing beds.

Stent

Metal mesh-like structures, either bare metal or drug coated, delivered by catheter to obstructed areas of coronary and non-coronary arteries and deployed using inflatable balloon systems. Stents are designed to hold open arteries following the inflation of the balloon catheter delivery system.

Surgical Operations

A surgical operation occurs when one patient uses an operating room. Therefore, a surgery involving multiple procedures (even multiple, unrelated surgeries) performed during one scheduling is to be counted as one surgical operation. Another definition of a surgical operation could be a "patient scheduling".

Suspense ("In Suspense")

This is a designation describing a hospital license or specific services that are temporarily taken out of service. The licensee may request the designation or CDPH, Licensing and Certification Division may determine the designation on its own. (See Title 22, Division 5, Sections 70129-70135, California Code of Regulations, for details.)

Temporary Pacemaker Insertion

The insertion of a pacemaker to temporarily pace the heart until the heart rhythm returns to normal. The procedure is similar to the permanent implantation, except that the pulse generator is outside of the patient's body rather than being implanted. Temporary pacemakers are generally used for a short time (two to three days.)

Thrombolytic Agents

Chemicals that are introduced by cardiac catheter or intravenously to dissolve blood clots lodged in arteries, e.g., Streptokinase Infusion, t-PA, etc.

Transfers (Intra-hospital)

This refers to patients being moved from one bed designation to another bed designation within the hospital. These patients were initially admitted to critical care, i.e. intensive care, coronary care, acute respiratory care, burn and intensive care newborn nursery. After being treated at critical care unit, these patients may be transferred to medical/surgical beds for observation and recovery before being formally discharged from the hospital.

Value

The value of equipment depends on the method of acquisition.

- Purchase – The value of purchased equipment is the total purchase price.
- Lease – The value of equipment under a capital lease is the present value of the future series of lease payments.
- Donation – The value of donated equipment is the fair market value of the equipment at the time of donation.

Viable Birth

This denotes capable of life. For example, a viable premature baby is one who is able to survive outside the womb.