SASB STANDARDS
Now part of IFRS Foundation

Health Care Delivery

Sustainability Accounting Standard

HEALTH CARE SECTOR

Sustainable Industry Classification System® (SICS®) HC-DY

Under Stewardship of the International Sustainability Standards Board

INDUSTRY STANDARD | VERSION 2023-12

IFRS Sustainability

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ABOUT THE SASB STANDARDS

As of August 2022, the International Sustainability Standards Board (ISSB) of the IFRS Foundation assumed responsibility for the SASB Standards. The ISSB has committed to maintain, enhance and evolve the SASB Standards and encourages preparers and investors to continue to use the SASB Standards.

IFRS S1 *General Requirements for Disclosure of Sustainability-related Financial Information* (IFRS S1) requires entities to refer to and consider the applicability of disclosure topics in the SASB Standards when identifying sustainability-related risks and opportunities that could reasonably be expected to affect an entity's prospects. Similarly, IFRS S1 requires entities to refer to and consider the applicability of metrics in the SASB Standards when determining what information to disclose regarding sustainability-related risks and opportunities.

In June 2023, the ISSB amended climate-related topics and metrics in the SASB Standards to align them with the industry-based guidance accompanying IFRS S2 *Climate-related Disclosures*. In December 2023, the ISSB amended the non-climate-related topics and metrics in connection with the International Applicability of SASB Standards project.

Effective Date

This version 2023-12 of the Standard is effective for all entities for annual periods beginning or after January 1, 2025. Early adoption is permitted for all entities.

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INTRODUCTION

Overview of SASB Standards

The SASB Standards are a set of 77 industry-specific sustainability accounting standards ("SASB Standards" or "Industry Standards"), categorised pursuant to the Sustainable Industry Classification System® (SICS®).

SASB Standards include:

1. **Industry descriptions** – which are intended to help entities identify applicable industry guidance by describing the business models, associated activities and other common features that characterise participation in the industry.

2. **Disclosure topics** – which describe specific sustainability-related risks or opportunities associated with the activities conducted by entities within a particular industry.

3. **Metrics** – which accompany disclosure topics and are designed to, either individually or as part of a set, provide useful information regarding an entity's performance for a specific disclosure topic.

4. **Technical protocols** – which provide guidance on definitions, scope, implementation and presentation of associated metrics.

5. **Activity metrics** – which quantify the scale of specific activities or operations by an entity and are intended for use in conjunction with the metrics referred to in point 3 to normalise data and facilitate comparison.

Entities using the SASB Standards as part of their implementation of ISSB Standards should consider the relevant ISSB application guidance.

For entities using the SASB Standards independently from ISSB Standards, the *SASB Standards Application Guidance* establishes guidance applicable to the use of all Industry Standards and is considered part of the Standards. Unless otherwise specified in the technical protocols contained in the Industry Standards, the guidance in the SASB Standards Application Guidance applies to the definitions, scope, implementation, compilation and presentation of the metrics in the Industry Standards.

Historically, the *SASB Conceptual Framework* set out the basic concepts, principles, definitions and objectives that guided the SASB Standards Board in its approach to setting standards for sustainability accounting.

Use of the Standards

SASB Standards are intended to aid entities in disclosing information about sustainability-related risks and opportunities that could reasonably be expected to affect the entity's cash flows, its access to finance or cost of capital over the short, medium or long term. An entity determines which Industry Standard(s) and which disclosure topics are relevant to its business, and which associated metrics to report. In general, an entity should use the SASB Standard specific to its primary industry as identified in SICS® . However, companies with substantial business in multiple SICS® industries should refer to and consider the applicability of the disclosure topics and associated metrics in additional SASB Standards.

The disclosure topics and associated metrics contained in this Standard have been identified as those that are likely to be useful to investors. However, the responsibility for making materiality judgements and determinations rests with the reporting entity.

Industry Description

The Health Care Delivery industry owns and manages hospitals, clinics and other health care related facilities. Entities provide a range of services, including inpatient and outpatient care, surgery, mental health, rehabilitation and clinical laboratory services. Demand for health care delivery services is driven largely by insurance coverage rates, demographics, illness and injury rates. The industry is characterised by high fixed labour and facilities costs, and an increased regulatory focus on reduced costs of care and improved outcomes. Health care delivery entities also face significant competition for patients and resources from private, non-profit and religious health care systems.

SUSTAINABILITY DISCLOSURE TOPICS & METRICS

Table 1. Sustainability Disclosure Topics & Metrics

TOPIC	METRIC	CATEGORY	UNIT OF MEASURE	CODE
Energy Management	(1) Total energy consumed, (2) percentage grid electricity and (3) percentage renewable	Quantitative	Gigajoules (GJ), Percentage (%)	HC-DY-130a.1
Waste Management	Total amount of medical waste: percentage (a) incinerated, (b) recycled or treated and (c) landfilled	Quantitative	Metric tonnes (t)	HC-DY-150a.1
	Total amount of: (1) hazardous and (2) non-hazardous pharmaceutical waste, percentage (a) incinerated, (b) recycled or treated and (c) landfilled	Quantitative	Metric tonnes (t), Percentage (%)	HC-DY-150a.2
Patient Privacy & Electronic Health Records	Description of policies and practices to secure customers' personal health data records and other personal data	Discussion and Analysis	n/a	HC-DY-230a.2
	(1) Number of data breaches, (2) percentage involving (a) personal data only and (b) personal health data, (3) number of customers affected in each category, (a) personal data only and (b) personal health data [1]	Quantitative	Number, Percentage (%)	HC-DY-230a.3
	Total amount of monetary losses as a result of legal proceedings associated with data security and privacy [2]	Quantitative	Presentation currency	HC-DY-230a.4
Access for Low-Income Patients	Discussion of strategy to manage the mix of patient insurance status	Discussion and Analysis	n/a	HC-DY-240a.1
Quality of Care & Patient Satisfaction	Number of serious reportable events	Quantitative	Number	HC-DY-250a.2
	Hospital-acquired condition rates per hospital	Quantitative	Percentage (%)	HC-DY-250a.3
	Number of (1) unplanned and (2) total readmissions per hospital	Quantitative	Number	HC-DY-250a.6
Management of Controlled Substances	Description of policies and practices to manage the number of prescriptions issued for controlled substances	Discussion and Analysis	n/a	HC-DY-260a.1

continued...

[1] Note to **HC-DY-230a.3** – The disclosure shall include a description of corrective actions implemented in response to data breaches.

[2] Note to **HC-DY-230a.4** – The entity shall briefly describe the nature, context and any corrective actions taken because of monetary losses.

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TOPIC	METRIC	CATEGORY	UNIT OF MEASURE	CODE
Pricing & Billing Transparency	Description of policies or initiatives to ensure that patients are adequately informed about price before undergoing a procedure	Discussion and Analysis	n/a	HC-DY-270a.1
	Discussion of how pricing information for services is made publicly available	Discussion and Analysis	n/a	HC-DY-270a.2
	Number of the entity's 25 most common services for which pricing information is publicly available, percentage of total services performed (by volume) that these represent	Quantitative	Number, Percentage (%)	HC-DY-270a.3
Workforce Health & Safety	Total recordable incident rate (TRIR) for (a) direct employees and (b) contract employees	Quantitative	Rate	HC-DY-320a.1
Employee Recruitment, Development & Retention	(1) Voluntary and (2) involuntary turnover rate for: (a) physicians, (b) non-physician health care practitioners, and (c) all other employees	Quantitative	Percentage (%)	HC-DY-330a.1
	Description of talent recruitment and retention efforts for health care practitioners	Discussion and Analysis	n/a	HC-DY-330a.2
Climate Change Impacts on Human Health & Infrastructure	Description of policies and practices to address: (1) the physical risks because of an increased frequency and intensity of extreme weather events, (2) changes in the morbidity and mortality rates of illnesses and diseases associated with climate change and (3) emergency preparedness and response	Discussion and Analysis	n/a	HC-DY-450a.1
Fraud & Unnecessary Procedures	Total amount of monetary losses as a result of legal proceedings associated with medical fraud [3]	Quantitative	Presentation currency	HC-DY-510a.1

Table 2. Activity Metrics

ACTIVITY METRIC	CATEGORY	UNIT OF MEASURE	CODE
Number of (1) facilities and (2) beds, by type	Quantitative	Number	HC-DY-000.A
Number of (1) inpatient admissions and (2) outpatient visits	Quantitative	Number	HC-DY-000.B

[3] Note to **HC-DY-510a.1** – The entity shall briefly describe the nature, context and any corrective actions taken because of monetary losses.

Energy Management

Topic Summary

Health Care Delivery entities operate energy-intensive facilities and rely on both purchased electricity and fuel. The consumption of both can contribute to environmental impacts, including climate change and pollution. Legislative attempts to limit these impacts and to incentivise energy efficiency and renewable energy may result in price volatility associated with fossil fuels and conventional electricity. Entities that improve energy efficiency may decrease costs and limit exposure to energy price fluctuations.

Metrics

HC-DY-130a.1. (1) Total energy consumed, (2) percentage grid electricity and (3) percentage renewable

1 The entity shall disclose (1) the total amount of energy it consumed as an aggregate figure, in gigajoules (GJ).

1.1 The scope of energy consumption includes energy from all sources, including energy purchased from external sources and energy produced by the entity itself (self-generated). For example, direct fuel usage, purchased electricity, and heating, cooling and steam energy are all included within the scope of energy consumption.

1.2 The scope of energy consumption includes only energy directly consumed by the entity during the reporting period.

1.3 In calculating energy consumption from fuels and biofuels, the entity shall use higher heating values (HHV), also known as gross calorific values (GCV), which are measured directly or taken from the Intergovernmental Panel on Climate Change (IPCC).

2 The entity shall disclose (2) the percentage of energy it consumed that was supplied from grid electricity.

2.1 The percentage shall be calculated as purchased grid electricity consumption divided by total energy consumption.

3 The entity shall disclose (3) the percentage of energy it consumed that was renewable energy.

3.1 Renewable energy is defined as energy from sources that are replenished at a rate greater than or equal to their rate of depletion, such as geothermal, wind, solar, hydro and biomass.

3.2 The percentage shall be calculated as renewable energy consumption divided by total energy consumption.

3.3 The scope of renewable energy includes renewable fuel the entity consumed, renewable energy the entity directly produced and renewable energy the entity purchased, if purchased through a renewable power purchase agreement (PPA) that explicitly includes renewable energy certificates (RECs) or Guarantees of Origin (GOs), a Green-e Energy Certified utility or supplier programme, or other green power products that explicitly include RECs or GOs, or for which Green-e Energy Certified RECs are paired with grid electricity.

3.3.1 For any renewable electricity generated on-site, any RECs and GOs shall be retained (not sold) and retired or cancelled on behalf of the entity for the entity to claim them as renewable energy.

3.3.2 For renewable PPAs and green power products, the agreement shall explicitly include and convey that RECs and GOs be retained or replaced and retired or cancelled on behalf of the entity for the entity to claim them as renewable energy.

3.3.3 The renewable portion of the electricity grid mix that is outside of the control or influence of the entity is excluded from the scope of renewable energy.

3.4 For the purposes of this disclosure, the scope of renewable energy from biomass sources is limited to materials certified to a third-party standard (for example, Forest Stewardship Council, Sustainable Forest Initiative, Programme for the Endorsement of Forest Certification, or American Tree Farm System), materials considered eligible sources of supply according to the *Green-e Framework for Renewable Energy Certification, Version 1.0* (2017) or Green-e regional standards, and/or materials that are eligible for an applicable state renewable portfolio standard.

4 The entity shall apply conversion factors consistently for all data reported under this disclosure, such as the use of HHVs for fuel usage (including biofuels) and conversion of kilowatt hours (kWh) to GJ (for energy data including electricity from solar or wind energy).

Waste Management

Topic Summary

Health Care Delivery entities generate a significant amount of regulated medical and pharmaceutical waste. Disposal fees for these types of waste are typically higher than that of conventional waste and may present a significant cost for the industry. Entities that reduce the amount of waste generated by enhanced waste segregation strategies, recycling and reuse may limit their exposure to these costs.

Metrics

HC-DY-150a.1. Total amount of medical waste: percentage (a) incinerated, (b) recycled or treated and (c) landfilled

1 The entity shall disclose the total amount of medical waste generated, in metric tonnes, aggregated for all facilities it owns and operates, and the percentage (a) incinerated, (b) recycled or treated and (c) landfilled.

2 Medical waste (also known as regulated medical waste, infectious waste, biomedical waste or biohazardous waste) that may be subject to applicable jurisdictional laws or regulations includes:

2.1 Cultures and stocks—cultures and stocks of infection agents and associated biological cultures, including cultures from medical and pathological laboratories, and stocks of infectious agents from research and industrial laboratories, waste from the production of biological, discarded, live and attenuated vaccines, and culture dishes and devices used to transfer, inoculate and mix cultures.

2.2 Pathological wastes—human pathological wastes, including tissues, organs, body parts and body fluids removed during surgery and autopsy, or other medical procedures, and specimens of body fluids and their containers.

2.3 Human blood and blood products—(1) liquid waste human blood; (2) blood products; (3) items saturated or dripping with human blood; or (4) items saturated or dripping with human blood now caked with dried human blood, including serum, plasma and other blood components, and their containers used or intended for use in patient care, testing and laboratory analysis, or the development of pharmaceuticals. Intravenous bags also are included in this category.

2.4 Sharps—sharps used in animal or human patient care or treatment, or in medical research or industrial laboratories, including hypodermic needles, syringes (with or without the attached needle), Pasteur pipettes, scalpel blades, blood vials, needles with attached tubing and culture dishes (regardless of presence of infectious agents). Also included are other types of broken or unbroken glassware that were in contact with infectious agents, such as used slide and cover slips.

2.5 Animal waste—contaminated animal carcasses, body parts and bedding of animals known to have been exposed to infectious agents during research (including research in veterinary hospitals), production of biologicals or testing of pharmaceuticals.

2.6 Isolation wastes—biological waste and discarded materials contaminated with blood, excretion, exudates or secretions from humans who are isolated to protect others from specific highly communicable diseases, or isolated animals known to be infected with highly communicable diseases.

2.7 Unused sharps—unused, discarded sharps including hypodermic needles, suture needles, syringes and scalpel blades.

3 The entity shall calculate the percentages of medical waste by their final disposition method as the total weight of medical waste generated that was (a) incinerated, (b) recycled or treated and (c) landfilled, divided by the total weight of medical waste generated.

3.1 Recycling or treatment shall include disposal via recycling facility, treatment facility or other (for example, return to a supplier or commercial composting).

4 If the entity uses a waste transport service, broker or intermediary to handle its medical waste, the entity shall make a good faith effort to determine the final disposition method.

HC-DY-150a.2. Total amount of: (1) hazardous and (2) non-hazardous pharmaceutical waste, percentage (a) incinerated, (b) recycled or treated and (c) landfilled

1 The entity shall disclose (1) the total amount of hazardous pharmaceutical waste generated, in metric tonnes, aggregated for all facilities it owns and operates, and the percentage (a) incinerated, (b) recycled or treated and (c) landfilled.

1.1 Hazardous pharmaceutical waste is defined in accordance with applicable jurisdictional legal or regulatory framework(s) where the waste was generated.

1.2 Hazardous pharmaceutical waste generally displays these characteristics: ignitibility, corrosivity, reactivity or toxicity.

1.3 The entity shall calculate the percentage of hazardous pharmaceutical waste by the final disposition method as the total weight of hazardous pharmaceutical waste generated that was (a) incinerated, (b) recycled or treated and (c) landfilled, divided by the total weight of hazardous pharmaceutical waste generated.

1.3.1 Recycling or treatment shall include disposal via recycling facility, treatment facility or other (for example, return to a supplier or commercial composting).

1.4 The entity may use the United Nations Environmental Programme (UNEP) Basel Convention on the Control of Transboundary Movements of Hazardous Wastes and Their Disposal for the purposes of defining hazardous pharmaceutical waste for operations located in jurisdictions that lack applicable legal or regulatory definitions.

1.5 The entity shall disclose the applicable jurisdictional standard or regulation used to define hazardous pharmaceutical waste.

2 The entity shall disclose (2) the total amount of non-hazardous pharmaceutical waste generated, in metric tonnes, aggregated for all facilities it owns and operates, and the percentage (a) incinerated, (b) recycled or treated and (c) landfilled..

2.1 Non-hazardous (solid) waste is defined as any garbage or refuse, sludge from a wastewater treatment plant, water supply treatment plant, or air pollution control facility and other discarded material, including solid, liquid, semi-solid, or contained gaseous material resulting from industrial, commercial, mining and agricultural operations, and from community activities. It may require special handling because it is a controlled substance or poses an environmental or human health threat.

2.2 The entity shall calculate the percentages of non-hazardous pharmaceutical waste by their final disposition method as the total weight of non-hazardous pharmaceutical waste generated that was (a) incinerated, (b) recycled or treated and (c) landfilled, divided by the total weight of non-hazardous pharmaceutical waste generated.

2.2.1 Recycling or treatment shall include disposal via recycling facility, treatment facility or other (for example, return to a supplier or commercial composting).

3 If other disposition methods for hazardous or non-hazardous pharmaceutical waste exist (for example, composting or permanent long-term storage), then the entity should disclose these.

4 If the entity uses a waste transport service, broker or intermediary to handle its pharmaceutical waste, the entity shall make a good faith effort to determine the final disposition method.

Patient Privacy & Electronic Health Records

Topic Summary

Many jurisdictions require health care providers to establish administrative, physical and technical safeguards to protect the integrity, confidentiality, interoperability and availability of patient health information. Failure to comply with such regulations may result in civil and criminal penalties.

Metrics

HC-DY-230a.2. Description of policies and practices to secure customers' personal health data records and other personal data

1 The entity shall describe the nature, scope and implementation of its policies and practices related to securing customer personal health data records and other personal data, with a specific focus on how it manages the collection, use and retention of customers' information.

1.1 Personal data is defined as any information that relates to an identified or identifiable living individual. Various pieces of information, which collected together can lead to the identification of a particular person, also constitute personal data.

1.1.1 The entity may define personal data based on an applicable jurisdictional definition. In such cases, the entity shall disclose the applicable jurisdictional standard or definition used.

1.2 Personal health data is defined as personal data related to the physical or mental health of an individual, including the provision of health care services, which reveals information about the individual's health status.

1.2.1 The entity may define personal health data based on an applicable jurisdictional definition. In such cases, the entity shall disclose the applicable jurisdictional standard or definition used.

2 The entity shall describe the information 'lifecycle' (collection, use, retention, processing, disclosure and destruction) and how information-handling practices at each stage may affect individuals' privacy.

2.1 With respect to data collection, the entity may discuss the data or types of data it collects without consent of an individual, data that requires opt-in consent, and data that requires an opt-out action from the individual.

2.2 With respect to data usage, the entity may discuss the data or types of data it uses internally and under what circumstance the entity shares, sells, rents or otherwise distributes data or information to third parties.

2.3 With respect to data retention, the entity may discuss the data or types of data it retains, duration of retention, and practices used to ensure that data is stored securely.

3 The entity shall discuss the systems used to ensure compliance with applicable jurisdictional laws or regulations related to the collection, usage, storage and disposal of personal health data and personal data.

4 The entity shall discuss its efforts to ensure compliance in the context of how it implements these three categories of system security:

4.1 administrative safeguards, which are defined as documented, formal policies and procedures to manage the selection and execution of security measures to protect data and manage the conduct of staff in relation to the protection of data;

4.2 physical safeguards, which are defined as the protection of physical computer systems and the buildings holding such systems from natural and environmental hazards and inappropriate intrusion or removal; and

4.3 technical safeguards, which are defined as processes to protect information, authenticate users and control individual access to information.

5 Relevant practices to discuss include internal monitoring practices, technology and security programmes to prevent data breaches, training programmes and protocols for employees who handle personal health data or personal data, and disposal methods for paper and electronic personal health data records.

6 The entity shall disclose if it employs increased security measures to ensure the security of personal health data, including a discussion of those additional measures.

7 The entity should exclude any information that compromises the security of its systems or its customers' personal health data or personal data.

HC-DY-230a.3. (1) Number of data breaches, (2) percentage involving (a) personal data only and (b) personal health data, (3) number of customers affected in each category, (a) personal data only and (b) personal health data

1 The entity shall disclose (1) the total number of data breaches identified during the reporting period.

1.1 A data breach is defined as an unauthorised occurrence on, or conducted through, an entity's information systems that jeopardises the confidentiality, integrity or availability of an entity's information systems or any information contained therein.

1.1.1 Information systems are defined as information resources, owned or used by the entity, including physical or virtual infrastructure controlled by such information resources, or components thereof, organised for the collection, processing, maintenance, use, sharing, dissemination or disposition of an entity's information to maintain or support operations.

1.2 The scope of the disclosure excludes occurrences in which an entity has reasonable and supportable belief that the occurrence (i) does not pose a risk of damage to the entity's business performance or prospects and (ii) does not pose a risk of economic or social disadvantage to individuals.

2 The entity shall disclose (2) the percentage of data breaches in which customers' (a) personal data, but not personal health data, was subject to the data breach.

2.1 Personal data is defined as any information that relates to an identified or identifiable living individual. Various pieces of information, which collectively can lead to the identification of a particular person, also constitute personal data.

2.1.1 The entity may define personal data based on an applicable jurisdictional definition. In such cases, the entity shall disclose the applicable jurisdictional standard or definition used.

2.2 Personal health data is defined as personal data related to the physical or mental health of an individual, including the provision of health care services, which reveals information about the individual's health status.

2.2.1 Personal health data is a subset of personal data.

2.2.2 The entity may define personal health data based on an applicable jurisdictional legal or regulatory definition. In such cases, the entity shall disclose the applicable jurisdictional standard or definition used.

2.3 The scope of the disclosure shall include incidents during which encrypted data was acquired with an encryption key that also was acquired, as well as whether a reasonable belief exists that encrypted data could be converted readily to plaintext.

2.3.1 Encryption is defined as the process of transforming plaintext into ciphertext.

3 The entity shall disclose (2) the percentage of data breaches in which customers' (b) personal health data was subject to the data breach.

4 The entity shall disclose (3) the total number of unique customers affected by data breaches in which the customers' (a) personal data, but not personal health data, was subject to the data breach.

5 The entity shall disclose (3) the total number of unique customers affected by data breaches in which the customers' (b) personal health data was subject to the data breach.

6 Accounts that the entity cannot verify as belonging to the same customer shall be disclosed separately.

7 The entity may delay disclosure if a law enforcement agency has determined that notification impedes a criminal investigation and may be delayed until the law enforcement agency determines that such notification does not compromise the investigation.

Note to **HC-DY-230a.3**

1 The entity shall describe any corrective actions taken in response to data breaches, such as changes in operations, management, processes, products, business partners, training or technology.

2 All disclosure shall be sufficient such that it is specific to the risks the entity faces, but disclosure itself would not compromise the entity's ability to maintain data privacy and security.

3 The entity may disclose its policy for disclosing data breaches to affected customers in a timely manner.

HC-DY-230a.4. Total amount of monetary losses as a result of legal proceedings associated with data security and privacy

1 The entity shall disclose the total amount of monetary losses incurred during the reporting period resulting from legal proceedings associated with data security and privacy.

2 The legal proceedings shall include any adjudicative proceeding involving the entity, whether before a court, a regulator, an arbitrator or otherwise.

3 The losses shall include all monetary liabilities to the opposing party or to others (whether as the result of settlement, verdict after trial or otherwise), including fines and other monetary liabilities incurred during the reporting period as a result of civil actions (for example, civil judgements or settlements), regulatory proceedings (for example, penalties, disgorgement or restitution) and criminal actions (for example, criminal judgements, penalties or restitution) brought by any entity (for example, governmental, business or individual).

4 The scope of monetary losses shall exclude legal and other fees and expenses incurred by the entity in its defence.

5 The scope of the disclosure shall include legal proceedings associated with the enforcement of applicable jurisdictional laws or regulations.

Note to **HC-DY-230a.4**

1 The entity shall briefly describe the nature (for example, judgement or order issued after trial, settlement, guilty plea, deferred prosecution agreement or non-prosecution agreement) and context (for example, cyberattack or employee error) of all monetary losses resulting from legal proceedings.

2 The entity shall describe any corrective actions implemented in response to the legal proceedings. This may include specific changes in operations, management, processes, products, business partners, training or technology.

Access for Low-Income Patients

Topic Summary

Some care delivery entities will continue to face challenges associated with serving uninsured and low-income patients. Health care delivery entities that develop innovative pricing structures that allow them to profit from increased private insurance enrolment and to expand their patient base may create a positive effect on revenue. Disclosure on how entities manage the provision of care to uninsured populations may allow users to understand the associated risks and opportunities.

Metrics

HC-DY-240a.1. Discussion of strategy to manage the mix of patient insurance status

1 The entity shall discuss its strategy to manage the effects of having patients with a mix of insurance statuses at its facilities.

2 If relevant, the entity should discuss how it manages risks and opportunities associated with patients within these categories:

2.1 those with private insurance;

2.2 those with government sponsored insurance; and

2.3 those who are uninsured.

3 Alternative pricing mechanisms may include discounted or sliding fee schedules, care given for charity (as a write-off), or discounts for prompt payment for uninsured customers.

4 The entity shall discuss programmes it implements for uninsured individuals, which may include financial assistance programmes and participation in indigent care programmes.

4.1 Financial assistance programmes are defined as those typically administered by hospitals that provide no-cost or discounted cost care for patients who demonstrate an inability to pay for health care services.

4.2 Indigent care programmes are defined as those typically administered by jurisdictions that provide financial discounts for patients who demonstrate an inability to pay for health care services.

Quality of Care & Patient Satisfaction

Topic Summary

Quality care delivery and patient satisfaction are essential value drivers for health care delivery entities. The link between quality of care performance and value creation may be strengthened by effective management focus on improving health care quality measures. In addition, entities may improve health care outcomes and preserve brand value by developing programmes to reduce excessive patient readmission rates and hospital-acquired conditions.

Metrics

HC-DY-250a.2. Number of serious reportable events

1 The entity shall disclose the aggregate number of serious reportable events that occurred during the reporting period at the health care facilities it operates.

1.1 Serious reportable events are defined as serious, largely preventable, and of concern to both the public and health care providers and are required to be reported to applicable jurisdictional legal or regulatory authorities.

1.2 Serious reportable events may include:

1.2.1 surgical or invasive procedure events involving the wrong site, patient or procedure, unintended foreign object retention, or intraoperative or immediate post-operative death;

1.2.2 product or device events involving patient death or serious injury from drug, device or biological contamination; device use, misuse or malfunction; or intravascular air embolism in a health care setting;

1.2.3 patient protection failure events involving discharge or release of patients with impaired faculties without an authorised person, patient elopement or disappearance, or patient suicide or attempted suicide in a health care setting;

1.2.4 care management events involving: patient or neonatal death or serious injury from medication error, unsafe blood products administration, low-risk pregnancy labour or delivery in a health care setting; accidents (for example, falls); irretrievable loss of an irreplaceable biological specimen, or failure to follow-up or communicate laboratory, pathology or radiology test results; serious pressure ulcers acquired after admission to a health care setting; or artificial insemination with the wrong donor sperm or egg;

1.2.5 environmental events involving patient or staff death or serious injury from electric shocks, burns or physical restraints or bedrails in a health care setting; or events involving oxygen or other gas designated systems containing no gas, the wrong gas or contaminated toxic gas;

1.2.6 radiologic events involving the patient or staff death or serious injury from the introduction of a metallic object into the magnetic resonance imaging (MRI) area; and

1.2.7 potentially criminal events involving patient or staff death or serious injury from physical assault in a health care setting; patient or resident abduction; care ordered or provided by someone impersonating a licensed health care provider; or sexual abuse or assault of a patient in a health care setting.

2 Where necessary to provide an accurate representation, the entity should disclose serious reportable event figures for individual facilities (for example, if a small subset of healthcare facilities constitutes a disproportionate number of the serious reportable events).

3 The entity shall disclose serious reportable events occurring in any health care setting under its operation, including:

3.1 hospitals;

3.2 outpatient or office-based surgery centres;

3.3 ambulatory practice settings or office-based practices; and

3.4 long-term care or skilled nursing facilities.

HC-DY-250a.3. Hospital-acquired condition rates per hospital

1 The entity shall disclose the percentage incidence rates for each hospital-acquired condition reported to applicable jurisdictional legal or regulatory authorities for each of the hospitals it operates.

1.1 Hospital-acquired conditions may include:

1.1.1 healthcare-associated infections;

1.1.2 pressure ulcer;

1.1.3 Iatrogenic pneumothorax;

1.1.4 in-hospital fall with hip fracture;

1.1.5 perioperative haemorrhage or haematoma;

1.1.6 post-operative acute kidney injury requiring dialysis;

1.1.7 post-operative respiratory failure;

1.1.8 perioperative pulmonary embolism or deep vein thrombosis;

1.1.9 post-operative sepsis;

1.1.10 post-operative wound dehiscence; and

1.1.11 unrecognised abdominopelvic accidental puncture/laceration.

1.2 Health care-associated infections include central line associated bloodstream infections, catheter-associated urinary tract infections, surgical site infections, methicillin-resistant staphylococcus aureus (MRSA) bacteraemia, and clostridium difficile infections.

1.3 The entity shall calculate each incidence rate as the number of patients diagnosed with each condition in a hospital divided by the total number of patients admitted to that hospital, multiplied by 100 to generate a percentage.

2 Entities shall disclose the applicable jurisdictional legal or regulatory authorities under which each hospital operates.

3 The entity shall disclose the total number of inpatient admissions per hospital for comparative reference.

4 The entity may summarise its findings in a table, such as:

Table 3. Sample Hospital-acquired Condition Incidence Rate Reporting Template

HOSPITAL-ACQUIRED CONDITION	INCIDENCE RATE FACILITY A	INCIDENCE RATE FACILITY B	INCIDENCE RATE FACILITY C	INCIDENCE RATE FACILITY D
a) Health care-associated infections				
b) Pressure ulcer				
c) Iatrogenic pneumothorax				
d) In-hospital fall with hip fracture				
e) Perioperative haemorrhage or hematoma				
f) Post-operative acute kidney injury requiring dialysis				
g) Post-operative respiratory failure				
h) Perioperative pulmonary embolism or DVT				
i) Post-operative sepsis				
j) Post-operative wound dehiscence				
k) Unrecognised abdominopelvic accidental puncture/ laceration				

HC-DY-250a.6. Number of (1) unplanned and (2) total readmissions per hospital

1 The entity shall disclose (1) the number of unplanned readmissions for each hospital it operates.

1.1 Readmission is defined as a patient admission to a hospital within 30 days of the patient's discharge from the same or another hospital.

1.2 Unplanned readmission is defined as a readmission previously unscheduled or unanticipated by the relevant health care providers in the normal course of treatment.

2 The entity shall disclose (2) the total number of patient readmissions per hospital for comparative reference.

3 Reasons for unplanned readmissions may include unresolved acute illness, chronic illness, the development of new medical complications, or from gaps in outpatient care.

Management of Controlled Substances

Topic Summary

The Health Care Delivery industry is in a unique position with respect to the evolving use of controlled substances and managing the risk of addiction. As the provider of care, the industry also treats individuals suffering from addiction and related health concerns. Health Care Delivery entities face significant costs in addressing the health care needs of those suffering from addiction and related illnesses. Industry-wide efforts to re-evaluate controlled substance management strategies through the development of new policies, training and oversight may have positive financial effects.

Metrics

HC-DY-260a.1. Description of policies and practices to manage the number of prescriptions issued for controlled substances

1 The entity shall describe its policies and practices related to the prescription of controlled substances, including the activities required to implement them, as well as the positions affected by such policies and practices, which may include:

1.1 registration and use of jurisdictional prescription drug monitoring programmes;

1.2 the scope, positions affected and percentage of the workforce covered by training programmes related to controlled substances, including the evidence-based treatment of pain;

1.3 programmes implemented by the entity to identify and provide care for patients with substance abuse disorders;

1.4 policies and procedures to ensure the safe storage and disposal of controlled substances; and

1.5 policies and programmes related to the prescription of opioid antagonists (naloxone, naltrexone and others) or other drugs that counter the effects of controlled substances.

2 The entity may discuss factors that limit its ability to manage the number of prescriptions issued for controlled substances.

Pricing & Billing Transparency

Topic Summary

Concern regarding pricing and billing transparency in the Health Care Delivery industry has resulted in increased legal and regulatory scrutiny in some jurisdictions. Coupled with increased attention to health care cost containment, this scrutiny may increase regulatory oversight of pricing and billing practices in this industry. Entities that achieve compliance and institute transparent pricing structures may better protect shareholder value.

Metrics

HC-DY-270a.1. Description of policies or initiatives to ensure that patients are adequately informed about price before undergoing a procedure

1 The entity shall describe the nature, scope and implementation of policies and initiatives regarding transparency and clear communication of procedure pricing or treatment alternatives with respect to the price of a procedure.

2 The scope of initiatives disclosed may include:

2.1 providing price information to patients through written communication;

2.2 posting information to a public website; and

2.3 providing in-person consultation to patients prior to services.

3 The entity shall describe how information is provided to patients paying out-of-pocket versus those with insurance coverage. For those with insurance coverage, this may include coordinating with the patient's insurer to determine the amount paid out-of-pocket and the amount paid by the insurer.

4 The entity shall describe if a precise total price, a range of prices, an estimate of price or some other pricing information is provided to patients, such as the percentage (or amount) of the price for which the patient may be responsible.

HC-DY-270a.2. Discussion of how pricing information for services is made publicly available

1 The entity shall describe the scope, format and mechanism for making pricing information publicly available (for example, via a public website or in cooperation with government initiatives to consolidate pricing data).

2 The entity shall discuss if such information is made available for inpatient services and outpatient services (occurring in any ambulatory setting such as a hospital, clinic or physician's office).

3 The entity shall disclose if the scope of information made available includes a precise total price, a range of prices, an estimate of price or some other pricing information.

HC-DY-270a.3. Number of the entity's 25 most common services for which pricing information is publicly available, percentage of total services performed (by volume) that these represent

1 The entity shall disclose the number of its 25 most common inpatient and outpatient services for which it provides public pricing information.

1.1 The entity's most common services are defined as the most frequently billed services by count of procedures over the past three years, including the current reporting period.

2 The entity shall calculate the percentage of total services performed (by volume) that these represent.

2.1 The percentage shall be calculated as the number of the entity's 25 most common inpatient and outpatient services for which it provides public pricing information divided by its total number of procedures.

3 If the entity provides public pricing for more than 25 of its inpatient and outpatient services, the entity may disclose the number of services for which it provides public pricing.

Workforce Health & Safety

Topic Summary

The Health Care Delivery industry is heavily dependent on a skilled workforce, and employees routinely are exposed to injury, illness and infection during regular duties. Relative to other industries, Health Care Delivery has one of the highest rates of injury and illness. Entities that manage this issue more effectively may reduce costs associated with workers' compensation, productivity, morale and employee retention. Entities often mitigate risks by implementing proactive health and safety management protocols, developing employee training requirements, and conducting regular audits of their own safety practices.

Metrics

HC-DY-320a.1. Total recordable incident rate (TRIR) for (a) direct employees and (b) contract employees

1 The entity shall disclose its total recordable incident rate (TRIR) for work-related injuries and illnesses.

1.1 An injury or illness is considered a recordable incident if it results in death, days away from work, restricted work or transfer to another job, medical treatment beyond first aid, or loss of consciousness. Additionally, a significant injury or illness diagnosed by a physician or other licensed health care professional is considered a recordable incident, even if it does not result in death, days away from work, restricted work or job transfer, medical treatment beyond first aid, or loss of consciousness.

1.1.1 First aid is defined as emergency care or treatment for an ill or injured person before regular medical aid can be provided.

1.1.2 The entity may use applicable jurisdictional criteria for definitions of a recordable incident and a non-recordable incident such as first aid. The entity shall disclose the legal, regulatory or industry framework used as the source for these criteria and definitions.

2 All disclosed rates shall be calculated as: (statistic count × 200,000) / total number of hours worked by all employees in the year reported.

2.1 The 200,000 in the rate calculation represents the total number of hours 100 full-time workers working 40 hours per week for 50 weeks per year can provide annually.

3 The scope of the disclosure includes work-related incidents only.

3.1 Work-related incidents are injuries and illnesses resulting from events or exposures in the work environment.

3.2 The work environment is the establishment and other locations where one or more employees are working or are present as a condition of their employment.

3.3 The work environment includes not only physical locations, but also the equipment or materials used by the employee during the course of work.

3.4 Incidents that occur while an employee is travelling are work-related if, at the time of the injury or illness, the employee was engaged in work activities in the interest of the employer.

3.5 A work-related incident must be a new case, not a previously recorded injury or illness being updated.

4 The entity shall disclose the rates for each of these employee categories:

4.1 direct employees, defined as individuals on the entity's payroll, whether they are full-time, short service, part-time, executive, labour, salary, seasonal, migrant or hourly employees; and

4.2 contract employees, defined as individuals who are not on the entity's payroll, but whom the entity supervises or manages, including independent contractors and those employed by third parties (for example, temp agencies and labour brokers).

5 The scope of the disclosure includes all employees regardless of employee location or type of employment.

Employee Recruitment, Development & Retention

Topic Summary

Health care delivery entities will continue to face increased competition for physicians because of increased demand, which is intensified by current and future shortages. The ability to recruit, develop and retain health care practitioners is critical to success in this industry, and disclosure on related performance indicators allows users to understand how entities are managing this important human capital issue.

Metrics

HC-DY-330a.1. (1) Voluntary and (2) involuntary turnover rate for: (a) physicians, (b) non-physician health care practitioners, and (c) all other employees

1 The entity shall disclose separately the (1) voluntary and (2) involuntary employee turnover rate during the reporting period as a percentage for (a) physicians, (b) for non-physician health care practitioners and (c) for all other employees.

1.1 Physicians include specialists and primary care physicians in the Minor Group 221 Medical Doctor within Sub-major Group 22 Health Professionals from the International Labour Organization's (ILO) International Standard Classification of Occupations 08 (ISCO-08).

1.2 Non-physician health care practitioners include physician's assistants and nurse practitioners within Sub-major Group 22 Health Professionals from the ILO's ISCO-08:

1.2.1 222 Nursing and Midwifery Professionals; and

1.2.2 226 Other Health Professionals.

1.3 All other employees includes employees not classified as physicians or non-physician health care practitioners.

2 For each category of employees, the entity shall calculate (1) the voluntary turnover rate as the number of employee-initiated separations (for example, resignation or retirement) during the reporting period, divided by the average number of workers employed during the reporting period.

3 For each category of employees, the entity shall calculate (2) the involuntary turnover rate as the number of entity-initiated separations (for example, dismissal, downsizing, redundancy or non-renewal of contract) during the reporting period, divided by the average number of workers employed during the reporting period.

HC-DY-330a.2. Description of talent recruitment and retention efforts for health care practitioners

1 The entity shall describe how it attracts and retains health care practitioners.

1.1 Health care practitioners include specialists, primary care physicians, physician's assistants and nurse practitioners within the Sub-major Group 22 Health Professionals from the International Labour Organization's (ILO)'s International Standard Classification of Occupations 08 (ISCO-08):

1.1.1 221 Medical Doctors;

1.1.2 222 Nursing and Midwifery Professionals; and

1.1.3 226 Other Health Professionals.

2 The scope of the disclosure shall include:

2.1 flexible scheduling;

2.2 leadership development initiatives;

2.3 loan repayment programmes;

2.4 mental and physical health support;

2.5 mentorship programmes;

2.6 'no call' positions; and

2.7 part-time employment.

3 The entity may describe these elements of its programmes, including disclosure of any quantitative metrics:

3.1 overview;

3.2 implementation;

3.3 participation; and

3.4 effectiveness.

Climate Change Impacts on Human Health & Infrastructure

Topic Summary

An increase in extreme weather events associated with climate change may present physical threats to health care delivery facilities and create challenges in serving affected populations. Coupled with the potential spread of infectious diseases and food and water scarcity, these events may present material implications for the Health Care Delivery industry.

Metrics

HC-DY-450a.1. Description of policies and practices to address: (1) the physical risks because of an increased frequency and intensity of extreme weather events, (2) changes in the morbidity and mortality rates of illnesses and diseases associated with climate change and (3) emergency preparedness and response

1 The entity shall describe the nature, scope and implementation of its policies and practices related to addressing the risks to physical infrastructure and assets presented by changes in the frequency, severity, type and geographical location of extreme weather events such as:

1.1 Risks to physical infrastructure located in flood prone low-lying or hurricane-prone areas

1.2 Risks to physical infrastructure based on facility design, such as having important medical equipment in basements or the availability of backup power

2 The entity shall describe the nature, scope and implementation of its policies and practices related to addressing the risks presented by the changes in prevalence, geography and severity of some diseases likely to be impacted by climate change, such as:

2.1 The need for added or flexible capacity because of an influx of patients suffering from heat-related illness

2.2 Obtaining the necessary facilities and expertise to identify and treat changing disease profiles in patients, including:

2.2.1 Malaria, dengue fever and other vector borne diseases that affect tropical populations, but, because of climate change, may target non-tropical regions in the future

2.2.2 Heat-related diseases (for example, lung diseases such as asthma caused by increases in ground level ozone)

2.2.3 Waterborne diseases (for example, cholera because of increased flooding incidence)

2.2.4 Human developmental disorders (for example, malnutrition because of decreased food availability)

3 The entity shall describe the nature, scope and implementation of its policies and practices related to emergency preparedness and response.

3.1 The discussion shall include the regulatory environment in which the entity operates and whether it requires specific emergency preparedness and response plans.

3.2 The entity may disclose whether it has implemented external policies or best practices voluntarily, such as those outlined in the World Health Organization's Hospital Emergency Response Checklist.

Fraud & Unnecessary Procedures

Topic Summary

Health care delivery entities may be subject to significant fines and penalties if their staff are found to be engaged in medical fraud. Many entities must have written policies for all employees and contractors regarding false claims, false statements and whistle-blower protections. The ability to ensure compliance in this area may have implications for health care delivery entities, including one-time charges and reputational damage.

Metrics

HC-DY-510a.1. Total amount of monetary losses as a result of legal proceedings associated with medical fraud

1 The entity shall disclose the total amount of monetary losses incurred during the reporting period resulting from legal proceedings associated with medical fraud.

1.1 The scope of the disclosure includes legal proceedings related to upcoding, charges for treatment not given, performing medically unnecessary services solely to generate revenue, misrepresenting non-covered treatments as medically necessary covered treatments to obtain revenue, falsifying diagnoses to justify procedures that are medically unnecessary, unbundling, accepting kickbacks for patient referrals, failing to provide necessary services prepaid under a health plan, double charging, and misrepresenting the type of treatment.

2 The legal proceedings shall include any adjudicative proceeding involving the entity, whether before a court, a regulator, an arbitrator or otherwise.

3 The losses shall include all monetary liabilities to the opposing party or to others (whether as the result of settlement, verdict after trial or otherwise), including fines and other monetary liabilities incurred during the reporting period as a result of civil actions (for example, civil judgements or settlements), regulatory proceedings (for example, penalties, disgorgement or restitution) and criminal actions (for example, criminal judgements, penalties or restitution) brought by any entity (for example, governmental, business or individual).

4 The scope of monetary losses shall exclude legal and other fees and expenses incurred by the entity in its defence.

5 The scope of the disclosure shall include legal proceedings associated with the enforcement of applicable jurisdictional laws or regulations.

Note to **HC-DY-510a.1**

1 The entity shall briefly describe the nature (for example, judgement or order issued after trial, settlement, guilty plea, deferred prosecution agreement or non-prosecution agreement) and context of all monetary losses resulting from legal proceedings.

2 The entity shall describe any corrective actions it has implemented in response to the legal proceedings. This may include specific changes in operations, management, processes, products, business partners, training or technology.

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