CHILDREN'S HOSPITALS GRADUATE MEDICAL EDUCATION PAYMENT PROGRAM

ANNUAL REPORT FORM HRSA 100-2

Children's Hospitals Graduate Medical Education Payment P

HRSA 100-2-A: Discharge Data by Payor and Zip Code

Hospital Name:	
Medicare Provider Number:	
Date of Report:	12/31/12

1. DISCHARGES BY PAYOR

Provide the number of discharges for the academic year most recently completed (July 1, 2011 - June 30, 2012) for each of the following payment groups. Include all Medicaid payments including Medicaid managed care and any other Medicaid payments under the Medicaid and/or CHIP category. Self-pay refers to patients who have made out-of-pocket payments for services. Uncompensated care means care for which the hospital receives no payment. Do *not* include lab services under Outpatient Visits. **See detailed guidance for complete instructions.**

Payor	Inpatient Discharges	Outpatient Visits	Emergency Department Visits
Private Insurance			
Medicaid and/or CHIP			
Medicare			
Other Public (TRICARE, Indian Health Service)			
Self-pay			
Uncompensated Care			
Total			

2. DISCHARGES BY ZIP CODE

Please enter the number of discharges for the academic year most recently completed (July 1, 2011 - June 30, 2012) by zip code in the highlighted cell of the mock table provided as an example below. Also, include a **separate CD** that provides the number of inpatient discharges for the most recent academic year (July 1, 2011 - June 30, 2012) by city, state and zip code. The total number of inpatient discharges must equal total number of inpatient discharges documented in section one above. Please include the name and Medicare Provider Number of your hospital at the top of the listing and on the outside of the CD.

Zip Code (up to 9 digits, if possible)	City	State	No. of Inpatient Discharges
Zip Code 1	Roanoke	VA	12
Zip Code 2	Las Vegas	NV	40
Zip Code 3	Springfield	IL	32
Total			

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HRSA 100-2-B: Discharge Data Aggregated by Selected Chronic Diseases

Hospital Name:	0
Medicare Provider Number:	00-0000
Date of Report:	12/31/12

Please list the number of unique inpatient discharges, outpatient visits, and ER visits, by the ICD-9 codes provided in the table below. Primary and all secondary diagnoses should be included when preparing the table. Please note that at-risk neonates are identified using V codes for low birth weight. Do not include lab services under Outpatient Visits. **See detailed guidance for complete instructions.**

Chronic Disease	ICD-9 Codes	Inpatient Discharges	Outpatient Visits	Emergency Department Visits
AIDS (incl HIV positive)	042, V08, 0795			
Arthropathies (excl infectious, joint pain)	710, 712-718, 720-723, 725-729, 731-39, V49			
Asthma	493			
Cardiac disease	392-454, 456-458			
Cerebral palsy and other paralyses	342-344			
CNS disorders (excl epilepsy, paralyses)	324-341, 347-349, V48			
Congenital anomalies (excl spina bifida)	740, 742-59, 771			
Cystic fibrosis and other	277			
Diabetes Mellitus	250			
Endocrine, other than diabetes	252-259			
Epilepsy	345; 780.39			

Chronic Disease	ICD-9 Codes	Inpatient Discharges	Outpatient Visits	Emergency Department Visits
Gastroenteritis, colitis & malabsorption	555-7, 579,V44			
Hematologic (sickle cell, excl, anemia)	281-289; excluding 285.9			
Mental Retardation	317-319			
Metabolic/immune disorders	270-275, 279			
Neoplasms	140-215, 217-239, V10			
Neuromuscular disorders (incl polio)	350-359, 045-049,138			
Dental diseases	520-522, 524-526			
Renal failure	582-589			
Spina bifida	741			
Thyroid disease	240-246			
Neonatal	V21.30-V21.35			
Psychiatric/mental health	295-316			

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HRSA 100-2-C: Patient Safety Initiatives

Hospital Name:	0
Medicare provider number:	00-0000
Date of report:	12/31/12

For each of the following patient safety initiatives, indicate whether your children's hospital had any of the listed initiatives in place in the most recently completed academic year (2011-2012) and if any changes in the initiatives have occurred since the previous academic year (2010-2011).

Please indicate the rationale for any changes in the initiative (i.e., newly introduced, eliminated, enhanced) and list the benefits of the changes, including, for example, but not limited to, increases in medical knowledge; improvements in clinical competence; increased awareness of psychosocial and behavioral aspects of health and illness; increased awareness of the availability of community resources. **See detailed guidance for complete instructions.**

	Part of the Hospital's Patient Safety Program in Most Recent Academic Year (2011-2012) ✓=YES Blank=NO	Hospital has Made Changes in Initiative since the previous academic year (2010-2011) ✓=YES Blank=NO	Reasons for Change	Benefits of Initiative
Root cause or error analysis				
Chart audits				
Rapid response team (RRT)				
Voluntary and confidential error reporting system				
Required error reporting system				
Mandatory error disclosure				
Standardization of drug dosing				
Computerized physician order entry				
Logic-based forcing functions in computerized physician order entry (e.g., screen for inaccurate data entry, drug interactions, etc.)				
Automatic drug dispensing linked to computerized physician order entry				

	Part of the Hospital's Patient Safety Program in Most Recent Academic Year (2011-2012) ✓=YES Blank=NO	Hospital has Made Changes in Initiative since the previous academic year (2010-2011) ✓=YES Blank=NO	Reasons for Change	Benefits of Initiative
Elimination of look-alike and sound-alike meds				
Electronic medical records				
Institution of protocols/guidelines				
Reducing hand-offs				
Availability of translators				
Formalized support mechanisms for residents that err and harm or kill a patient				
Logs and literature reviews regarding analysis of errors to be included in each resident's portfolio.				
Resident participation in quality assurance committees				
Other (specify):				