Georgia AHEAD Operational Readiness Assessment: Companion Guide

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Purpose of the Companion Guide

Objective

The Operational Readiness Assessment ("Assessment") provides a point-in-time evaluation of Georgia's rural hospitals and their readiness to participate in value-based transformation under the AHEAD Model. Using a standardized framework while recognizing each hospital's unique operational, financial, and service delivery environment, the Assessment will support readiness, cohorting and guide technical assistance.

The Assessment is intended to reflect current operational realities to determine where technical assistance may help bolster organizations, not to penalize organizations for areas still under development.

Suggested Completion Process

The Assessment is designed to be a collaborative and reflective process that helps hospitals evaluate current capabilities, identify operational strengths and gaps, and prepare for future transformation activities. While some questions may appear straightforward, many require input from multiple departments and operational perspectives to ensure responses accurately reflect current organizational practices, infrastructure, and bandwidth. To aid in completing this survey across the organization, there are two avenues through which hospitals may choose to approach submission:

1. The survey tool is designed to allow multiple individuals within the same organization to contribute to a single survey response. At the beginning of the survey, there are domain links within the Table of Contents organized by different domains or topic areas. Organizations should determine in advance which individuals are responsible for completing each domain and its associated questions.

Coordinating how the survey is completed is important, as **responses entered by all people will be visible to all contributors**. It is strongly recommended that only one person should be in the survey at a time. This prevents inconsistent, overwriting, or missed responses. Changes and responses submitted within assigned sections will be recorded as part of the organization's overall survey submission. **Responses are recorded by page when you click "next page".**

Note: Once you submit the survey, it is locked to further changes. If you have any issues, please email the AHEAD inbox for assistance at ahead@dch.ga.gov.

2. *Appendix A* to this Companion Guide lists the questions individually in a word document format. Hospital leaders can send specific sections or questions to be answered by staff on paper before compiling all answers to be input into the survey tool.

Because the Assessment spans governance, financial, clinical, workforce, quality, technology, policy, and community partnership domains, hospitals are strongly encouraged to use a cross-functional approach when completing the Assessment. The following representation is suggested to assist with completing the following domains:

Domain	Suggested Participants
Governance, Leadership & Strategic Alignment	CEO, COO, Board Liaison, Strategy Officer
Change Management & Strategic Planning	PMO Lead, Transformation Office
Workforce Capacity & Readiness	HR Director, Nursing Leadership
Rural-Specific Assets & Constraints	Executive Leadership, Operations
Quality Measurement & Clinical Performance	Quality Director, Performance Improvement
Clinical Care Transformation & Population Health	COO, CMO, Physician Relations, Network Development
Behavioral Health & Non-Clinical Drivers of Health	Behavioral Health Director, CMO
Community & Regional Collaboration	Community Relations, Strategy
Medicaid Alignment & State Policy Readiness	Medicaid Director, Government Affairs
Payment Model Experience & Contracting Capacity	CFO, Finance Director, Revenue Cycle
Health IT, Data & Analytics	CIO, IT Director, Analytics Lead

Hospitals may also decide, but are not required, to include external partners or affiliated organizations, where appropriate, particularly for questions related to regional collaboration, care coordination, workforce pipelines, or community-based partnerships.

Final review and sign-off by executive leadership is strongly recommended, particularly for responses related to strategic priorities, financial readiness, transformation capacity, and organizational partnerships.

Submission Instructions

Steps to Complete Your Hospital Operational Readiness Assessment

Step 1: Locate Link and Hospital ID

- Find the Operational Readiness Assessment link and your Hospital ID in the initial email sent by Georgia Department of Community Health, titled “Action Required | AHEAD Program Operational Readiness Assessment Survey.”
- That email also explains the purpose of the assessment and the review timeline.

Step 2: Access the Assessment

- Click on the Operational Readiness Assessment link included in the email.

Step 3: Verify Your Information On the first screen

- Select your Hospital ID from the dropdown (It must match the ID supplied in the email)
- Enter your email address.
- Enter your hospital name
- Select a Domain or click Next Page (on the bottom right) to open the assessment.

Step 4: Complete the Assessment

- Recommend that your organization determine in advance which individuals are responsible for completing each domain and its associated questions. Share your link with the identified individuals and provide instructions for the domains and/or questions they need to address. **Note- all responses entered will be visible to all contributors.**
- Answer all questions. **Responses are recorded by page when you click "next page"**.
- This survey uses display logic to tailor questions based on prior responses. As a result, some follow-up questions may not be displayed if they are not applicable or needed based on your answers.
- When you have completed the survey, go to the Final Preparation Review link at the bottom of the Table of Contents.
- The designated point of contact will be responsible for the final survey submission for your organization. Follow the instructions on the Final Preparation for Review for final review and submission.
- Select "Proceed to Final Review" and it will allow you to review all domains that you completed, or you can scroll directly to the end of the survey and click "Submit" to move to the next page.
- A screen will appear that allows you to review all answers and download a PDF. This is a read only page. If an error is found at this point, please reach out to the ahead@dch.ga.gov inbox for technical assistance. After reviewing all answers, please select the final “Submit”. Once you select the final "Submit", the survey is locked for the entire organization, and no further changes can be made. It will be followed by a thank you message.

Important:

- Do not have more than one person in the assessment simultaneously.
- Multiple users accessing the same assessment at the same time can interfere with how responses are recorded and may result in lost or incomplete data.

The Assessment is intended to reflect current operational realities to determine where technical assistance may help bolster organizations, not to penalize organizations for areas still under development.

Need Assistance? For technical issues or questions, contact the AHEAD Program inbox at ahead@dch.ga.gov.

General Expectations

DCH asks hospitals to answer questions honestly and completely. The Assessment is an opportunity to reflect both existing strengths and areas that are still evolving. **Organizations are not expected to demonstrate perfect maturity across all domains.** In many cases, identifying operational gaps or developing capabilities is an important and ***expected*** part of the transformation process.

The Assessment is NOT a:	
Compliance Audit	The Assessment is not intended to function as a regulatory audit, compliance review, or enforcement activity. Responses are not designed to measure compliance with federal or state certification standards, accreditation requirements, or reimbursement conditions.
Punitive Evaluation	The Assessment is not intended to penalize hospitals for operational limitations, resource constraints, or areas where capabilities are still developing. Assessment of findings will be used to support planning, readiness evaluation, and identification of potential support opportunities—not to assign penalties or negative performance determinations.
Certification Determination	Completion of the Assessment does not result in certification, formal designation, or approval status related to participation in any specific payment or transformation model.

	Rather, the Assessment is intended to inform readiness discussions and organizational planning activities.

The Assessment is intended to support hospitals in preparing for evolving healthcare delivery and payment models while recognizing the unique operational realities and challenges faced by rural and community-based providers.

Confidentiality & Data Use

Commitment to Confidentiality

All submitted data is treated as confidential and used solely for the Georgia Rural Health Transformation Program. Hospitals are encouraged to provide complete and transparent information regarding current operations, capabilities, challenges, and transformation needs. DCH recognizes that many responses may include operationally sensitive, strategic, financial, or organizational information. The intent of the Assessment process is to support readiness evaluation and transformation planning, not to publicly evaluate or compare individual organizations.

For Open Records Requests and concerns, please contact rhtp.orr@dch.ga.gov for additional details and guidance.

How Assessment Information Will Be Used

Information collected through the Assessment may be used to:

- Evaluate operational readiness across the eleven Assessment domains
- Identify common statewide and regional transformation challenges
- Inform technical assistance and support strategies
- Support readiness assessment cohorting
- Identify opportunities for operational improvement and collaboration
- Inform statewide planning and transformation initiatives
- Develop aggregate findings, trends, and recommendations

Assessment responses may also support:

- Technical assistance planning
- Transformation roadmap development

- Strategic prioritization discussions
- Gap analyses
- Regional readiness evaluations
- Operational support planning

The Assessment is intended to provide a current-state understanding of hospital readiness and operational capacity and may serve as one input into broader transformation planning activities.

Individual Hospital Information

Hospitals should note that:

- Assessment reviewers may include authorized project staff, technical assistance teams, DCH staff, or designated evaluation partners
- Information may be reviewed in conjunction with supporting documentation and follow-up discussions
- Certain aggregate findings or statewide trends may be summarized across participating organizations

Where aggregate reporting is developed, information will generally be presented in a manner that minimizes identification of individual hospitals unless explicit permission has been provided or disclosure is otherwise required.

Protection of Sensitive Information

Hospitals are encouraged to exercise appropriate discretion when answering questions that may contain:

- Proprietary business information
- Contractual terms
- Financially sensitive data
- Protected operational strategies
- Security-sensitive infrastructure information
- Personally identifiable information (PII)
- Protected health information (PHI)

Hospitals should **not include** any patient-level or personally identifiable information within submitted answers.

Data Quality and Verification

Submitted information may be reviewed for completeness, consistency, and clarification purposes. Hospitals remain responsible for ensuring that submitted information:

- Is accurate to the best of their knowledge
- Reflects current operational practices
- Does not intentionally omit material operational context
- Complies with internal organizational approval requirements

DCH recognizes that operational capabilities and organizational conditions may evolve over time. Responses are intended to reflect current state conditions at the time of submission.

Questions Regarding Data Submission

Hospitals with questions regarding data handling procedures, documentation requirements, or submission protocols are encouraged to contact the team for clarification prior to submission: AHEAD Mailbox at ahead@dch.ga.gov.

Please note that all privacy and open records questions should be directed to rhtp.orr@dch.ga.gov.

Technical Assistance & Support

Hospitals are encouraged to ask questions, seek clarification, and engage with the assessment team for support throughout the completion process.

Like in the previous financial assessment, the team will host an assessment office hour (email invitation and timing to be determined).

Hospitals may seek, through the AHEAD mailbox, assistance related to:

- Interpretation of the Assessment questions
- Submission requirements
- Identification of appropriate respondents
- Technical issues related to submission processes
- Clarification of Assessment concepts

Hospitals are encouraged to raise questions early in the process, particularly if clarification may affect the completion of accurate responses.

Frequently Asked Questions (FAQ)

1) **Can multiple people complete one section or domain?**

Yes. In fact, cross-functional collaboration is strongly encouraged throughout the Assessment process. Many domains require input from multiple departments or operational leaders to ensure responses are accurate, complete, and representative of current practices. It is important to note that only one person should be in the survey at one time to ensure all answers are saved.

2) **How should we respond if capability is only partially implemented?**

Hospitals should answer based on the organization's **current** operational state. If a capability is partially implemented, in pilot phase, or only operational in certain departments or locations, please describe the current level of implementation and provide additional context where helpful.

3) **Are estimates acceptable if exact data is unavailable?**

Yes. Reasonable estimates may be used when exact data is not readily available. Hospitals should note when estimates are being provided and use the best information currently available at the time of submission.

4) **How will incomplete responses affect the Assessment?**

Hospitals are encouraged to complete all sections to the best of their ability. Incomplete responses may limit the assessment team's ability to fully evaluate operational readiness or identify technical assistance needs.

5) **Can hospitals revise or update submissions after submission?**

Additional clarification or follow-up information may be requested during the review process. Hospitals may also have opportunities to provide updates or supplemental information during the follow up conversations.

6) **Is the Assessment intended to compare hospitals with one another?**

No. The purpose of the Assessment is to understand each hospital's individual baseline readiness, operational environment, and support needs. While aggregate trends and statewide findings may be analyzed, the Assessment will not be used to rank or compare participating hospitals.

7) **Will Assessment findings impact funding or participation decisions?**

Assessment findings will give both the state and the assessed hospital a clearer picture of what full AHEAD Model participation may entail for the hospital. Funding decisions are not made from this assessment. The results of this survey may inform decisions about participation in the AHEAD Model.

8) **What if our organization is still early in its transformation journey?**
Most organizations are actively building capabilities related to workforce stabilization, care redesign, behavioral health integration, analytics, and value-based care. Identifying areas that are still evolving is an *expected* and *important* part of the Assessment process.

9) **Who should we contact with questions during the Assessment process?** Hospitals should direct all questions regarding the Assessment process, timelines, or submission procedures to the AHEAD Mailbox at ahead@dch.ga.gov.

Appendix A:
Operational Readiness Assessment Questions

Domains Included

#	Question	Response
SECTION 1: GOVERNANCE, LEADERSHIP & STRATEGIC ALIGNMENT		
1	Please select which of the following executive/governing positions are present at your hospital.	For each role, select one: Chief Executive Officer (CEO) ☐ Role does not exist ☐ Role exists informally or responsibilities are minimally assigned ☐ Role exists part-time, shared, interim, or outsourced ☐ Role is formally established but has limited capacity or influence ☐ Role is fully established and actively engaged in hospital operations ☐ Role is fully established, strategically integrated, and consistently driving organization performance Chief Financial Officer (CFO) ☐ Role does not exist ☐ Role exists informally or responsibilities are minimally assigned ☐ Role exists part-time, shared, interim, or outsourced ☐ Role is formally established but has limited capacity or influence ☐ Role is fully established and actively engaged in hospital operations

#	Question	Response
		☐ Role is fully established, strategically integrated, and consistently driving organization performance Chief Medical Officer (CMO) ☐ Role does not exist ☐ Role exists informally or responsibilities are minimally assigned ☐ Role exists part-time, shared, interim, or outsourced ☐ Role is formally established but has limited capacity or influence ☐ Role is fully established and actively engaged in hospital operations ☐ Role is fully established, strategically integrated, and consistently driving organization performance Chief Operating Officer (COO) ☐ Role does not exist ☐ Role exists informally or responsibilities are minimally assigned ☐ Role exists part-time, shared, interim, or outsourced ☐ Role is formally established but has limited capacity or influence ☐ Role is fully established and actively engaged in hospital operations ☐ Role is fully established, strategically integrated, and consistently driving organization performance Chief Medical Information Officer (CMIO) ☐ Role does not exist ☐ Role exists informally or responsibilities are minimally assigned ☐ Role exists part-time, shared, interim, or outsourced ☐ Role is formally established but has limited capacity or influence

#	Question	Response
		☐ Role is fully established and actively engaged in hospital operations ☐ Role is fully established, strategically integrated, and consistently driving organization performance
2-3	Does your hospital have a designated leader (or team) accountable for quality and value-based initiatives? Please list any relevant and ongoing value-based initiatives.	☐ Yes ☐ No Relevant and ongoing value-based initiatives: _____
4	Has your hospital leadership been formally briefed on current AHEAD Model requirements and understand the model's structure enough to make an informed decision when formal endorsement is needed?	☐ Leadership has not been briefed on AHEAD ☐ Awareness of AHEAD exists but no formal briefing has occurred ☐ Informal briefing has occurred ☐ Formal briefing completed
5	To what extent has your hospital begun planning and preparing for participation in value-based payment models, including potential alignment with AHEAD Model's goals and future global budget arrangements?	☐ No discussions or planning activities related to value-based care or alternative payment models ☐ Initial awareness or informal discussions among leadership regarding value-based care opportunities and implications ☐ Leadership has begun assessing organizational readiness, including evaluating current capabilities, challenges, or potential impacts of value-based payment models ☐ A preliminary strategy, roadmap, or planning effort has been initiated and includes identified priorities, stakeholders, or governance structures
6	How frequently does the hospital Board review transformation performance and associated financial risk?	☐ Never reviewed ☐ Reviewed irregularly ☐ Annually ☐ Bi-annually (every six months)

#	Question	Response
		☐ Quarterly ☐ Monthly or more frequently
7	To what extent does leadership support and facilitate cross-department collaboration for quality improvement?	☐ No support demonstrated ☐ Occasional, informal support ☐ Some structured collaboration ☐ Active support with some accountability ☐ Strong support with tracking ☐ Fully integrated cross-dept leadership
8	There is a documented escalation process for performance or compliance risks, and governance bodies meet frequently enough to address emerging risks.	☐ No escalation process ☐ Informal escalation only ☐ Defined process, but rarely used ☐ Documented process, occasionally activated ☐ Active process, frequent governance meetings ☐ Fully embedded, proactive risk governance
9	If your hospital is part of a system: governance is clearly defined between system and hospital levels.	☐ No clarity exists ☐ Responsibilities are minimally defined ☐ Some governance structures are defined, but inconsistencies or gaps remain ☐ Partially to mostly defined ☐ Governance roles, escalation pathways, and decision-making authority are clearly documented and consistently applied ☐ Fully defined through formal agreements, with strong alignment, accountability, and collaboration between system and hospital leadership ☐ N/A

#	Question	Response
10	Roles and responsibilities are clearly defined within current structure to know who within the organization would lead AHEAD strategy, operations, finance, and performance oversight.	☐ No defined roles or accountability for AHEAD activities ☐ Limited role definition; responsibilities are informal ☐ Some roles identified, but gaps or overlap exist ☐ Roles are partially to mostly defined across key functions ☐ Roles and responsibilities are clearly documented and communicated ☐ Fully documented RACI matrix (Responsible, Accountable, Consulted, Informed) with active governance and accountability
11	Leadership has authority to reallocate staff or approve new roles for AHEAD.	☐ No authority to reallocate or approve new roles ☐ Minimal authority; approvals rarely granted ☐ Limited authority for temporary or minor changes ☐ Limited to mostly full authority ☐ Broad authority with minor to moderate approval barriers ☐ Full authority with rapid approval processes
12	The executive sponsor or body has authority over clinical, financial, and operational decisions affecting AHEAD performance.	☐ Sponsor has no decision authority ☐ Advisory role only ☐ Limited authority in select areas ☐ Partial to mostly full authority ☐ Broad authority across most domains ☐ Full authority over clinical, financial, and operational decisions ☐ Not applicable; No Executive Sponsor / body assigned
13	Leadership has engaged with departments and units within the hospital to share potential initiatives or performance improvement strategies related to the AHEAD Model.	☐ No departmental engagement ☐ Rare or informal engagement ☐ Inconsistent engagement across departments

#	Question	Response
		☐ Sporadic to structured engagement ☐ Regular engagement with key departments ☐ Systematic, documented engagement across all key departments ☐ N/A
14	Has a formal AHEAD governance structure (e.g., steering committee) been established with explicit oversight of AHEAD implementation activities?	☐ No governance structure established for AHEAD ☐ Discussed but not yet established ☐ Committee identified; charter not finalized ☐ Committee established; meets irregularly ☐ Committee established; meets regularly with documented agenda ☐ Fully operational steering committee with charter, membership, meeting schedule, and performance oversight
SECTION 2: CHANGE MANAGEMENT & STRATEGIC PLANNING		
15	Is an executive sponsor formally assigned and accountable for organizational-wide transformation progress?	☐ No sponsor identified ☐ Informal sponsor, no defined role ☐ Formal sponsor, no direct reporting structure ☐ Formal sponsor, ad hoc reporting ☐ Formal sponsor with quarterly or monthly reporting ☐ Executive sponsor fully accountable with active governance and routine reporting
16	Does the hospital maintain a documented multi-year transformation roadmap with milestones?	☐ No roadmap ☐ <2 years, no milestones ☐ ≥2 years, milestones incomplete ☐ ≥2 years with defined milestones

#	Question	Response
		☐ ≥2 years, milestones tracked and updated ☐ Comprehensive multi-year roadmap actively managed and tied to performance goals
17	How formally does the organization prioritize competing initiatives, including transformation efforts?	☐ No prioritization process ☐ Informal leadership discretion ☐ Formal framework, basic prioritization process inconsistently applied ☐ Formal framework, with moderate consistency ☐ Formal framework, transformation is in top 5 priorities ☐ Enterprise-wide prioritization process with transformation among top strategic priorities
18	To what extent does the hospital have dedicated project management resources to support transformation?	☐ Formal Project Management Office (PMO) with standardized governance and reporting ☐ No dedicated resources ☐ Partial FTE support ☐ Dedicated project manager for select initiatives ☐ Dedicated PMO with governance and reporting ☐ Fully staffed PMO with enterprise-wide transformation oversight
19	What level of experience does the organization have with large-scale transformations in the past five years?	☐ No significant transformation initiatives undertaken ☐ Transformation initiatives were planned but not implemented ☐ One or more initiatives were launched but not fully implemented or sustained ☐ One or more initiatives were successfully implemented ☐ Multiple initiatives were successfully implemented with measurable results ☐ Multiple initiatives were sustained over time and informed subsequent transformation efforts

#	Question	Response
20	How effectively does the hospital define and use Key Performance Indicators (KPIs) to monitor implementation progress?	☐ No KPIs defined ☐ KPIs defined but not tracked ☐ KPIs tracked quarterly ☐ KPIs tracked monthly ☐ KPIs tracked in real time or near-real time ☐ KPIs tracked in near/real time and integrated into operational decision-making
21	Does the hospital maintain any transformation specific performance dashboard that tracks implementation milestones, quality performance, utilization, avoidable admissions/readmissions, ED trends, care management engagement, and budget-to-actual performance?	☐ Yes ☐ No
22	What level of formal feedback mechanisms are used to inform ongoing implementation improvements?	☐ None ☐ Single feedback channel ☐ Multiple channels used informally ☐ Formal feedback mechanisms in place ☐ Formal mechanisms in place and tied to action plans ☐ Continuous feedback loops with documented action cycles
23	How effectively has the organization identified and mitigated key implementation risks?	☐ No risks identified ☐ Risks identified, no mitigation plans ☐ Partial mitigation plans ☐ Formal mitigation plans established ☐ Formal mitigation/risk-management plan with routine monitoring ☐ Formal risk-management plan with continuous monitoring and mitigation
24	To what extent has the organization engaged external partners to support transformation in the past three years?	☐ No engagement

#	Question	Response
		☐ One-time engagement ☐ Limited engagements ☐ Ongoing partnerships ☐ Strategic partnerships with measurable value ☐ Long-term strategic partnerships integrated into transformational efforts
25	How capable is the organization of effectively managing and utilizing external technical assistance (TA)?	☐ No internal capacity to manage TA ☐ Minimal capacity ☐ Moderate capacity ☐ Strong capacity with defined processes ☐ High capacity with successful utilization ☐ Advanced capacity with demonstrated sustained internal success
SECTION 3: WORKFORCE CAPACITY & READINESS		
26	Select one to best describe your population health staffing model.	☐ No model in place ☐ Ad hoc or fragmented responsibilities ☐ Limited structure with inconsistent role definition ☐ Defined staffing model, uneven implementation ☐ Well-structured model with clear governance and staffing alignment ☐ Mature, purpose-built model aligned to risk tiers and value-based care objective
27	Which of the following dedicated or functionally aligned roles currently support population health management?	Select all that apply: *Clinical & Care Management:* ☐ RN care managers ☐ LPN/Care coordinators

#	Question	Response
		☐ Social workers / Case managers ☐ Community health workers / Care navigators ☐ Pharmacists / Clinical pharmacy support ☐ Behavioral health specialists (embedded or aligned) ☐ Advanced practice providers supporting population health ☐ Transitional care/post-discharge coordination staff *Medical Leadership & Governance:* ☐ Physician leadership for population health (e.g., Medical Director) ☐ Administrative leadership accountable for population health outcomes ☐ Multidisciplinary care management governance structure ☐ Physician champions for value-based care or care transformation *Analytics, Quality & Performance:* ☐ Population health data analysts ☐ Quality improvement specialists ☐ Performance improvement/Lean resources ☐ Actuarial or financial analytics support for risk-based contracts ☐ Other: _____
28-29	Does your hospital have sufficient primary care provider capacity (employed or affiliated PCPs, NPs, PAs) to serve as the foundation for population health management under a global budget?	Select one: ☐ Sufficient — primary care capacity meets current and anticipated population health management needs ☐ Adequate — capacity is sufficient for current volume but may not support AHEAD growth requirements ☐ Insufficient — meaningful PCP gaps limit ability to anchor population health management

#	Question	Response
		☐ Critical shortage — PCP capacity is a significant constraint on AHEAD participation Comments:
30	Please describe your hospital's current overall workforce vacancy rate.	Select one: ☐ Less than 5% ☐ 5–9% ☐ 10–14% ☐ 15–20% ☐ Greater than 20%
31	Please indicate the roles where your hospital experiences persistent critical shortages (Select all that apply).	Select all that apply: ☐ Registered nurses ☐ Behavioral health clinicians ☐ Specialty nurses ☐ Respiratory therapists ☐ Imaging/diagnostic staff ☐ Care managers/social workers ☐ IT/analytics staff ☐ None ☐ Other (please list): _____
32	Please indicate the physician specialties or provider roles where your hospital or health system expects to have filled positions and experiences persistent recruitment or retention challenges (Select all that apply).	Select all that apply: ☐ Primary care physicians (Family Medicine/Internal Medicine) ☐ Emergency medicine physicians ☐ Hospitalists

#	Question	Response
		☐ General surgeons ☐ Behavioral health/psychiatrists ☐ Obstetricians/Gynecologists (OB/GYN) ☐ Pediatricians ☐ Anesthesiologists/CRNAs ☐ Radiologists ☐ Cardiologists ☐ Orthopedic surgeons ☐ Neurologists ☐ Pulmonologists/Critical care physicians ☐ Oncology specialists ☐ Advanced practice providers (NPs/PAs) ☐ Locum tenens coverage needs ☐ Telehealth/virtual specialty coverage ☐ Other specialty/provider type (please specify): _____ ☐ None
33	Which of the following factors contribute most to physician staffing shortages at your organization? (Select all that apply)	Select all that apply: ☐ Difficulty recruiting to rural communities ☐ Provider burnout/turnover ☐ Retirement of existing workforce ☐ Competition from urban health systems ☐ Limited residency/training pipeline ☐ Compensation constraints ☐ Housing/community relocation barriers ☐ Limited specialty call coverage

#	Question	Response
		☐ Licensing/credentialing delays ☐ Other (please specify): _____
34	Please indicate the workforce turnover by role (past 12 months) for your hospital: RNs, ICU/Specialty Nurses, APPs, Physicians, BH Clinicians, Allied Health.	For each role, select one turnover range: RNs ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30% ICU/Specialty Nurses ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30% APPs ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30% Employed Physicians ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30% BH Clinicians ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30% Allied Health ☐ <10% ☐ 10–15% ☐ 16–20% ☐ 21–30% ☐ >30%
35	To what extent does your hospital use travel nurses?	Select one: ☐ No use ☐ Limited use ☐ Moderate use ☐ Significant reliance
36	What percentage of nursing hours are covered by travel/agency staff?	Select one: ☐ <5% ☐ 5–10% ☐ 11–20% ☐ >20% ☐ Not applicable
37	To what extent does your hospital use contracted behavioral health clinicians?	Select one: ☐ No use ☐ Limited use

#	Question	Response
		☐ Moderate use ☐ Significant reliance
38-39	Does your hospital have succession plans for key roles critical to support care model transformation (e.g., CMO, quality director, care management lead)?	☐ Yes — documented succession plans exist for all key AHEAD roles ☐ Partial — succession plans exist for some but not all key roles ☐ No — no formal succession planning for AHEAD-critical positions *Key roles to consider: CMO, Quality Director, Care Management Lead, CMIO, AHEAD Program Manager* Comments: _____
40	Clinical and administrative staff understand how their roles impact quality and patient outcomes.	☐ Not present / Staff generally do not understand how their work impacts quality or patient outcomes ☐ Rarely occurs / Awareness exists in isolated departments or among leadership only ☐ Limited or inconsistent / Some staff understand quality goals, but knowledge is inconsistent across teams ☐ Partially established / Most staff demonstrate basic understanding of quality priorities and outcome measures ☐ Consistently demonstrated /Staff routinely connect daily work to quality, safety, and patient outcomes ☐ Fully established and/or High performing / Quality accountability is embedded organization-wide, with staff actively using data and participating in improvement efforts
41	The hospital has adequate staffing capacity to support quality improvement work.	☐ Strongly disagree / Severe staffing shortages prevent meaningful quality improvement activities

#	Question	Response
		☐ Minimal evidence / Staffing is highly strained; quality work occurs only in response to urgent needs or compliance requirements ☐ Limited or inconsistent / Limited staffing capacity exists, but improvement efforts are inconsistent or difficult to sustain ☐ Moderate / Staffing generally supports core operations and some quality improvement initiatives ☐ Strong / Dedicated time and personnel are available to support ongoing quality improvement work ☐ Fully established / Staffing levels and organizational structure fully support proactive, data-driven quality improvement across departments
42	Clinical and operations staff are open to workflow changes to improve quality.	☐ Not present / Staff are resistant to workflow or process changes ☐ Rarely occurs / Change efforts frequently encounter opposition or lack of engagement ☐ Limited or inconsistent / Some teams are receptive to change, but adoption is inconsistent ☐ Partially established / Staff are generally willing to test and adopt workflow improvements when supported ☐ Consistently demonstrated / Teams actively participate in process improvement discussions and implementation efforts ☐ Fully Established and /or High performing / Continuous improvement and adaptability are embedded in organizational culture, with staff proactively identifying and implementing workflow enhancements
43	To what extent are frontline staff formally engaged in transformation design and implementation?	☐ No engagement ☐ Informal input ☐ Engagement in limited initiatives

#	Question	Response
		☐ Formal engagement strategy exists ☐ Formal engagement with measurable participation
44	How consistently are transformation updates communicated to staff?	☐ No communication ☐ Ad hoc ☐ Periodic (< quarterly) ☐ Monthly ☐ Weekly or more frequent
45	To what extent does the organization use data and cross-department collaboration to drive improvement?	☐ Rarely or never ☐ Occasionally ☐ Sometimes ☐ Often ☐ Always, with enterprise dashboards
46	How does the organization proactively identify and manage resistance to change?	☐ No formal approach ☐ Informal manager handling ☐ Feedback collected irregularly ☐ Formal process and regular feedback ☐ Formal process with tracked mitigation actions
SECTION 4: RURAL-SPECIFIC ASSETS & CONSTRAINTS		
47	Does the hospital maintain essential service coverage despite reliance on a small or multi-role workforce?	☐ Workforce availability does not affect service availability ☐ Occasional staffing shortages create operational challenges, but services are maintained

#	Question	Response
		☐ Persistent staffing shortages require service reductions, temporary closures, or limited-service hours ☐ Significant workforce shortages threaten the sustainability of one or more essential services
48	Does dependence on locum tenens, contract staff, or traveling clinicians limit continuity of care and care transformation efforts?	☐ Minimal reliance on contracted workforce ☐ Moderate reliance, but continuity of care and transformation activities are not affected ☐ Significant reliance creates challenges for continuity of care, quality improvement, or transformation efforts ☐ Heavy reliance is a major operational or strategic barrier ☐ Significant or heavy reliance, but continuity of care and transformation activities are relatively unaffected
49	Does the hospital have sufficient clinical workforce stability to support care transformation and participation in a multi-year payment model?	☐ Workforce is stable with low vacancy and turnover rates ☐ Some vacancies or turnover exist but do not significantly affect operations ☐ Persistent vacancies or turnover affect operations and care redesign efforts ☐ Workforce instability is a major barrier to long-term transformation initiatives
50	Is the hospital's ability to expand or redesign services limited by difficulty recruiting and retaining staff?	☐ Not a limitation ☐ Minor limitation affecting selected positions ☐ Moderate limitation affecting multiple service lines ☐ Significant limitation preventing service expansion or redesign
51	Does the hospital's geographic distance from higher-level or specialty care create significant challenges for timely patient care?	☐ Minimal or no impact ☐ Some delays or coordination challenges for certain services ☐ Frequent delays or access barriers for multiple services ☐ Major challenge affecting timely access to care

#	Question	Response
52	Is the hospital's care coordination hampered by limited availability of post-acute, behavioral health, or specialty services in our region?	☐ Adequate service availability supports care coordination ☐ Limited availability creates occasional challenges ☐ Significant service gaps regularly affect care coordination ☐ Major shortages substantially impede care coordination
53	Does the hospital adapt care delivery approaches to address common rural non-medical barriers (transportation, food access, caregiver availability)?	Select all that apply: ☐ Transportation assistance/referrals ☐ Food access programs or referrals ☐ Community health workers or care navigators ☐ Partnerships with community-based organizations ☐ Screening and referral workflows ☐ No formal strategies currently in place ☐ Other: _____
54	Do the hospital's telehealth services, if used, meaningfully expand access to care for patients in its rural community?	☐ Telehealth is not currently used ☐ Telehealth is used but has limited impact on access ☐ Telehealth expands access for selected services or populations ☐ Telehealth is a significant component of access strategy and care delivery
55	Does limited broadband access, digital literacy, or availability of private spaces significantly restrict patients' ability to use telehealth?	Select all that apply: ☐ Limited broadband access ☐ Limited device availability ☐ Digital literacy challenges ☐ Lack of private space for visits ☐ Reimbursement or operational challenges ☐ No significant barriers identified ☐ Other: _____

#	Question	Response
56	Has the hospital implemented strategies to help patients overcome telehealth access barriers?	Select all that apply: ☐ Digital literacy training ☐ Device lending or support programs ☐ Broadband access partnerships ☐ Telehealth support staff or navigators ☐ Community telehealth access sites ☐ Specialty telehealth via PCP office ☐ No formal strategies currently in place ☐ Other: _____
57	Does the hospital leverage alternative or flexible care delivery approaches (mobile services, outreach clinics) to meet rural community needs?	Select all that apply: ☐ Mobile health services ☐ Outreach clinics ☐ Community-based care teams ☐ Home-based services ☐ School-based services ☐ None currently implemented ☐ Other: _____
58	Does the hospital have strong, trusted relationships with the community that support patient engagement and health improvement collaboration?	☐ Strong partnerships with community organizations and regular collaboration on health initiatives ☐ Established relationships with some community partners ☐ Limited community partnerships and collaboration ☐ Minimal community engagement activities
SECTION 5: QUALITY MEASUREMENT & CLINICAL PERFORMANCE		

#	Question	Response
59	Executive leadership and/or Board of Directors actively set and/or approve quality and performance improvement goals.	☐ Does not apply ☐ Quality goals are not formally established or reviewed by executive leadership or the Board ☐ Executive leadership or the Board is informed of quality goals but has limited involvement in setting or approving them ☐ Executive leadership reviews and approves quality goals; Board involvement is limited or periodic ☐ Executive leadership and the Board routinely review and approve quality goals annually ☐ Executive leadership and the Board actively establish, monitor, and adjust quality goals as part of strategic planning
60	Quality Improvement (QI) projects are data-driven and aligned with organizational priorities.	☐ No QI projects underway, or does not apply ☐ Projects are selected informally with little data used, and alignment with priorities is incidental ☐ Some data or anecdotal input informs project selection, but the process is inconsistent and undocumented; Alignment with organizational priorities is rarely assessed ☐ Projects generally align with priorities, some performance data informs selection, but outcomes review is sporadic ☐ Projects are data-informed and clearly aligned with organizational priorities. Performance data is tracked consistently but outcome review is not systematically completed ☐ Quality improvement activities are systematically prioritized using performance data and organizational goals, with outcomes routinely evaluated
61	The hospital can reliably extract clinical performance data from its Electronic Health Record (EHR) without significant manual workarounds.	☐ Clinical performance data cannot be extracted from the EHR

#	Question	Response
		☐ Clinical performance data extraction requires extensive manual work or vendor assistance ☐ Most clinical performance data can be extracted but requires moderate manual manipulation ☐ Most clinical performance data can be extracted reliably with minimal manual effort ☐ Clinical performance data is routinely extracted through automated or standardized processes ☐ Does not apply
62	Data extracted from the hospital's EHR is reliable and accurate	☐ Data quality is not routinely validated or is unreliable ☐ Data accuracy issues are common and require frequent correction ☐ Data is generally reliable but requires periodic validation or cleanup ☐ Data is routinely validated and considered reliable for operational and quality reporting ☐ Data quality is consistently monitored and trusted for strategic, operational, and regulatory reporting ☐ Does not apply
63	How often are quality/clinical performance metrics reviewed by leadership?	☐ Metrics are not routinely reviewed ☐ Metrics are reviewed occasionally or only when issues arise ☐ Metrics are reviewed at least annually or semi-annually ☐ Metrics are reviewed quarterly by executive leadership ☐ Metrics are reviewed quarterly or more frequently and used to guide improvement actions ☐ Does not apply

#	Question	Response
64	How regularly is performance on CMS quality measures (readmissions, HCAHPS, mortality, patient safety) is monitored by leadership?	☐ CMS quality measures are not routinely monitored ☐ Selected CMS measures are reviewed occasionally ☐ Most CMS measures are reviewed periodically but not consistently each quarter ☐ CMS quality measures are reviewed quarterly by leadership ☐ CMS measures are routinely monitored and used to drive organizational performance improvement ☐ Does not apply
65	Quality leaders, hospital administrators, executive leadership and board understand how quality performance will affect reimbursement under a global budget payment arrangement.	☐ Little or no understanding of quality requirements under a global budget model ☐ Limited awareness among a few leaders ☐ General understanding exists but knowledge is inconsistent ☐ Leadership understands how quality performance will influence success under a global budget model ☐ Leadership is actively incorporating global budget quality requirements into organizational planning ☐ Does not apply
66	The hospital can submit required quality reports accurately and on time.	☐ Required reports cannot be consistently completed ☐ Reports are frequently delayed or require significant external support ☐ Reports are generally submitted on time but require substantial manual effort ☐ Required reports are routinely submitted accurately and on time ☐ Reporting processes are standardized, efficient, and consistently meet reporting requirements ☐ Does not apply

#	Question	Response
67	The hospital has the capability to respond to ad hoc quality requests accurately and within specified turnaround times.	☐ Ad hoc reporting capability does not exist ☐ Ad hoc reports require significant manual effort and long turnaround times ☐ Most ad hoc reports can be produced with moderate effort ☐ Required and ad hoc reports are routinely produced within requested timeframes ☐ Does not apply
68	The hospital consistently captures and submits CPT II and Z codes to support quality measurement and reporting.	☐ CPT II and Z codes are not routinely captured ☐ Coding occurs inconsistently or only for selected services ☐ Most applicable coding is captured but inconsistently submitted or monitored ☐ Applicable CPT II and Z codes are routinely captured and submitted ☐ Coding processes are standardized, monitored, and routinely used to support quality improvement and reporting ☐ Does not apply
69	The hospital fully utilizes clinical decision support and quality reporting capabilities of its EHR.	☐ Clinical decision support and reporting features are rarely or never used ☐ Limited EHR capabilities are used for selected workflows ☐ Several decision support and reporting functions are used, but many capabilities remain underutilized ☐ Most relevant EHR decision support and quality reporting capabilities are routinely used ☐ EHR functionality is fully leveraged to support clinical decision-making, quality improvement, and performance monitoring ☐ EHR does not offer or hospital does not have access to clinical decision support or quality reporting capabilities

#	Question	Response
70	Hospital IT staff has capacity/capability to support analytics and reporting needs.	☐ IT staffing is insufficient to support analytics and reporting ☐ IT capacity exists only for basic operational reporting ☐ IT capacity supports routine or required reporting but limits additional initiatives ☐ IT staffing is sufficient to support current reporting and analytics needs ☐ IT staffing and expertise support ongoing analytics and reporting for required strategic and transformation initiatives ☐ Does not apply
71	Technology infrastructure supports and enables effective quality improvement activities.	☐ Technology infrastructure significantly limits quality improvement efforts ☐ Basic infrastructure exists but frequently limits performance improvement activities ☐ Basic infrastructure exists but sometimes limits performance improvement activities ☐ Infrastructure reliably supports quality measurement, reporting, and improvement initiatives ☐ Technology infrastructure is optimized to support continuous quality improvement, analytics, and care transformation ☐ Does not apply
SECTION 6: CLINICAL CARE TRANSFORMATION & POPULATION HEALTH		
72	Which care models does your organization have the capabilities and infrastructure to support (whether currently active or recently concluded)?	☐ Fully fee-for-service (FFS) ☐ Primarily FFS ☐ Early value-based initiatives (i.e., pay for reporting) ☐ Mix of FFS and value-based models with limited standardization ☐ Mostly value-based care delivery ☐ Predominantly value-based, with mature, standardized care models

#	Question	Response
73	To what degree do you standardize care delivery through the use of evidence-based care pathways?	☐ No standardized pathways ☐ Limited or informal care pathways ☐ Pathways used inconsistently ☐ Limited deployment for specific diagnoses ☐ Standardized across multiple diagnoses and sites ☐ Widely standardized and consistently followed
74	How effectively does your organization manage patients across the full care continuum (acute, post-acute, community)?	☐ No coordinated continuum management ☐ Minimal coordination beyond hospital walls ☐ Basic transition management ☐ Defined transition processes, variable execution ☐ Coordinated continuum management ☐ Seamless, accountable continuum management
75	How well are physicians aligned with and incentivized toward value-based care goals?	Select first: ☐ Marketplace ☐ Medicaid ☐ Traditional Medicare ☐ Medicare Advantage ☐ State Health Benefit Plan (SHBP) ☐ Commercial Then for each select: ☐ No alignment with value-based care goals ☐ Minimal alignment between compensation and value ☐ Limited incentives or participation

#	Question	Response
		☐ Partial linkage or voluntary participation ☐ Strong physician engagement ☐ Full alignment with compensation, governance, and culture
76	To what extent do frontline clinicians use real-time data to guide clinical decisions?	☐ No meaningful data use ☐ Data is retrospective or rarely used at point of care ☐ Limited dashboard ☐ Dashboards exist but limited workflow integration ☐ Real-time data supports case decisions ☐ Real-time, predictive insights embedded in care delivery
77	Do clinicians receive point-of-care alerts for gaps in care?	☐ Yes ☐ No
78-80	Do you have performance dashboards? If so, how often are performance dashboards reviewed at the provider, service-line, or leadership level? How do you measure clinical performance/quality?	☐ Yes ☐ No If yes: complete the table below to indicate review frequency by level (provider, service-line, leadership). ☐ No dashboards or formal performance review ☐ Ad-hoc and infrequent review ☐ Dashboards exists with limited use ☐ Reviewed quarterly ☐ Reviewed monthly ☐ Monthly or more frequent review with action tracking ☐ Other _____ If no, how do you measure performance? _____
81	Are predictive or risk models embedded into clinical workflows, and how often are they acted upon?	☐ No predictive or risk models used ☐ Risk models not embedded into clinical workflows

#	Question	Response
		☐ Limited or pilot workflow integration ☐ Embedded risk models, but uneven/infrequent utilization ☐ Regularly used within workflows ☐ Fully integrated and routinely acted upon
82	How effectively does your organization identify and address social and non-medical drivers of health?	☐ No screening or interventions ☐ Limited or informal screening ☐ Screening with inconsistent follow-up ☐ Screening exists; limited closed-loop interventions ☐ Coordinated interventions with measurable impact ☐ Integrated, measurable whole-person care model ensuring consistent, high-quality care for all patients
83	Does your hospital routinely stratify clinical outcomes by demographics or population characteristics and use those results to drive improvement?	If yes: ☐ No risk stratification process ☐ Minimal or ad hoc stratification ☐ Limited stratification without action planning ☐ Partial or inconsistent stratification ☐ Routine stratification with some improvement efforts ☐ Routine stratification used to drive measurable improvement If you selected, partial, explain which characteristics are used to stratify: _____ If you selected No, provide additional context as to why you do not stratify: _____
84	How effectively does your organization identify high-risk patients?	☐ No risk stratification process

#	Question	Response
		☐ Limited identification of high-risk patients ☐ Risk models exist with inconsistent interventions ☐ Risk models exist
85	How mature and scalable are your care management programs in driving measurable outcomes?	☐ No formal care management programs ☐ Fragmented or pilot programs only ☐ Defined programs with limited scale ☐ Defined programs with variable impact ☐ Scaled programs with measurable outcomes ☐ Fully scaled, risk-stratified, outcomes-proven programs
86	To what extent does your organization influence and manage performance across the care network, including post-acute providers?	☐ No network performance management ☐ Open network with minimal oversight ☐ Informal partner coordination ☐ Preferred partners with limited accountability ☐ Active network performance management ☐ High-performing network with active performance management
87	Does your organization use preferred or narrow networks to steer volume, and for which services?	Select from dropdown: ☐ Yes, preferred network ☐ Yes, narrow network ☐ No If yes, for which services: _____
88	The hospital has processes to monitor avoidable readmissions.	☐ Yes ☐ No ☐ Other, explain: _____
89	The hospital has processes to reduce avoidable readmissions.	☐ Yes ☐ No

#	Question	Response
		☐ Other, explain: _____
90	Providers actively engage patients and caregivers in care planning.	☐ Yes, standard, documented process ☐ Partial, depends on patient/caregiver ☐ No, no standard care planning process
91	Does your hospital have a standardized, documented process for medication reconciliation at discharge?	Select one: ☐ Yes — standardized, documented process ☐ Partial — process exists but lacks documentation ☐ No — no standardized medication reconciliation process at discharge
92	What percentage of your patients discharged to home receive a follow-up contact (phone or visit) within 48–72 hours of discharge?	Select one: ☐ 0–25% of discharges receive follow-up contact within 48–72 hours ☐ 26–50% ☐ 51–75% ☐ 76–100% ☐ Not tracked — no systematic follow-up contact process or data
93	How effectively does your organization engage patients outside traditional clinical settings?	☐ No outreach or engagement strategy ☐ Minimal digital or outreach capability ☐ Limited engagement tools or outreach efforts ☐ Multiple tools with inconsistent engagement ☐ Coordinated multi-channel engagement strategies ☐ Omnichannel, personalized, high-engagement strategies
94	How do you engage non-compliant or hard-to-reach patients?	☐ Manual outreach attempts with limited tracking of efforts ☐ Manual outreach attempts with tracking of efforts

#	Question	Response
		☐ Standardized outreach using EHR registries, with basic tracking of outreach attempts ☐ Multiple outreach channels and patient segmentation ☐ Proactive, data-driven outreach with prioritization and outcome tracking ☐ Automated, personalized, and multi-channel outreach integrated with EHR/CRM systems ☐ Not applicable, organization does not have standardized process or outreach strategy / not applicable
95	Is there omnichannel communication (text, phone, virtual) for patients?	☐ Yes ☐ No
96	Is there a co-located or virtually integrated behavioral health provider available to support patients at the point of care?	Select one: ☐ Yes — co-located BH provider available within care setting and virtual/tele-BH integrated into care setting workflows ☐ Yes — co-located BH provider available within care setting ☐ Yes — virtual/tele-BH integrated into care setting workflows ☐ Partial — BH accessible by referral but not integrated at point of care ☐ No — no BH integration at point of care
97	Does your hospital have the operational ability to identify, track, and manage a defined patient population across care settings?	Select one: ☐ Yes — defined processes exist to identify, track, and manage patients across care settings ☐ Partial capability — some tracking exists but not systematically across all settings ☐ No capability — unable to consistently identify or manage an attributed population

#	Question	Response
98	What is your approximate rate of completion for key preventive care services among your populations (annual wellness visits, colorectal cancer screening, cervical cancer screening, childhood immunizations)?	For each population below, indicate the approximate completion rate for each measure. ☐ Marketplace ☐ Medicaid ☐ Traditional Medicare ☐ Medicare Advantage ☐ State Health Benefit Plan (SHBP) ☐ Commercial Annual Wellness Visits: ☐ <25% ☐ 25–50% ☐ 51–75% ☐ >75% ☐ Not tracked Colorectal Cancer Screening: ☐ <25% ☐ 25–50% ☐ 51–75% ☐ >75% ☐ Not tracked Cervical Cancer Screening: ☐ <25% ☐ 25–50% ☐ 51–75% ☐ >75% ☐ Not tracked Childhood Immunizations (if applicable): ☐ <25% ☐ 25–50% ☐ 51–75% ☐ >75% ☐ Not tracked
SECTION 7: BEHAVIORAL HEALTH & HEALTH-RELATED SOCIAL NEEDS		
99	Please select the behavioral health (BH) services your hospital offers (inpatient, outpatient, clinic-based).	For each service, select ☐ Yes ☐ No: Inpatient: Behavioral health beds (# ____), Child & adolescent, Adult, Geriatric, Psychiatric eval & management, Structured therapy, Substance use treatment, Nursing Outpatient: Standard outpatient, Partial hospitalization, Intensive outpatient – peer supports, Intensive outpatient – psychosocial rehabilitation, Individual psychotherapy, Specialized group therapy, Medication management/psychiatric evals, Substance use treatment

#	Question	Response
		Clinic-based services Other: _____
100	Please identify current non-hospital partnerships or referral agreements with BH entities.	Select all that apply: ☐ Residential treatment facility programs ☐ Crisis residence (short-term, <15 days) ☐ Therapeutic group home or community residence ☐ Respite care service programs ☐ Emergency/crisis services (24-hour) ☐ Partial hospitalization/day hospital ☐ Intensive outpatient programs ☐ Day treatment programs ☐ Family support programs ☐ Home-based treatment services ☐ Faith-based organizations ☐ Natural supports programs (individual, family, community) ☐ Peer supports ☐ Intensive case management programs ☐ Office or outpatient clinics ☐ Non-clinical drivers of health service providers ☐ Other: _____
101	Please identify the most prevalent non-clinical drivers of health identified by the hospital's patients.	Select all that apply: ☐ Unemployment / lack of durable employment ☐ Lack of education / personal educational adversity

#	Question	Response
		☐ Language barrier ☐ Housing instability / homelessness ☐ Personal or family involvement with the justice system ☐ Food insecurity ☐ Transportation barriers ☐ Utility/energy needs ☐ Involvement with child protective services ☐ Caregiver burden ☐ Domestic violence/safety ☐ Exposure to community and/or family violence, ☐ Social isolation/loneliness ☐ Financial strain ☐ Substance use ☐ Mental health needs not addressed by current services ☐ Whole health needs not addressed by current services ☐ Other: _____
SECTION 8: COMMUNITY & REGIONAL COLLABORATION		
102	The hospital participates in a formally defined regional governance structure for health planning and accountability.	☐ No regional governance participation ☐ Informal, ad hoc, or planned participation ☐ Formal participation with limited implementation ☐ Active participation with routine engagement ☐ Established governance with shared accountability ☐ Fully integrated regional governance leadership

#	Question	Response
103	Community Health Needs Assessments (CHNAs) are conducted with active and intentional community engagement, through interviews, thorough surveys, or other similar mediums.	☐ No formal CHNA engagement process ☐ Minimal or informational engagement ☐ Limited community participation ☐ Structured engagement processes in place ☐ Broad and consistent community engagement ☐ Fully integrated, community-driven CHNA process
104	Community-Based Organizations (CBOs) and/or public health agencies actively participate in the CHNA process.	☐ No CBO/public health participation ☐ Informal or occasional participation ☐ Limited formal participation ☐ Structured participation from key partners ☐ Active multi-organization collaboration ☐ Fully integrated partnership throughout the CHNA process ☐ Not applicable, organization has not conducted a CHNA / CHNA not applicable
105	CHNA findings inform regional or broad community investment decisions.	☐ CHNA findings not used for investment decisions ☐ Informal consideration of findings ☐ Limited use in planning or investments ☐ Findings regularly inform decisions ☐ Findings drive coordinated investment strategies ☐ CHNA findings systematically guide regional investments ☐ Not applicable
106	The hospital assesses community health needs regularly and uses results to inform priorities.	☐ No regular assessment process ☐ Assessments conducted inconsistently ☐ Assessments conducted with limited use

#	Question	Response
		☐ Regular assessments inform some priorities ☐ Assessments routinely guide planning and investments ☐ Community health assessments fully integrated into strategic decision-making
107	The hospital currently has formal relationships (MOUs/Contracts) with Federally Qualified Health Centers (FQHCs), Rural Health Centers (RHCs), and independent primary care practices.	☐ No formal relationships ☐ Informal relationships only ☐ Limited formal agreements ☐ Multiple formal partnerships established ☐ Active partnerships with coordinated activities ☐ Fully integrated partnerships with shared accountability
108	Which best describes the hospital's current engagement with primary care providers regarding care transformation or potential AHEAD participation?	Select one: ☐ Hospital leadership has not identified potential partners but intends to engage with primary care providers ☐ Hospital leadership does not intend to engage with primary care partners at this time ☐ Hospital leadership has identified potential partners but has not initiated discussions ☐ Initial discussions have occurred with one or more primary care partners ☐ Ongoing discussions are occurring with multiple primary care partners regarding future collaboration ☐ Collaborative planning is actively underway with committed partners ☐ Other: _____
109	Describe the nature of your hospital's operational relationship with FQHCs or RHCs in your service area (shared care protocols, shared patients, or joint quality improvement activities).	Select one: ☐ Formal shared protocols + joint quality improvement activities with FQHCs/RHCs

#	Question	Response
		☐ Formal referral relationship only (MOU/contract exists but no shared protocols) ☐ Informal relationship (no formal agreement; ad hoc collaboration) ☐ No active relationship with FQHCs/RHCs ☐ No FQHC or RHC in service area
110	The hospital coordinates care with post-acute providers using shared workflows or protocols.	☐ No coordination with post-acute providers ☐ Informal or planned coordination ☐ Limited formal workflows or protocols ☐ Standardized workflows with active coordination ☐ Coordinated regional transition processes ☐ Fully integrated post-acute care coordination model
111	The hospital has partnerships with behavioral health providers in the region supporting cross-setting care.	☐ No behavioral health partnerships ☐ Informal or planned partnerships ☐ Limited formal partnerships ☐ Active partnerships supporting care coordination ☐ Coordinated cross-setting behavioral health integration ☐ Fully integrated behavioral health collaboration model
112	CBOs/public health agencies in the region are integrated into care coordination or care planning workflows.	☐ No integration with CBOs/public health agencies ☐ Informal or limited coordination ☐ Limited formal coordination ☐ Structured participation in care workflows ☐ Active collaboration across care planning activities ☐ Fully integrated community-based care coordination model

#	Question	Response
113	Regional care coordination protocols or transition-of-care workflows are standardized and shared with hospitals and other healthcare facilities in the region.	☐ No shared protocols or workflows ☐ Informal or inconsistent coordination ☐ Limited standardized workflows ☐ Standardized workflows across select partners ☐ Broad regional adoption of workflows ☐ Fully standardized and routinely shared regional coordination protocols
114	Population-focused interventions are planned or in place.	☐ No planned interventions ☐ Early planning activities only ☐ Limited interventions implemented ☐ Defined population-focused interventions in place ☐ Coordinated interventions with measurable outcomes ☐ Comprehensive, scalable population health intervention strategy
SECTION 9: MEDICAID ALIGNMENT & STATE POLICY READINESS		
115 - 116	Does the hospital contract with all state Medicaid care management organizations (CMOs)?	☐ Yes ☐ No If Yes, indicate which organizations: _____
117 - 118	Is the hospital actively aligning payment incentives across Medicaid, Medicare, and commercial payers utilizing alternative payment models (APMs)?	☐ Yes ☐ No If Yes, indicate which models: _____
119 - 120	Does the hospital actively participate in state-led collaboratives or payer alignment workgroups?	☐ Yes ☐ No If Yes, indicate which workgroups: _____

#	Question	Response
121 - 122	Has the hospital had substantive discussions with Georgia Medicaid CMOs (Peach State Health Plan, CareSource, and Amerigroup) regarding care coordination and performance expectations in support of advancing value-based models?	Select all that apply: ☐ Yes — Peach State Health Plan (substantive discussions) ☐ Yes — CareSource (substantive discussions) ☐ Yes — Amerigroup (substantive discussions) ☐ Introductory/exploratory discussions only ☐ No discussions with Georgia CMOs about value-based care models to date
SECTION 10: PAYMENT MODEL EXPERIENCE & CONTRACTING CAPACITY		
123 - 124	Has your hospital previously participated in any CMS Innovation Center (CMMI) models (e.g., CPC+, ACO REACH, BPCI, CHART)?	☐ Yes ☐ No If yes, which model(s) (Select all that apply): ☐ Comprehensive Primary Care Plus (CPC+) ☐ ACO REACH (or predecessor Global and Professional Direct Contracting) ☐ Bundled Payments for Care Improvement (BPCI/BPCI-A) ☐ CHART Model (Community Health Access and Rural Transformation) ☐ Other CMMI model: _____
125 - 135	Indicate which value-based payment models your hospital has participated in.	MSSP (upside only): ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A MSSP (two-sided risk): ☐ Yes ☐ No ☐ Active ☐ Completed

#	Question	Response
		Performance: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A BPCI/BPCI-A: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A Primary Care PMPM: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A Pay-for-Performance: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A MIPS: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A Commercial VBC: ☐ Yes ☐ No ☐ Active

#	Question	Response
		Performance: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A Medicaid Managed Care VBC: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A PCMH: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A Other: ☐ Yes ☐ No ☐ Active *Performance*: ☐ Majority exceeded targets ☐ Mix above/below ☐ Majority below targets ☐ Not assessed/N/A
136	Provide the total years of cumulative value-based care experience across all models.	Enter number (estimate acceptable):_____
137 - 138	Has your hospital ever exited a value-based arrangement prior to contract completion?	☐ Yes ☐ No If yes, please describe the circumstances: _____
139 - 156	Please indicate which payer types have an active VBC arrangement, the type of arrangement, and % revenue.	Medicare FFS: Active VBC arrangement? ☐ Yes ☐ No

#	Question	Response
		Type (Select all that apply): ☐ Pay-for-Performance only ☐ Shared savings (upside only) ☐ Shared savings with downside risk ☐ Episode/bundled payment ☐ Other Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50% Medicare Advantage: Active VBC arrangement? ☐ Yes ☐ No Type (Select all that apply): ☐ Pay-for-Performance only ☐ Shared savings (upside only) ☐ Shared savings with downside risk ☐ Episode/bundled payment ☐ Other Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50% Medicaid FFS/DCH: Active VBC arrangement? ☐ Yes ☐ No Type (Select all that apply): ☐ Pay-for-Performance only ☐ Shared savings (upside only) ☐ Shared savings with downside risk ☐ Episode/bundled payment ☐ Other Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50% Medicaid Managed Care: Active VBC arrangement? ☐ Yes ☐ No Type (Select all that apply): ☐ Pay-for-Performance only ☐ Shared savings (upside only) ☐ Shared savings with downside risk ☐ Episode/bundled payment ☐ Other Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50%

#	Question	Response
		Commercial: Active VBC arrangement? ☐ Yes ☐ No Type (Select all that apply): ☐ Commercial: Pay-for-Performance only ☐ Commercial: Shared savings (upside only) ☐ Commercial: Shared savings with downside risk ☐ Commercial: Episode/bundled payment ☐ SHBP: Pay-for-Performance only ☐ SHBP: Shared savings (upside only) ☐ SHBP: Shared savings with downside risk ☐ SHBP: Episode/bundled payment ☐ Other:_____ Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50% Other: Active VBC arrangement? ☐ Yes ☐ No Type (Select all that apply): ☐ Pay-for-Performance only ☐ Shared savings (upside only) ☐ Shared savings with downside risk ☐ Episode/bundled payment ☐ Other Approx. % of Net Patient Revenue under VBC: ☐ <5% ☐ 5–10% ☐ 11–25% ☐ 26–50% ☐ >50%
157	Which of the following best describes how your hospital engages in value-based contract negotiation and execution?	Select all that apply: ☐ Fully independent contracting authority ☐ System-led contracting (hospital part of a health system) ☐ Clinically Integrated Network (CIN) contracting ☐ ACO-led contracting ☐ Joint contracting/delegated authority model ☐ Third-party convener or management services organization (MSO)

#	Question	Response
		☐ Hybrid model (different structures by payer/line of business) ☐ No current value-based contracting authority ☐ Other: _____
158 - 159	Does your hospital have access to legal counsel with healthcare contract and value-based payment expertise?	☐ Yes ☐ No Source of legal support: ☐ Internal ☐ External ☐ Health system ☐ None
160 - 161	Does your hospital have access to actuarial resources for financial modeling of risk-bearing arrangements?	☐ Yes ☐ No If yes, what is the source of actuarial support: ☐ Internal ☐ External ☐ Health system ☐ None
162	Who leads payer contract negotiations at your hospital?	Select all that apply: ☐ CFO ☐ CEO ☐ CMO/Medical Director ☐ Revenue Cycle Director ☐ Legal ☐ Health System Contracting Team ☐ External Consultant ☐ Other: _____
163	How familiar is your hospital leadership with the CMS AHEAD Model's hospital global budgets (HGB) methodology?	Select one: ☐ Not familiar ☐ Limited familiarity — heard of the model but have not reviewed the details ☐ Somewhat familiar — aware of model design but have not done detailed analysis ☐ Very familiar — we have reviewed the 2023 NOFO and understand the methodology structure
164 - 166	Is your hospital currently a member of an ACO?	Select one: ☐ Yes — ACO holds financial accountability/risk for cost and quality ☐ Yes — ACO participation without downside financial risk ☐ Former member (no longer participating)

#	Question	Response
		☐ No current ACO participation If yes (current or former): ACO name(s): _____ ACO role (Select all that apply): ☐ Governing board representation ☐ Clinical leadership participation ☐ Data sharing/analytics only ☐ Attribution without governance role
167	Which of the following partnership types does your hospital currently maintain to support coordinated, population-based care?	Select all that apply: *Formal, Contractual Partnerships:* ☐ Clinically Integrated Network (CIN) ☐ Contractual care management agreement with PCPs ☐ Shared savings/risk-based agreement with physician groups ☐ Contracted partnerships with CBOs (housing, food security, BH) ☐ Other formal partnership: _____ *Informal/Operational relationships:* ☐ Informal referral or care coordination agreements ☐ Shared care pathways or protocols (noncontractual) ☐ Data sharing without financial alignment ☐ Ad hoc collaboration only
168	How would your hospital describe its current readiness to align cost growth performance across all payers simultaneously?	Select one: ☐ Early Stage — payer-specific strategies, limited cross-payer data visibility ☐ Developing — partial alignment across contracts, growing enterprise analytics ☐ Advanced — unified strategy, aligned incentives, enterprise analytics, payer-agnostic care models

#	Question	Response
169 - 170	Does your hospital have dedicated staff responsible for managing payer contract performance and compliance?	Select one: ☐ Yes — dedicated managed care contract management staff ☐ Yes — managed care contracting managed within broader finance, quality, or revenue cycle roles ☐ No — managed care contract oversight is minimal or ad hoc Roles supporting contract management (Select all that apply): ☐ Managed care/Payer contracting ☐ Finance/FP&A ☐ Revenue cycle ☐ Quality/Performance improvement ☐ Population health/Care management ☐ Analytics/Decision support ☐ Legal/Compliance ☐ External vendor or consultant ☐ Other: _____
171 - 173	Does your hospital monitor performance against managed care contract terms?	Select one: ☐ Yes — routinely and systematically ☐ Yes — limited or ad hoc ☐ No — not actively monitored *Elements monitored (Select all that apply):* ☐ Payment rates and reimbursement accuracy ☐ Utilization management (prior auth, LOS, denials) ☐ Quality or pay-for-performance metrics ☐ Cost/efficiency benchmarks ☐ Attribution, member volumes, or service mix ☐ Contractual incentives, withholds, or penalties

#	Question	Response
		☐ Not applicable Frequency: ☐ Monthly ☐ Quarterly ☐ Annually ☐ Ad hoc/issue-driven
174 - 175	Does your hospital have the reporting infrastructure to submit claims, quality measures, and utilization of data required under VBC contracts?	Select one: ☐ Yes — automated or standardized reporting ☐ Yes — manual or partially manual reporting ☐ No — reporting depends primarily on payer-provided data *Systems/sources supporting reporting (Select all that apply):* ☐ EHR reporting tools ☐ Claims/billing systems ☐ Contract management or reimbursement modeling software ☐ Enterprise data warehouse ☐ Quality reporting systems ☐ Payer portals or dashboards ☐ CIN/ACO analytics platform ☐ External analytics/reporting vendor ☐ Other: _____
176 - 177	Has your hospital conducted a gap assessment of its contracting infrastructure relative to global budget model requirements?	☐ Yes ☐ No If yes, primary gaps identified (Select all that apply): ☐ Contract performance visibility across payers ☐ Timely access to claims or utilization data ☐ Financial modeling of alternative payment terms ☐ Contract interpretation or compliance tracking ☐ Care management alignment with payer requirements

#	Question	Response
		☐ Governance or decision-making processes ☐ Staffing or expertise constraints ☐ Other: _____
178	Overall, how would you characterize your hospital's managed care contracting infrastructure maturity?	Select one: ☐ Advanced — proactive contract management across payers with strong analytics and governance ☐ Moderate — effective contract oversight, limited advanced analytics or modeling ☐ Basic — reactive or compliance-focused contract management ☐ Limited — minimal infrastructure beyond claims payment and issue resolution
179	What is your hospital's primary barrier to expanding value-based contract participation?	Select all that apply: ☐ Insufficient data infrastructure or analytics capacity ☐ Limited legal or actuarial support ☐ Lack of payer willingness to engage in VBC arrangements ☐ Leadership or board-level uncertainty about risk ☐ Inadequate financial reserves to absorb downside risk ☐ Workforce or operational capacity constraints ☐ Limited familiarity with available models ☐ Fragmented payer mix — no single payer represents sufficient volume for sustainable risk accountability ☐ Other: _____
SECTION 11: HEALTH IT, DATA & ANALYTICS		

#	Question	Response
180	Which of the following population health and performance reporting functions does your EHR currently support?	Select all that apply: ☐ Patient registries ☐ Care gap identification ☐ Risk stratification or patient segmentation ☐ Automated quality measure reporting ☐ None of the above ☐ Other: _____
181	Does your EHR support structured data capture for CMS and state quality reporting?	Select one: ☐ Yes ☐ Partial ☐ No
182	Do most affiliated providers in your service area use the same EHR platform as your hospital?	Select all that apply: ☐ Yes — same EHR platform ☐ No — different EHR platform ☐ Unsure
183	How are patient records typically exchanged between your hospital and affiliated providers using different EHR systems?	Select all that apply: ☐ Electronic exchange (e.g., HIE, Direct, interfaces) ☐ Electronic exchange, but not routinely integrated into workflows ☐ Manual exchange (fax, portal access, scanned documents) ☐ No routine exchange ☐ Other: _____
184	How would you describe your hospital's current interoperability capabilities?	Select one: ☐ Fully interoperable with external partners using recognized standards ☐ Interoperable with select partners or limited use cases ☐ Limited interoperability capabilities

#	Question	Response
		Comments: _____
185	Which interoperability standards or frameworks does your hospital support?	Select all that apply: ☐ HL7 interfaces ☐ FHIR APIs ☐ Direct secure messaging ☐ Health Information Exchange (HIE) participation ☐ TEFCA participation ☐ None ☐ Other: _____
186	Does your hospital have access to clinical claims data?	Select all that apply: ☐ Medicare (e.g., MSSP, ACO REACH, other CMS programs) ☐ Medicare Advantage ☐ Medicaid FFS ☐ Medicaid Managed Care ☐ Commercial payers ☐ Through a health system, CIN, or ACO partner ☐ No, we do not currently receive claims data ☐ Unsure ☐ Other: _____
187	Does your hospital currently perform eCQM reporting using QRDA (electronic Clinical Quality Measures / Quality Reporting Document Architecture) files?	Select one: ☐ Yes ☐ No
188	How is eCQM/QRDA reporting primarily managed?	Select one:

#	Question	Response
		☐ Fully internal (hospital staff using internal systems) ☐ Internal with limited external support (e.g., consulting, validation) ☐ Hybrid (shared responsibility between internal team and vendor) ☐ Fully outsourced to a third-party vendor
189	Which of the following challenges has your hospital experienced with eCQM/QRDA reporting?	Select all that apply: ☐ Limited internal staff expertise ☐ Difficulty extracting data from EHR systems ☐ Data quality or completeness issues ☐ Complexity of QRDA file generation/validation ☐ Vendor limitations or performance issues ☐ Cost of third-party solutions ☐ Keeping up with changing measure specifications ☐ Lack of interoperability between systems ☐ Time/resource burden on staff ☐ No significant challenges
190	Are care managers and clinicians able to easily access and use patient-level reports to identify care gaps, missed follow-up visits, or chronic disease management needs?	Select one: ☐ Yes ☐ Limited ☐ No
191 - 192	To what extent have connectivity or poor network issues affected your hospital's ability to exchange clinical data, participate in HIE or transmit quality reporting data?	Select one: ☐ Not at all ☐ Some challenges but able to transmit ☐ Not able to reliably transmit If answered "Some Challenges" or "Not Able to Reliably Transmit", please explain. _____

#	Question	Response
193 - 194	What level of broadband connectivity is available at your hospital?	Select all that apply: ☐ Fiber ☐ Cable ☐ DSL ☐ Satellite Comments on how connectivity affects HIT performance, data exchange, and telehealth: _____
195-196	What level of broadband connectivity is available at your affiliated clinics?	Select all that apply: ☐ Fiber ☐ Cable ☐ DSL ☐ Satellite Comments on how connectivity affects HIT performance, data exchange, and telehealth: _____
197	What telehealth services are currently offered?	Select all that apply: ☐ Primary care/Primary care follow-up ☐ Behavioral health (including psychiatry and counseling) ☐ Specialty physician consultations (non-emergency) ☐ Emergency department telehealth/Tele-emergency ☐ Tele-ICU/Critical care ☐ Stroke (Telestroke) ☐ Maternal health/Obstetrics (including maternal-fetal medicine) ☐ Cardiology ☐ Remote patient monitoring (RPM) ☐ Chronic disease management ☐ Post-discharge follow-up/Care management ☐ Telepharmacy ☐ Infectious Disease ☐ eConsults/Asynchronous specialty consultations ☐ Other: _____

#	Question	Response
		☐ None
198	Does your hospital participate in telehealth partnerships with larger health systems or academic medical centers?	Select one: ☐ Yes ☐ No
199	What percentage of telehealth visits occur via video versus audio-only modalities?	Percentage of telehealth visits via video vs. audio-only: ☐ 0–20% ☐ 21–40% ☐ 41–60% ☐ 61–80% ☐ 81–100%
200	Where is patient scheduling primarily handled?	Select all that apply: ☐ Within the EHR ☐ Billing/practice management system ☐ Billing/practice management system
201	Does your hospital use a centralized scheduling model?	Select one: ☐ Yes — centralized ☐ Partially centralized ☐ No — decentralized
202	Do patients have the ability to schedule or request appointments electronically within a patient portal?	Select one: ☐ Full self-scheduling capabilities ☐ Appointment requests only ☐ No
203	Is scheduling data routinely used for care coordination or care management?	Select one: ☐ Yes ☐ Limited/ad hoc ☐ No

#	Question	Response
204	Are there known limitations or challenges with current scheduling workflows?	Select all that apply: ☐ Capacity constraints ☐ Limited visibility ☐ Manual processes ☐ System limitations ☐ None ☐ Other: _____
205	Do patients have access to an online patient portal?	Select one: ☐ Yes ☐ No
206	Does your hospital support digital check-in or registration?	Select one: ☐ Yes — EHR-based ☐ Yes — third-party tool ☐ No
207 - 208	Does your hospital use any tools for appointment reminders, patient messaging, remote outreach, or surveys?	Select all that apply: ☐ Appointment reminders ☐ Patient messaging ☐ Remote outreach campaigns ☐ Patient surveys ☐ None If yes, please specify tool(s) used:
209 - 210	Does your hospital maintain a formal information security policy?	Select one: ☐ Yes ☐ No Comments:
211	Do staff receive annual security and privacy training?	Select one:

#	Question	Response
		☐ Yes – All staff (including contractors and clinical staff with system or PHI access) complete required annual training ☐ Limited – Training is provided but not consistently completed by all staff, not conducted annually, or not enforced across all roles ☐ No – Training is not provided
212	Does your hospital maintain role-based access controls?	Select one: ☐ Yes ☐ No
213	Who approves data sharing agreements?	Select all that apply: ☐ Compliance ☐ Legal ☐ IT ☐ Executive Leadership ☐ Other: _____
214	Is multi-factor authentication enforced?	Select one: ☐ Yes ☐ No
215	How many reportable PHI security incidents has your hospital experienced in the past 3 years?	Select one: ☐ 0 ☐ 1 ☐ 2–3 ☐ 4+
216	What are your hospital's biggest constraints related to data, reporting, or analytics?	Select all that apply: ☐ Staffing ☐ Technology limitations ☐ Budget

#	Question	Response
		☐ Competing priorities ☐ Other: _____