

IRDAI-NHA JOINT WORKING GROUP

Report of Network Hospital Management

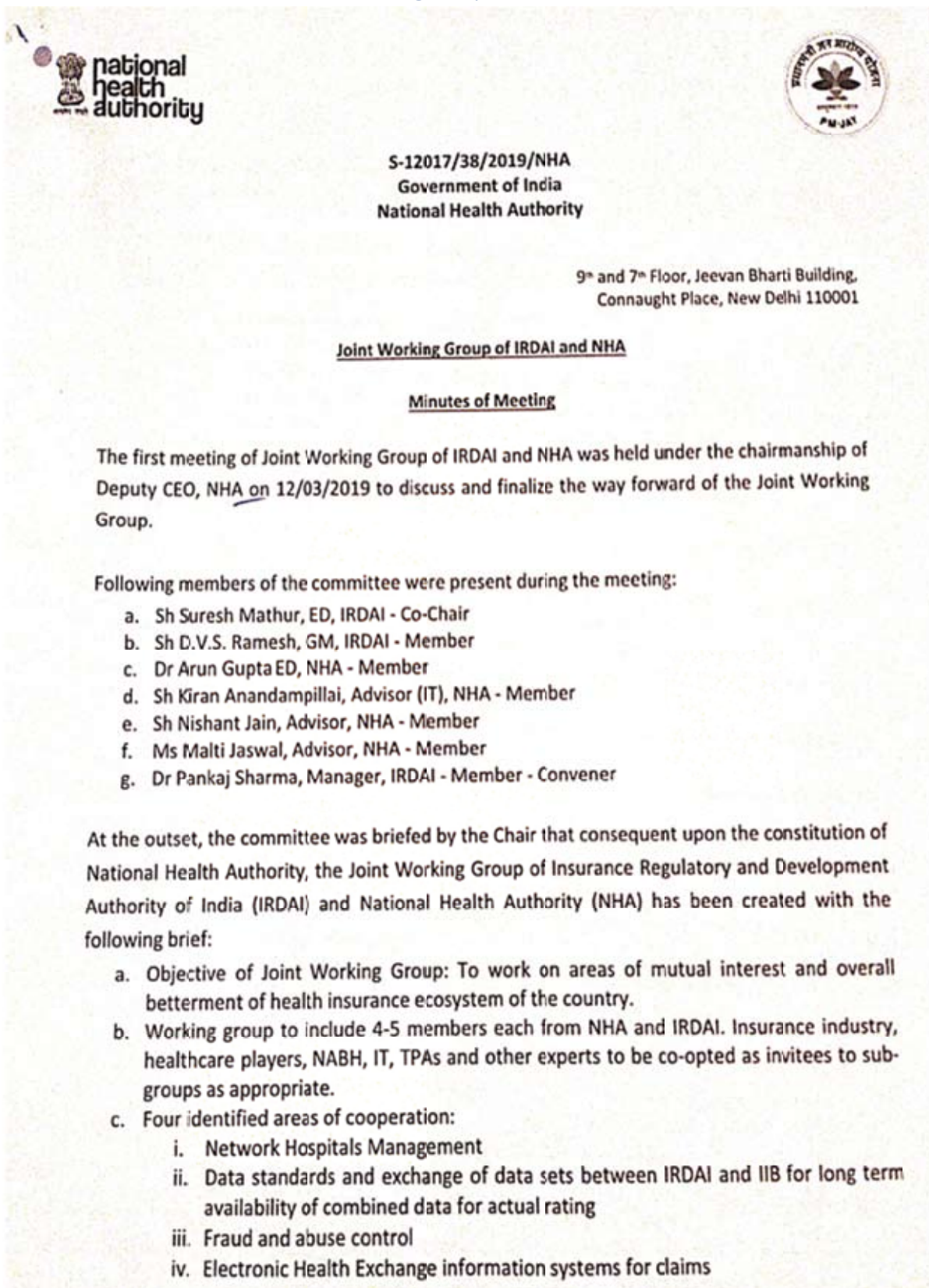
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Establishment of IRDAI-NHA Subgroup-1



With the permission of Chair, Sh Jagdeesha Reddy, Head of Health-IIB, Ms. Geetali Tare, ED-Finance, NHA and Mr. Surendra Tiwari, GM-Operations, NHA were part of the meeting.

The Joint Working Group had detailed discussions and deliberations during the meeting and agreed upon the following related to individual Groups:

1. Group: Network Hospital Management

- i. Chair – Sh Nishant Jain
- ii. Other Members - Mr. Kunnel Prem, Dr Arun Gupta, Dr. Pankaj Sharma
- iii. Co-opted Non-Members - CHI (NIN), GIC (Apollo Munich - Dr. Bhatatosh Mishra), QCI, NATHEALTH, AHPI, Ms. Geetali Tare, CBHI (NHRR), Ms. Sheena Chhabra
- iv. Timelines
  - a) Final Report : 3 months
  - b) 1st update to IRDAI Chairman & NHA CEO : 15/04/19
  - c) Meetings : Fortnightly
- v. Objectives of the Sub-Group:
  - a) Defining Hospital infrastructure and Facility Audits to understand capacity of Hospitals, Specialists availability
  - b) Developing a roadmap to get one Common list of Accredited / Verified hospitals for the entire industry including ROHINI, NHRR, NIN & PMJAY databases
  - c) Comparative Studies of Packages and their rates and mapping to uniform codes
  - d) Defining Standards and indicators for safe & quality Healthcare to patients
- vi. Discussion Points
  - a) Develop a common digital data format for hospital facility information that can be used by all the stakeholders for empanelment, analysis etc. The common data format to be accessible to all stakeholders via a central repository.
  - b) Devise an approach for mapping of packages with uniform codes
  - c) Defining Standards and indicators for safe & quality Healthcare to patients

Composition of the 'Subgroup-1 Network Hospital Management'

1. Chair: Dr. Nishant Jain,
2. Members:
  - a. Mr. Kunnel Prem,
  - b. Dr. Arun Gupta,
  - c. Dr. Pankaj Sharma
3. Co-opted Members:
  - a. Ms. Geetali Tare,
  - b. Dr. Bhabatosh Mishra,
  - c. Ms. Sheena Chhabra,
  - d. Representatives of Centre for Health Informatics (NIN),
  - e. Representatives of Quality Council of India (QCI),
  - f. Representatives of NATHEALTH,
  - g. Representatives of AHPI,
  - h. Representatives of Central Bureau of Health Intelligence (NHRR)

Executive Summary

In the past, there have been several efforts by both Central and State Governments to strengthen the demand side in the health sector by launching various Government-funded health insurance schemes to reduce ever increasing out-of-pocket expenses. After trying several initiatives, GoI has adopted two pronged approach under the umbrella of Ayushman Bharat. The first part of this strategy is of disease prevention and health promotion through upgradation of the existing network of Sub centres and Primary Health Centres to Health and Wellness Centres (HWC). The second part of the strategy is the Pradhan Mantri Jan Arogya Yojana (PM-JAY) which aims to create a system of demand-led health care reforms that meets the immediate hospitalisation needs of the eligible beneficiary family in a cashless manner thus insulating the family from catastrophic financial shock.

The insurance industry of India consists of nearly 63 life and non-life insurance companies. Other stakeholders in the Indian insurance market include agents (individual and corporate), brokers, surveyors and third-party administrators servicing health insurance claims. The government's policy of insuring the uninsured has gradually pushed insurance penetration in the country and led to a proliferation of insurance scheme. The future looks promising for the life insurance industry with several changes underway in the regulatory framework which will transform the way the industry conducts its business and engages with its customers. India currently is one of the lowest public spenders on health (1.46% of the GDP) with one of the highest out-of-pocket spending on health care. Amongst the developing economies, India is one of the least insured countries with commercial health insurance penetration hovering around 5% of Indian population. With increase in life expectancy and awareness, the ever-increasing middle-class population is understanding the need for investing in health financial risk protection in the form of health insurance. Also, with the launch of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), the percentage of the Indian population (approximately 65%) with some form of health financial risk protection tool (health insurance) has increased substantially.

With different schemes providing different benefit covers and varied health care providers, there lacks a coordinated approach and loss of potential efficiency and cost effectiveness due to having fragmented pools. Strong coordination and long-term convergence amongst current schemes can bring coherence in health care financing and will be beneficial in addressing

efficiency and equity challenges for the system. Keeping in mind the potential benefits of convergence in the health insurance space in the country and to coordinate on similar functions to avoid duplicity and to bring uniformity utilising each other's strengths, a Joint Working Group of NHA and IRDAI was formed. The primary objective of the subgroup is to work on areas of mutual interest and overall betterment of the health insurance ecosystem in the country and one of the area of cooperation was identified as 'Network Hospital Management'. This group was aimed at having common list of hospital infrastructure and facility audits with convergence of varied hospital registration mechanisms; harmony amongst health benefit packages and mapping of universal codes and defining standards and indicators for safe and quality health care to patients.

Currently each scheme/private insurance have individual hospital empanelment process, which replicates various activities and contribute to inefficiency and duplication of processes. It is recommended to have common empanelment portal which can be utilized by all the schemes/insurance companies with standardized empanelment criteria will be hugely beneficial with special focus on standard safety and quality parameters. It is also recommended to have single unique hospital registration process and repository, ideally ROHINI, instead of having several lists. This list will be beneficial as central health facility repository/registration number can be used by various schemes and insurance service providers for identification of the health facilities in geographical areas. This subgroup also recommends having package cost harmonization amongst various schemes as currently difference between cost of similar packages vary substantially. It also recommends use of much adopted ICD-PCS for uniform coding of the benefit packages

Background

In the past, there have been several efforts by both Central and State Governments to strengthen the demand side in the health sector by launching various Government-funded health insurance schemes to reduce ever increasing out-of-pocket expenses. The Rashtriya Swasthya Bima Yojana (RSBY) was launched with a cover of INR 30,000 per family per year catering mostly to secondary care hospitalisation conditions while many State schemes catered to tertiary care conditions. However, these schemes worked independent of the larger health care system in the country and resulted in further increasing the fragmentation of risk pools. Additionally, none of these schemes had any linkage with primary health care.

To address these challenges, the Government of India has adopted a two-pronged approach under the umbrella of Ayushman Bharat. The first part of this strategy is of disease prevention and health promotion to curb the increasing epidemic of non-communicable diseases. This shall be ensured through upgradation of the existing network of Sub centres and Primary Health Centres to Health and Wellness Centres (HWC). Nearly 150,000 HWCs shall be opened in the country which shall work toward reducing the overall disease burden and hospitalisation needs of the population.

The second part of the strategy is the Pradhan Mantri Jan Arogya Yojana (PM-JAY). PM-JAY aims to create a system of demand-led health care reforms that meets the immediate hospitalisation needs of the eligible beneficiary family in a cashless manner thus insulating the family from catastrophic financial shock. In the long run, the PM-JAY, through its system of incentives, aims to bring the private sector to the unserved areas of tier-2 and tier-3 cities. For public hospitals, PM-JAY shall be a means to generate additional revenue without adding any significant additional effort. PM-JAY subsumes the existing RSBY and also converges with various State Government funded health insurance/ assurance schemes. PM-JAY is the world's largest fully Government funded health insurance scheme for providing coverage to nearly 10.74 crore (107.4 million) poor families of the country by providing financial protection for selected secondary and tertiary care hospitalisations.

The primary objectives of the PM-JAY are to reduce catastrophic out-of-pocket health expenditure, improve access to health care and meet the unmet need of the population for hospitalisation care.

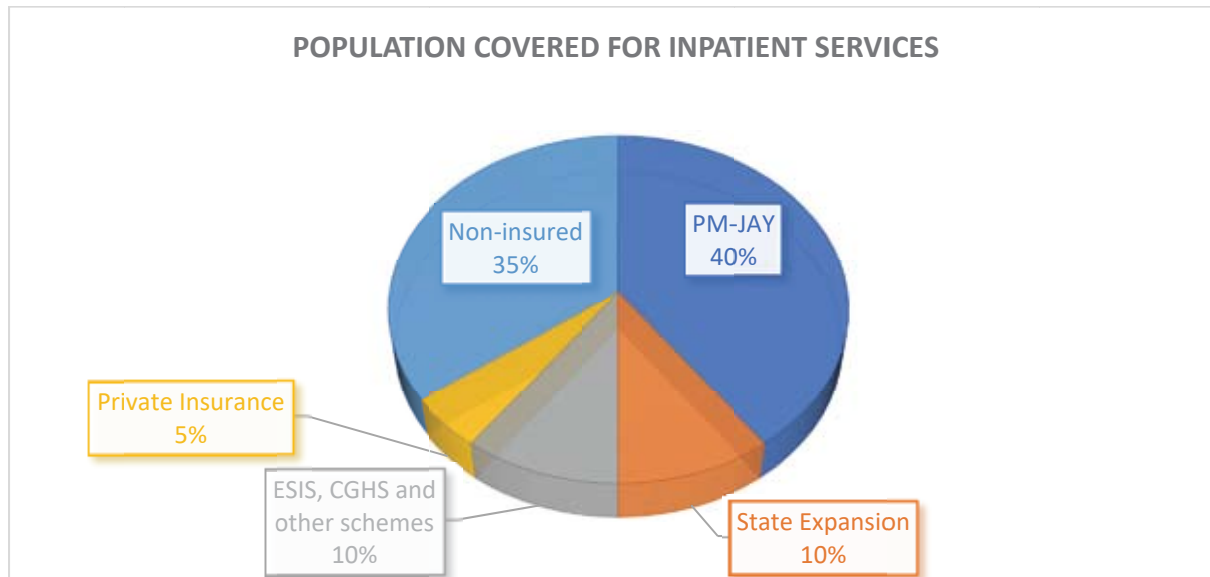
Insurance Sector in India- An Overview

The insurance industry of India consists of 63 insurance companies of which 24 are in life insurance business and 39 are non-life insurers (source: ibef.org). Other stakeholders in the Indian insurance market include agents (individual and corporate), brokers, surveyors and third party administrators servicing health insurance claims. The government's policy of insuring the uninsured has gradually pushed insurance penetration in the country and led to a proliferation of insurance schemes. Gross premiums written in India reached INR 5.53 trillion (US\$ 94.48 billion) in FY18, with INR 4.58 trillion (US\$ 71.1 billion) from life insurance and INR 1.51 trillion (US\$ 23.38 billion) from non-life insurance (source: ibef.org).

The future looks promising for the life insurance industry with several changes underway in the regulatory framework which will transform the way the industry conducts its business and engages with its customers. The overall insurance industry is expected to reach US\$ 280 billion by 2020 driven by increasing awareness, innovative products and more distribution channels (source: ibef.org). The life insurance industry in the country is expected grow by 12-15 per cent annually for the next three to five years. Demographic factors such as growing middle class, young insurable population and growing awareness of the need for protection and retirement planning will support the growth of Indian life insurance.

In the case of health insurance, the Indian market is optimistic due to key factors such as growing economy and huge uninsured population having enormous unmet needs for health care. India currently is one of the lowest public spenders on health (1.46% of the GDP) with one of the highest out-of-pocket spending on health care. Amongst the developing economies, India is one of the least insured countries with commercial health insurance penetration hovering around 5% of Indian population. With increase in life expectancy and awareness, the ever-increasing middle-class population is understanding the need for investing in health financial risk protection in the form of health insurance. In order to make available a standard health product across the industry IRDAI has recently issued a guideline for offering a standard health product by all insurers doing general and health insurance business. With the objective of providing the basic health insurance cover to customers to enable them to choose the coverage based on need, this product will help customers in getting standard coverage at affordable rates. This will also help in increasing health insurance penetration amongst the population. With the launch of Ayushman Bharat-Pradhan Mantri Jan Arogya Yojana (AB PM-JAY), the percentage of the Indian population with some

form of health financial risk protection tool (health insurance) has increased substantially. The following diagram describes the status of coverage of health financial risk protection especially for hospitalisation cover across the Indian population.



The diagram demonstrates that if we combine coverage provided by PM-JAY, other Central schemes, state schemes and private health insurance, then it can be seen that almost 65% of the population is covered by some sort of financial risk protection tool for hospitalisation cover in India. However, it is also important to note that with regard to outpatient coverage, only a small percentage of population is covered through existing schemes (CGHS, ESIS, Railways, etc.). Since the philosophy of the government is to provide primary care through the public health care system, substantial efforts are being made through the National Health Mission and HWCs to do so. With different schemes providing different benefit covers and varied health care providers, there lacks a coordinated approach and there is a loss of potential efficiency and cost effectiveness due to having fragmented pools. Each of these schemes is currently being operated without much linkage or coordination with other schemes. However, there is a lot of merit in developing an effective coordination mechanism between these schemes so as to improve their performance and also generate efficiencies. Strong coordination and long-term convergence amongst current schemes will bring coherence in health care financing and will address efficiency and equity challenges for the system. Keeping in mind the potential benefits of convergence in the health insurance space in the country and to coordinate on similar functions to avoid duplicity and to bring uniformity utilising each other's strengths, a Joint Working Group of

NHA and IRDAI was formed. The primary objective of the subgroup is to work on areas of mutual interest and overall betterment of the health insurance ecosystem in the country. Some major areas of cooperation for which IRDAI and NHA subgroups have been formed are as follows:

- a. Network Hospital Management
- b. Data Standards and exchange of data sets between IRDAI and IIB for long term availability of combined data for actual rating
- c. Fraud and Abuse Control
- d. Electronic Health Exchange Information System for Claims

Subgroup 1: Network Hospital Management

Subgroup 1 was formed under the chairmanship of Dr. Nishant Jain and members from NHA, IRDAI, and representatives of private health insurance companies, QCI, NATHEALTH, AHPI, CBHI and World Bank. Details of subgroup area have been attached on Page 3 to 5 of this report. The following are the major objectives of this subgroup:

1. Defining hospital infrastructure and facility audits to understand capacity of hospitals, specialists' availability
2. Developing a roadmap to get one common list of accredited/verified hospitals for the entire industry including ROHINI, NHRR, NIN and PM-JAY databases
3. Comparative studies of packages and their rates and mapping to uniform codes
4. Defining standards and indicators for safe and quality health care to patients

The subgroup aims at having a common digital data format for hospital facility registration. This registration database can act as a central, common repository of hospital database, which can be utilised by the stakeholders for empanelment, analysis, registration, etc. Currently, there are diverse and fragmented hospital databases, which is a duplication of almost similar efforts across several schemes, insurance companies and other stakeholders. Similarly, several health insurance schemes, private health insurance, etc., currently pay different costs for similar packages across hospitals in the country. This fragmented effort fails to utilise economies of scale as an empowered purchaser and puts the provider in charge of the negotiating process. If major purchasers of services converge on this critical activity, they will have the opportunity to not only bring more bang for the buck but also influence positive provider behaviour, which will not only

be beneficial to the health insurance industry but also to the beneficiaries/ subscribers of the health insurance services. The subgroup also aims at developing common quality and safety health care indicators for patients that can be utilised by the industry. These indicators will be basic common indicators which can be utilised to monitor safety and quality of services provided to the patients.

Each of the objectives mentioned above is detailed in separate sections in the following pages of this report and also provides recommendations and the way forward in achieving these objectives.

OBJECTIVE 1 Standardisation of Hospital
Empanelment

Background

Empanelment of the service provider is one of the key aspects in the health insurance business. It ensures quality of care and also screens hospitals for having defined processes and basic guidelines in place. In order to empanel the hospital, IRDA has provided definition of the hospital and also basic input parameters mandatory such as qualified medical and nursing staff, beds and having provision of maintaining daily records which can be utilised by insurance companies for claims adjudication and verification. For the empanelment, insurance companies or ISA apart from basic requirements can lay down information requirements relating to hospital facilities, infrastructure, manpower, etc. Public health insurance schemes too undertake empanelment of the hospitals to ensure that the health services delivered to its beneficiaries are safe and of acceptable quality for realising patient centric care. All activities working towards this strengthens and reinforces the primacy of an effective provider network, and its accountability towards the beneficiaries of the scheme. Empanelment is the aspect which while balancing adequate access would also ensure appropriate patient safety and quality. For empanelment of hospitals under AB PM-JAY, hospitals can be empanelled if they fulfil a minimum set of criteria related to infrastructure and other categories.

Currently there are several empanelment mechanisms followed by different insurance companies, TPAs, central government schemes, state schemes, etc. This creates duplication of efforts and leads to ambiguity amongst providers while complying with different norms. With the widening of the health insurance net and implementation of AB PM-JAY, strengthening the empanelment criteria shall be of paramount importance to address issues related to quality, patient safety and appropriateness of care. The strengthened empanelment process can be utilised across the industry and will ensure that minimum patient safety and quality norms are implemented across the country. It will drive genuine improvements in care delivery and eventually for improved health outcomes of the beneficiaries.

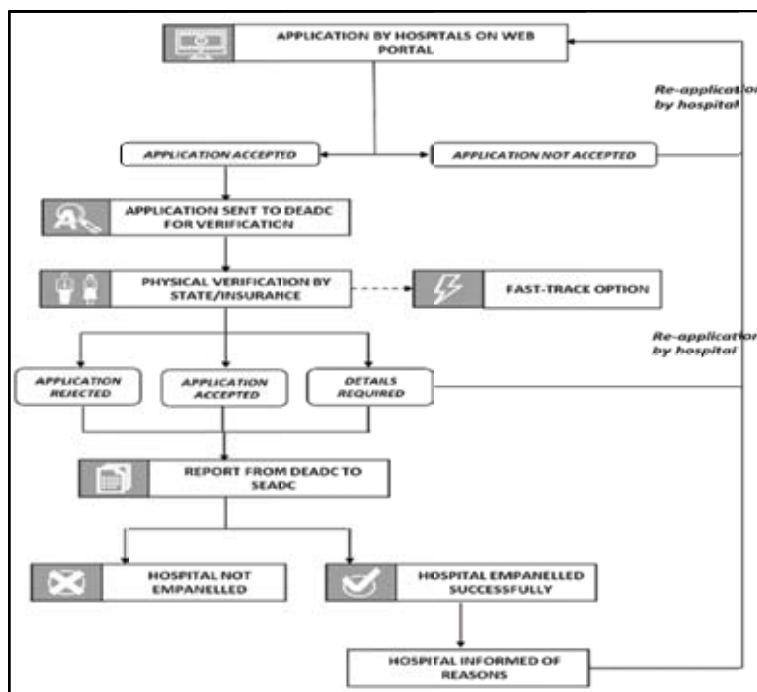
Hospital Empanelment Process under AB PM-JAY & State Schemes

Empanelment of hospitals under AB PM-JAY and state schemes are typically done by the agency which is implementing the scheme. The set of parameters associated with civil infrastructure (e.g. minimum number of beds), medical infrastructure (e.g. equipment), are developed as

precondition for the empanelment of any health care provider under government-sponsored health insurance scheme. AB PM-JAY has around 165 diverse parameters for categories of Hospital which include basic information, financial details, specialities offered, civil infrastructure, medical infrastructure, general services and manpower.

AB PM-JAY as well majority of state level insurance programmes have developed online portals for end-to-end empanelment process. The interested hospital having all the infrastructure as per the empanelment criteria can apply through the online portal. In turn to process the application, dedicated resources have been developed at district and state levels. The District level Empanelment Committee (DEC) is formed by representative from scheme administration, insurer, TPA and district health services. The major role of the DEC is to verify all the documents submitted by hospital, validate all the information by visiting the hospital, prepare and submit a report on its observation to the State level Empanelment Committee (SEC). The SEC holds the major power to approve or deny the hospital empanelment request as per the report received by DEC; however, the SEC may visit the hospital and cross-validate the information as per the report.

The process of empanelment starts once the empanelment request by a hospital is filed on the portal. As a first step, a member from the DEC verifies the documentation provided by the hospitals. The DEC committee visits the hospital and physically verifies all the submitted documents and validates proof of civil, medical infrastructure and other parameters. In case of any error, misrepresentation in documents,



the application is returned to the hospital for rectifying any errors in the documents. On physically inspecting the premises of the hospital and verification of the physical presence of the details entered in the empanelment application, the DEC team will submit its final inspection

report to the state through the portal. In this report, it provides its recommendation on whether the hospital should be empanelled or not based on their field-based inspection/verification.

The SEC has representation from SHA leadership, health department, medical officers, and the insurer. The SEC is responsible to approve or deny the empanelment request on the basis of reports submitted by the DEC. In case of refusal, the SEC will record in writing the reasons for refusal and can direct the hospital to remedy the deficiencies. The SEC also holds the right to visit the hospital and cross-verify the details furnished by the hospital.

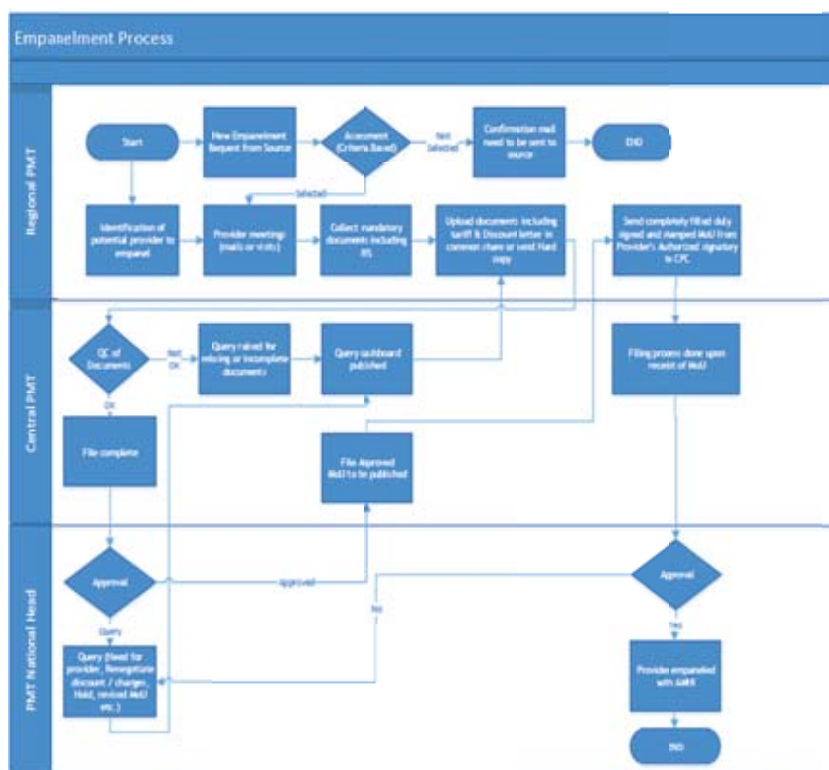
The empanelment process is a time-bound activity which takes place with the help of the online portal. Hospitals can see the status of their application; DEC and SEC can also request further information, documents from the hospital via the portal.

Industry & Private Insurer Empanelment Process

This has company specific empanelment parameters; however, the focus of empanelment is always on geographical distribution, infrastructure, cost effectiveness and quality of treatment. In addition, availability of dedicated staff and additional benefits that the hospital is offering to the customer is also considered for the empanelment.

Majority of insurance companies have their own online portal for the empanelment of hospital where they receive the request from hospitals. However in commercial insurance, empanelment

of the provider is key to having the appropriate number of hospitals so that the company is able to produce confidence among potential policy buyers.



The empanelment team conducts the research to identify potential hospitals for empanelment. If the hospital is willing, they upload the necessary documents to the portal for the application process. The regional PMT organises a meeting with the hospital staff to verify the details, validate the eligibility criteria and collect the necessary documents. Further, the regional PMT communicates the findings to the central PMT who conduct a quality check of documents and information provided by the hospital. Based on the reports received from central PMT, the national head of PMT is responsible for the approval and denial of the application. If the documents are satisfactory, then the application will get approved and it is sent to provider to get it stamped and signed by the authorised signatory. Upon receiving the signed MoU copy from the provider, filing process at central PMT level will take place and the provider is empanelled with the insurance company.

SUBGROUP FINDINGS

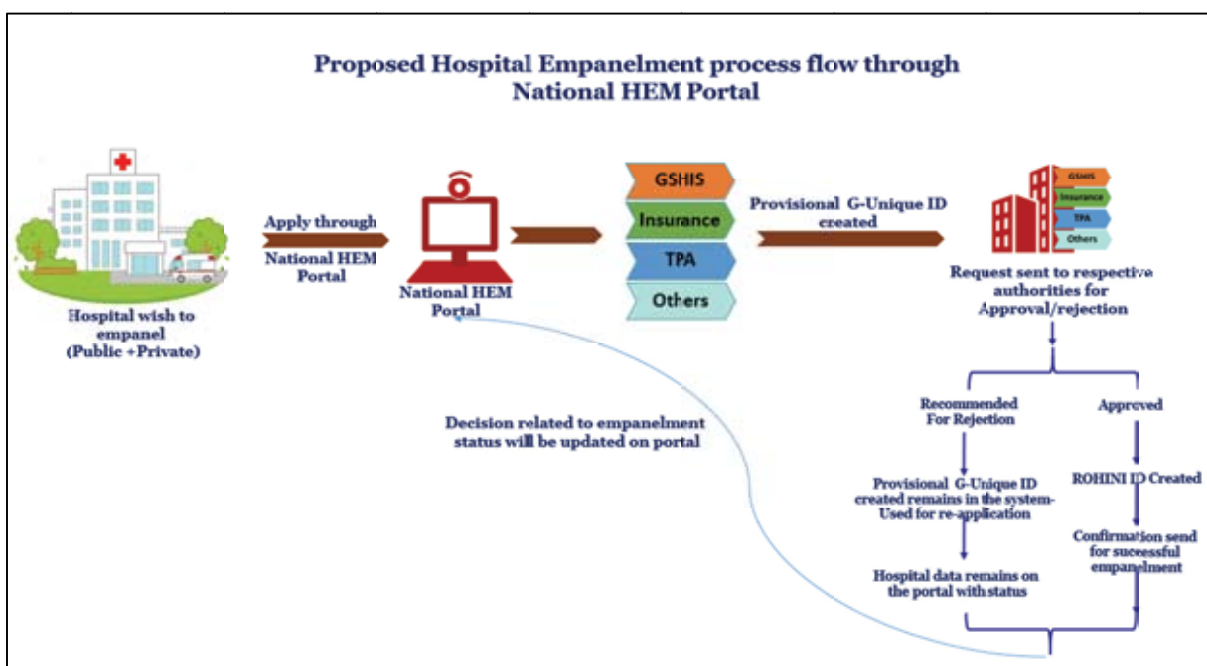
- The hospital empanelment process is very comprehensive in AB PM-JAY as well other government-sponsored health insurance schemes compared to private insurer industry.
- Empanelment parameters under the AB PM-JAY covers the larger ambit of hospital components including civil infrastructure, medical infrastructure, human resource details, legal, licensing requirement, financial details of the hospital, specialties offered, etc. However, apart from compulsory requirements mandated by IRDA, private health insurance and TPAs focus upon empanelment activity as per the availability of hospitals by geography and costing of packages, although basic infrastructure requirement and other parameters are similar.
- Hospital empanelment process is more structured and transparent on paper as per the guidelines in government-sponsored health insurance scheme, where the district and state level committees with the representation from all stakeholders share the responsibility of empanelment. However, in practice, it lacks constant monitoring and sustainable periodical screenings often due to lack of capacity and other issues faced by the schemes in implementation.

Recommendation

1. Common Empanelment Portal: National Hospital Empanelment Portal

Common empanelment portal can be developed for empanelment of hospitals which can be utilised by all schemes/ insurance companies/ TPAs as a common gateway to empanel the hospitals. This common portal will be useful in generating registration numbers to the hospitals meeting standardised empanelment criteria and also allow hospitals to apply for empanelment on different schemes where health insurance and TPAs may require scrutiny of a greater number of parameters. On meeting the standard empanelment criteria, ROHINI registration number can be generated and empanelment information of the hospital will be available to all the stakeholders interested in empanelling the hospital.

Detailed description of the process is as follows:



The public or private hospital will apply for empanelment using the common portal for empanelment under any public health insurance or with any health insurance or TPA. On applying for empanelment through the portal, they will be given a provisional unique ID and the application will be forwarded to respective scheme/ISA for scrutiny at their level. Required actions by respective stakeholders with regard to scrutiny of the facility for the purpose of empanelment will be taken and recommendation for approval/rejection of the application will be provided with detailed copies of the empanelment survey report. If the facility is recommended for empanelment, ROHINI ID will be generated which would mean that the facility meets minimum empanelment criteria required for the ROHINI ID.

Stakeholders can add parameters over and above standard empanelment criteria; however, their recommendation will be for standard empanelment criteria required for generation of ROHINI ID.

2. Standardisation of Empanelment Parameters

Standardisation of hospital empanelment efforts will not only simplify hospital empanelment process but will also ensure quality of care for the patients. It will also contribute towards equity in health care delivery as minimum quality will be ensured by empanelled hospitals irrespective of who is availing the services (i.e. whether it is beneficiary of the government scheme or subscriber of private health insurance). Insurance companies are free to build upon schemes and ISAs are free to add on additional empanelment criteria over standardised criteria.

3. Benchmark setting for the parameters

Benchmarking of the parameters may be based on following principles, however, basic empanelment criteria shall be met by all health care providers to ensure standardised quality of care across the industry.

- i. Location of the hospitals
- ii. Availability of service providers
- iii. Availability of required speciality in the vicinity

4. Utilisation of the same platform by accrediting bodies

This platform can be utilised by other accreditation bodies such as QCI, NHABH, etc., for hospitals in India where they can also use the same platform for the accreditation process.

See Annexure-1: Standard empanelment parameters

OBJECTIVE 2 Common List of Health Care Providers

Background

The health insurance industry has seen significant increase in the recent past through government-sponsored health insurance programmes and private/voluntary insurance in the country. Government-sponsored health insurance programmes like Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) aim to cover 40% population or around 50.74 million people. Similarly, state government programmes are further expanding coverage by increasing the financial security for health and ensuring cashless hospitalisation to the beneficiaries.

However, there is lack of information on availability of health care providers across the country. The information on availability of number of beds by speciality, doctors, paramedics, etc., is not available at one place. The Insurance Regulatory and Development Authority of India (IRDAI) and the health insurance industry have established various hospital database registries, however there is no common platform and data sharing between the various data registries present in the country. The subgroup developed by IRDAI has the mandate to develop a strategy to have one common data registry of hospitals to increase information on hospitals' availability in the country. This will also improve the access and reach of government-sponsored health insurance scheme.

Objective

- To examine the various hospital database registries available in the country, to understand the data elements, unique coding system, registration process and available health care establishment with various registries
- To define the standard common hospital registry for the country, which should include the common data elements, uniform coding system for the country

Registry of Hospitals in the Network of Insurance (ROHINI)

Hospitals registered under health insurance third-party administrator network are part of ROHINI. It enlists a total of 33,000 unique



and

hospitals and medical day-care centres. ROHINI registry is developed by Insurance Information Bureau of India (IIB), promoted by the Insurance Regulatory Development Authority of India (IRDAI). Registration under ROHINI is mandatory for all network hospitals as well as the

hospitals involved in cashless reimbursement claims or those that wish to provide this facility to be registered on ROHINI.

ROHINI can be accessed by various stakeholders including health care insurance companies, government bodies and regulators. ROHINI provides a 13-digit globally unique GS1 identifier ([GLN – Global Location Number](#)) to each of the listed hospitals/centres along with geo-coding of its address, thus preventing duplicate listing, and enables faster processing of insurance claims. ROHINI brings greater visibility to the hospitals and health care facilities across the nation. It facilitates fast, reliable and relevant analytical reporting at national, state, and regional level on geography-based trends, patterns of disease occurrence, cost patterns, etc. It provides authenticity thereby preventing insurance frauds due to misleading hospital information and facilitates information sharing among the various stakeholders of the insurance industry.

National Identification Number (NIN)

The Ministry of Health and Family Welfare (MoHFW) introduced the process for generating a National Identification Number (NIN) for all Health Facilities of India. The NIN Web Portal has been developed by the Centre for Health Informatics. The portal provides the platform to health care facilities to enter basic information and upon verification it generates the NIN number. The NIN number is a random but unique 10-digit number within India; it will be permanent for that health facility. To identify the accurate geographical location of the health facility, attributes like state, district, taluka, village codes based on MDDS (Meta Data & Data Standards) will be attached to NIN. As per the guidelines, the particular health facility should use the NIN number for all health applications to ensure inter-operability among programmes.

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY)

Ayushman Bharat Pradhan Mantri Jan Arogya Yojana (AB PM-JAY) has developed a rigorous empanelment process and uses the sophisticated Hospital Empanelment Management (HEM) solution for end-to-end empanelment. AB PM-JAY has around 15,680 unique hospitals. HEM software also generates the unique 12-digit number with combination of geographical attributes like state code, entity type and 4 to 5 digits random number. PM-JAY hospital registry has a very comprehensive database on infrastructure, human resources, and specialities offered by the hospital.

National Health Resource Repository (NHRR)

The National Health Resource Repository (NHRR) is the census of health care establishments, and collects data of all public and private health care facilities in the country. The NHRR registry aims at strengthening evidence-based decision making and developing a platform for citizen and provider-centric services by creating a robust, standardised and secured IT-enabled repository of India's health care resources. NHRR provides comprehensive data on all health resources including health facilities, doctors, chemists and diagnostics labs. It undertakes regular monitoring and impact assessment and engages in evidence-based monitoring of health facilities. The NHRR helps to harmonise public health information for judicious health resource allocation, management and monitoring through real world intelligence. Apart from allocating a unique hospital number, it also gives an insight on private sector engagement.

SUBGROUP FINDINGS

- There are multiple hospital database registries in the country and potentially risk duplication of efforts on collection and managing hospital data.
- Lack of convergence across registering bodies.
- The various hospitals registries are established for certain category of hospitals.
- Each registry has different parameters or data points with respect to the hospital infrastructure and other information.
- ROHINI is one of the most comprehensive hospital database registries available in the country with 33,000 unique hospitals from private industry.
- The ROHINI hospital code is a 13-digit globally unique GS1 identifier number, allotted to each hospital.
- The NHRR database on health care establishment in India is also comprehensive and includes public, private, trust hospitals from all over the country.
- The NHRR includes detailed information on civil infrastructure, medical infrastructure, human resources, services offered, utilisation and financial information of the hospitals.

Recommendation

1. Identification of unique hospitals

As there are multiple registries of hospitals available with some unique as well the common hospitals. The exercise to find out the unique hospitals from all different registries can be conducted. IIIB have been conducting a similar exercise, where the hospitals registered with different insurer, TPAs were analysed to identify the unique hospitals to further register under the ROHINI database. The Sub-group has recommended that the data from different hospital registries should be shared with the IRDAI/IIIB. Duplication of hospitals can be found out using unique identifier, e.g. PAN, TAN, etc.

NHRR data is a comprehensive database as it has line-listing of health care facilities from all parts of country and the details of each hospitals irrespective of hospital engagement with the insurance programme. The Sub-group has recommended that NHRR data can also be used to identify the actual number of health care facilities in the country and the gaps in coverage under the insurance programme. Hospitals from rural, remote and hard-to-reach areas can be found using the NHRR data to further engage and improve the access.

2. Common Hospital Registry

To promote the standardisation and effective utilisation of health care infrastructure under the insurance programme, a common platform of hospital information can be developed. The Sub-group has recommended that a unique common hospital registry needs to be developed in the country. In the way forward, utilising the common registration and empanelment portal, as recommended in Objective 1, shall be explored.

The portal will possess information on engagement of hospital with insurance programme or any other government scheme. Hospital information captures the geographical information of hospitals including the infrastructure, manpower, accreditation and facilities/specialities offered details. This registry should be dynamic in nature where the hospital administration can modify the details anytime using the portal. The Sub-group recommends using the ROHINI as a common hospital registry.

3. **ROHINI as common registry across the hospitals**

A unique hospital number will be useful for data sharing, inter-operability, portability across the scheme. It will also promote data sharing for fraudulent practices, misconduct, legal action, etc., to all the stakeholders and curb malpractices among the hospitals.

ROHINI has 13-digit globally unique GS1 identifier (GLN – Global Location Number) for each listed hospital/centre. It further has geo-coding of its address to prevent duplicate listing.

4. **Including Public hospitals under ROHINI**

As majority of private hospitals are already registered and part of the ROHINI database, it is important to bring public hospitals under the ROHINI database to meet the goal of a common hospital registry in the country. The Sub-group has proposed that public hospitals serving under the insurance programme, mostly CHCs and above, should get free ROHINI registration. The IRDAI and appropriate government authorities can facilitate and device a mechanism to ensure the public facility registration on ROHINI.

See Annexure 2: ROHINI Registration form to understand the data points and parameters required for hospital registry

OBJECTIVE 3 Uniform Package Rates and Codes

Background

Traditionally, development of package rates under government-sponsored health insurance schemes (GSHIS) is conducted at the time of design and planning of the programme. Clinical experts from health industry are involved in defining the cost of packages. Private health insurance industry also defines the base rates and negotiates with the hospital to arrive at better rates. Given the situation and increasing beneficiary base under government schemes as well private insurance, having uniform package rates and codes will improve the acceptance of insurance mechanism and reduce market destruction. Uniform package cost will also improve the quality of care by standardising care through treatment protocols.

Objective

- To understand the development of package cost and variation under various GSHIS and private health insurance industry
- Document the cost variation among the various GSHIS and insurance products
- Develop the strategy for uniform package cost across the GSHIS and insurance industry
- Develop the roadmap for use of uniform package codes/ nomenclature across the GSHIS and insurance industry

Figure 3 Number of Packages

The coverage under GSHIS across the various states are enormous, some scheme covers only secondary care services, while other cover tertiary care and scheme likes CGHS covers the comprehensive care services. The number of packages, their cost, number of specialities are differs scheme to scheme across the GSHIS and private insurance industry.

Scheme	# of Packages
PM-JAY	1394
Tamil Nadu	3204
Karnataka	1651
Chhattisgarh	1426
CGHS	1701
Pvt. Insurance	Avg 850

The differences across the cost of packages in GSHIS are very huge, as evidence shows a high difference of more than INR 10,000 in majority of tertiary care packages. Andhra Pradesh is paying higher amount than other states for the same package. Example: For Submandibular Mass Excision+ Reconstruction, AP is paying three times the cost

and Kerala is paying five times lower rates in comparison to the national package rate. In general, Kerala is paying lower rates for most packages.

Tertiary care packages	ABPM-JAY National	CG	AP	Kerala	Difference between lowest and highest
PTCA - single stent (medicated, inclusive of diagnostic angiogram)	65000	75000	65010	65000	10000
Fracture - Hip Internal Fixation (Intertrochanteric Fracture with implant) + rehabilitation	17000	17000	30000	13425	16575
Closed Reduction and Percutaneous Nailing	20000	20000	30000	9000	21000
TURP-Transurethral Resection of the Prostate, BPH, Monopolar/Bipolar/Laser	25000	30000	30000	40000	15000
Total Hip Replacement (cementless)	75000	75000	75000	80000	5000
Linear Accelerator, External Beam Radiotherapy 3D CRT/2D Planning (Radical/Adjuvant/ Neoadjuvant)	50000	50000	95000	50000	45000

Amounts in INR

Figure 4 Tertiary care package rates across various schemes

In case of tertiary packages, there is also variation in rates for similar packages across states as mentioned in the table. For linear accelerator, External Beam radiotherapy package, AP is paying a higher amount in comparison to other states and for Closed Reduction and Percutaneous Nailing Kerala is paying less than half of the national package rate. So, these differences in packages rate across states affect the quality of care.

Secondary Care Packages	ABPM-JAY National	CG	AP	Kerala	Difference between lowest and highest
Retinal Detachment Surgery	15000	25000	28096	15000	13096
Laparoscopic Appendectomy	18000	25000	35000	20000	17000
Laparoscopic Cholecystectomy	15000	30000	20000	22000	15000
Eversion of Hydrocele Sac – Bilateral	10000	10000	60000	7000	4000
Submandibular Mass Excision + Reconstruction	20000	20000	60000	3500	40000

Higher package rates may induce providers to seek beneficiaries with certain conditions and avoid treating those with less remunerative conditions. A hospital that is networked with two or more and also with private insurers may face multiple and significantly different rates for the same procedure. This situation of conflicting incentives may lead hospital managers to favour

admitting beneficiaries of one scheme over another or create an inequitable situation within a hospital in which more responsive care would be provided to beneficiaries from schemes with a higher rate structure.

Disease and Intervention Coding

The use of disease and health intervention coding is a critical component of health system strengthening providing significant improvements in understanding of health system activity and utilisation. Disease and intervention codes constitute the underlying data to enable meaningful performance management and quality improvement initiatives and can contribute to provider payment reform and strategic purchasing.

It is a complex and specialised field with many years of development in all high-income country health system contexts, including tax-funded free at point of use systems (e.g. English National Health Service¹), Social Health Insurance (e.g. Germany²) and the US health insurance market.³

A central consideration for establishment of a coding is mechanisms to code both disease and intervention to accurately represent not only what activity has been performed, but also the casemix and clinical indication for performing that activity. The International Classification of Disease (now in version 10, ICD-104), produced by the World Health Organisation, is the international standard for disease coding in all income country contexts. Traditionally, individual countries have established their own intervention coding depending on local health system requirements and organisation. The international standardisation of disease codes and localisation of intervention codes is largely due to the uniformity of health indications (e.g. a myocardial infarction is the same regardless of context) whereas the interventions associated treating that indication is highly dependent on context (i.e. management and treatment pathway for myocardial infarction is highly variable between a high and low-income country context).

However, recent developments by the Family for International Classifications Unit⁵ at WHO have produced the International Classifications of Health Interventions (ICHI)⁶ set that can

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¹<https://digital.nhs.uk/services/terminology-and-classifications/clinical-classifications>

²<https://www.dimdi.de/dynamic/en/classifications/icd/icd-10-gm/>

³<https://www.cdc.gov/nchs/icd/icd10cm.htm>

⁴<https://www.who.int/classifications/icd/icdonlineversions/en/>

⁵<https://www.who.int/classifications/en/>

⁶<https://www.who.int/classifications/ichi/en/>

potentially provide a common method of coding activity globally and will facilitate improved cross-country comparisons, and standardisation of health system strengthening activity.

The historical development of disease and intervention coding systems in health has largely been motivated by the need to establish payment mechanisms. The use of Diagnostic-Related Groups (DRGs) commonly incorporates a code representing activity, indication and case mix with an associated tariff for facilitate payments that are more sensitive to activity. Although firmly established in many high-income country contexts (with an associated wide body of country-specific research), there is relatively limited information on DRG use in Low and Middle Income Countries (LMICs). An exception is Mathauer and Wittenbecher (2013)⁷ which reviewed the experiences of multiple LMICs and their journey towards adoption of DRG systems for hospital payments. Experience shows a highly variant approach in terms of underlying health system capacity to initiate DRG reform, the variants of DRG tariffs chosen, payment ceilings and rates, and hospital autonomy and integration with existing payment approaches.

SUBGROUP FINDINGS

- Each insurance scheme including GSHIS, health insurance products have unique coverage in terms of number of packages, specialties covered, cost of package, and constitution of package cost.
- AB PM-JAY developed the diagnosis related packages, whereas some states use procedural level packages
- Rate setting is different across the insurance industry and various government sponsored schemes. In private health insurance industry, insurer negotiates rates with each hospital separately and sets the package costs. However, in GSHIS, package costs are developed commonly and hospitals willing to empanel need to accept the package costs.
- For a similar package or procedures, the cost difference is very high across various government-sponsored health insurance schemes as well under private insurances.

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⁷ Bulletin of the World Health Organization 2013;91:746-756A

Recommendation

1. Uniform nomenclature and approach on package development

The coverage across the multiple insurance schemes and products differs in India. Some schemes cover only secondary care services, some cover tertiary care services; comprehensive coverage is also part of some GSHIS. Sub-group has proposed the development of a standard package with uniform specialities and list of procedures across all the GSHIS schemes in India.

Various insurance products, especially those designed for the specific diseases, critical illness can have their own structure and list of procedures.

Development of benefit package is one of the important components of any health insurance scheme. Traditionally majority of schemes develop procedure-based packages where the actual surgical procedure is developed into packages. However, there are evidences where packages instead procedures were also developed under the GSHIS. To rectify this issue, the Sub-group has proposed to have procedure level

package development for the surgical category while medical packages can still be disease/diagnosis specific. The Sub-group has recommended that private insurance industry should also adopt the same approach and the list of packages develop by GSHIS to design their insurance products.

Various GSHIS has different nomenclature of procedures across the specialities, which creates duplication, confusion and restricts interoperability. Also, this is the major hurdle for implementing the standard disease coding across GSHIS. The Sub-group has proposed that the IRDAI and GSHIS led by PM-JAY can set up a committee for development of uniform nomenclature for specialities and packages. Some packages/procedures based on the treatment

S. No	Specialty Name
1	General Surgery
2	Otorhinolaryngology
3	Ophthalmology
4	Obstetrics & Gynecology
5	Orthopedics
6	Polytrauma
7	Urology
8	Neurosurgery
9	Interventional Neuroradiology
10	Plastic & reconstructive
11	Burns management
12	Cardiology
13	Cardio-thoracic & Vascular surgery
14	Pediatric surgery
15	Surgical Oncology
16	Oral and Maxillofacial Surgery
17	General Medicine
18	Pediatric medical management
19	Neo-natal
20	Pediatric cancer
21	Medical Oncology
22	Radiation Oncology
23	Mental Disorders Packages

protocol can be identified and separated for the dynamic nomenclature (e.g. cancer care packages are always a combination of new protocol and drugs, which can be in dynamic nature)

2. Uniform package cost among all the government sponsored health insurance scheme and additional cost element for private insurance industry

Costing of packages across GSHIS is major challenge and private health care providers were always bringing this issue to the attention of the insurance regulators/industry. Defining the package cost and their acceptance for the established cost under GSHIS can be done through stakeholder engagement and consultation with relevant stakeholders. The Sub-group recommends that to arrive at a uniform package cost under all GSHIS, a comprehensive gradation and incentive mechanism can be established after taking into account cost variations due to geography, quality of care, etc.

The Sub-group has recommended that the private insurance industry should also adopt the uniform cost of packages; however, the IRDAI can come up with the guidelines on inclusion of additional/variable cost for implants and category of wards. Private insurance can design the products as per the uniform package cost and the additional cost of implant and ward type.

3. Adoption of ICD-PCS coding

The Sub-group emphasised that the GSHIS and industry should focus on implementing the ICD-PCS coding, as it is mandatory by the IRDAI. The Sub-group also discussed defining incentive mechanisms for hospitals so that they adopt the ICD-PCS coding.

OBJECTIVE 4 Standard Safety and Quality
Parameters

Background

In the recent years, there has been an increased focus on improving quality of health care in India within the broader Universal Health Coverage (UHC) context. Patient safety has also been recognised as one of the key components of quality of care and many initiatives at Central and State levels have been taking place. Challenges in patient safety in India are several, ranging from Hospital Acquired Infections to biomedical waste management with everything in between such as medication and medical device safety, anti-microbial resistance, etc. Several demand-side financing schemes implement patient safety and quality initiatives and incentivise providers to implement quality accreditation parameters. The PM-JAY also provides capped incentive to NABH accredited hospitals over non-accredited ones to promote quality and patient safety. The private health insurance industry also uses wide range of initiatives for patient safety in different levels of care delivery

Development of a common minimum patient safety and quality parameters will be helpful in standardising patient safety and quality across various providers, in government and private insurance in India because even though a range of initiatives for patient safety are implemented in the country, they are implemented in a fragmented manner with poor monitoring. It will be imperative to converge this effort across the industry as it will ensure implementation of patient safety activities in a coordinated manner and contribute to overall agenda of improvement of quality of care within the UHC context in India.

Objectives

- Analyse various safety and quality indicators used by public health insurance schemes and health insurance companies
- Identify commonly utilisable, basic but key patient safety and quality parameters which can be utilised across the industry

The Sub-group has agreed on common parameters for quality and safety at hospitals. The major categories of indicators include civil and clinical infrastructure, manpower, training and capacity of resources, and key indicators related to the quality of care.

Recommendation

The Subgroup recommends developing a list of minimum safety and quality standards to be used across the health insurance sector. This shall ensure quality of services and patient safety at the

core of health care delivery to the beneficiary or subscriber of the health insurance. Having these patient safety criteria embedded in the minimum hospital empanelment criteria of the hospital will be helpful in having patient safety at the core of service delivery. The Subgroup also recommends exploring option of incorporating provision for payment based on patient safety performance on standardised patient safety indicators.

Detailed list of standard patient safety and quality indicators are mentioned in Annexure 3.

Hospital gradation and payment

It was also discussed and recommended that standard grading system for hospitals based on the quality parameters shall be prepared and same grading can be used by PM-JAY and private insurance market. An exercise shall be done to agree on these common grading parameters in discussion with National Accreditation Board of Health also.

Annexure 1: Standard Empanelment Criteria

A. Hospital Basics Information

Hospital Address	
Hospital Address*	
State*	
District*	
Block/ULB	
Block	
Village	
City/Town	
Hospital Pincode*	
Geographic Code Latitude	
Geographic Code Longitude	
Hospital Profile	
Hospital Specialty Type	
Establishment Year	
PAN Card Holder Name	private
Legal Entity Name	private
Hospital Ownership Type	private
Legal Entity Registration Number	private
Legal Entity Registration Date	private
Hospital Sub Type	public
Contact Information	
Organisation Head Name	
ID Proof Type	
Organisation Head ID Proof Number	
Organisation Head Contact Number	
Organisation Head FAX Number	
Organisation Head Email ID	
Contact Person Name	
Contact Person Phone Number	
Contact Person Email ID	
Other Empanelment and Accreditation Details	
Name of Accreditation Board	
Valid up to	
Accreditation Level	
If Others, Name of Accreditation Board	
Accreditation Identification Number	
Delisted from Gov Health Schemes	
Reasons for De-Empanelment from Gov Schemes	
Empanelled with other Gov Schemes	
CGHS Registration Number	
RSBY Registration Number	

ESIC Registration Number	
Other Scheme Registration Number	

B. Financial Details

Name of the authorised signatory to the hospital bank account*	
Name of the Bank Account of Hospital*	
Hospital Account Number*	
IFSC Code*	
Bank Name*	
Branch Name*	
TDS exemption*	private
Cancelled Cheque*	

C. Licence and certifications

Building & Infrastructure	
Building Plan Approval	
Fire Department Clearance Certificate	
Pollution Control Board Certificate	
Lift License	
Registrations & Certification	
Occupancy Certificate	
Opium License	
Hospital Registration Certificate	
State Medical Council/Association Registration	
Morphine License	
PCPNDT Act Registration	
Surgical Spirit License	
Bio-Medical Waste Management	
AERB	
TLD Badge	
Services	
Pharmacy License/Tie up*	
Blood Bank License/Tie-up Letter*	
Ambulance Registration Certificate/Tie-up Letter*	

D. Specialities offered

General Surgery	
ENT	
Ophthalmology	
Obstetrics & Gynaecology	

Orthopaedics	
Cardio Thoracic Surgery	
Paediatric surgery	
Genitourinary Surgery	
Neuro Surgery	
Surgical Oncology	
Medical Oncology	
Radiation Oncology	
Burns, Plastic& reconstructive Surgery	
Polytrauma	
Dental Surgery	
Paediatric Cancer	
Critical Care	
General Medicine	
Paediatrics	
Neonatology	
Cardiology	
Nephrology	
Neurology	
Chest diseases and respiratory medicine (Pulmonology)	
Psychiatry	Public

E. Civil Infrastructure

General	
Standardised Architectural Design	
Fire Fighting System *	
Bio-Medical Waste Management *	
Duty Staff Room	
Cattle Trap at Entrance and Exit	
Area/Bed (Sq. Ft) *	
Back-Up Electricity Supply *	
Number of Floors *	
Lift Provision	
Ramp Provision	
Wards	
Total Bed Strength *	
Number of In Patient Beds *	
Fully Equipped Operation Theatre *	
OPD *	
HDU	
General Ward *	
Existence of ICU with AC	
Casualty *	
Labour Room *	

Facilities	
Blood Bank	
CSSD	
Diet and Kitchen Facility	
Linen and Laundry	
Stores	
Medical Records Department	
Ambulatory Service	
Patient Attendant Facility	
Diagnostic Services	
Diagnostic Centre- Radiology (Basic) *	
Diagnostic Centre- Radiology (Advanced)	
Diagnostic Centre- Clinical Lab and Diagnostics	
General Surgery	
OPD with registers *	
Supportive Lab services *	
SICU with fowler beds *	
Post OP ward with fowler beds, *	
OT facility	
ENT	
OPD with registers *	
OP clinic with attached Investigation room. *	
Post OP ward *	
OT facility	
ICU *	
Audiology Unit *	
Ophthalmology	
OPD with registers *	
Dark room *	
Optometry room *	
Post-Op ward *	
OT *	
Speciality clinics (Retina, Glaucoma, Cornea & Squint)	
Supportive investigation services *	
Obstetrics & Gynecology	
Gynec and Family planning *	
Labour room *	
Separate labour rooms for clean & septic cases *	
labour table *	
Septic ward	
Antenatal wards *	
Post-natal wards *	
Eclampsia room *	
OT facility *	
Post OP wards *	

Wash area *	
Nursing station *	
General Medicine	
OPD with registers and equipment as per the general requirements	
Supportive Lab services *	
ICU with fowler beds	
Inpatient ward *	
HDU	
Dental Surgery	
Reception	
Waiting room	
Operating area with x-ray and dental chairs *	
Ceramic lab, acrylic lab	
Inpatient facility	
Pathology lab	
Pharmacy	
Wash area *	
Chest diseases and respiratory medicine (Pulmonology)	
ICU with ventilator support *	
OT support with ventilator *	
Support lab facilities *	
Radiation Oncology	
OT facility *	
Post-operative ward *	
ICU *	
Clinical lab support *	
Radiology and Imaging facility. *	
Treatment planning and mould room including computerised treatment planning system, simulator *	
Immobilisation cast making system *	
Cardio Thoracic Surgery	
Intensive Coronary care units *	
Acute medical care units *	
OT facility, full-fledged clinical laboratory, well equipped operation theatres of high aseptic conditions	
Blood bank facilities *	
Nursing station *	
CT - ICU	
Paediatric Surgery	
OT facility *	
NICU *	
PICU *	
SICU *	
Post-operative ward *	
Lab facility *	

Mother room & Feeding area	
Radiological/ fluoroscopy services (including IITV) *	
Blood bank facilities *	
Wash area *	
Nursing station *	
Genitourinary Surgery	
ICUs *	
Dialysis Unit *	
Renal Lab *	
Clinical Lab support *	
Radiology and Imaging support *	
RO Plant *	
Wash area *	
Storage facility *	
Endoscopy *	
Sew lithotripsy *	
OT facility	
Neuro Surgery	
OT facility *	
Post-op with ventilator *	
Neuro ICUs *	
Clinical Lab support *	
Radiology and Imaging support *	
CT & MRI facilities *	
Nursing Station *	
Surgical Oncology	
OT facility *	
Post-op with ventilator *	
ICUs *	
Clinical Lab support *	
Radiology and Imaging support *	
Treatment planning and mould room including computerised treatment planning system, simulator *	
Immobilisation cast making system	
Burns, Plastic & Reconstructive Surgery	
OT facility *	
Post-Op wards *	
SICU *	
Lab facility *	
Psychology support	
Physiotherapy support *	
Isolation/ Burns Ward with Nursing Station *	
Cardiology	
Intensive Coronary care units *	
Acute medical care units *	

OT facility, full-fledged clinical laboratory, well equipped operation theatres of high aseptic conditions *	
Blood bank facilities *	
ICCU *	
Nursing station *	
CT - ICU *	
Nephrology	
OT facility *	
ICUs *	
Dialysis Unit *	
Renal Lab *	
Clinical Lab support *	
Radiology and Imaging support *	
RO Plant *	
Wash area *	
Storage facility *	
Neurology	
OT facility *	
Neuro ICUs *	
Clinical Lab support *	
Radiology and imaging support *	
CT & MRI facilities *	
Nursing Station *	
OPD with registers, *	
Supportive Lab services including advanced investigations *	
Post-Op wards / SICU *	
Medical Oncology	
OT facility *	
ICUs *	
Clinical Lab support *	
Pain & palliative section	
Chemotherapy bay	
Radiology and Imaging facility. *	
Neonatology	
OT facility *	
NICU *	
PICU *	
SICU *	
Radiology and Imaging facility. *	
Clinical lab support *	
Post operative ward *	
Wash area *	
Nursing station *	
Polytrauma	
OPD with registers *	

Plaster room *	
OT facility *	
Post operative ward and ICU *	
Physiotherapy *	
Occupational therapy facilities	
Clinical lab support *	
Radiology and Imaging facility. *	

F. Medical Infrastructure

General	
Refrigerator *	
Water Cooler *	
Air Conditioners	
Generator *	
IT Infrastructure	
Computer/Laptop *	
Biometric Device	
Scanner	
Barcode Reader	
Webcam	
Printer	
Internet Connectivity	
Fax Machine	
Intercom	
Wards	
Blood Pressure Apparatus *	
Weighing Scale (For Adults) *	
Weighing Scale, Infant	
Oxygen Cylinders *	
Nitrous Oxide Cylinders	
Ambu-Bag with Mask *	
Fire Extinguishers (Various Types) Each	
Otoscope	
Wheel Chairs *	
Stretcher on Trolley	
Beds with Mattresses & Pillows *	
Bed Pan & Urinals *	
Nursing Station	
Height Measuring Stand *	
Suction Apparatus *	
Steriliser *	
Bedside Screens	
Regulator & Flow meters	
Emergency Lamp *	

Laryngoscope	
Saline Stands *	
Emergency/Recovery Trolley/Emergency Drug Tray *	
Oxygen Cylinder Stands *	
Side Rails	
Attendant Stool *	
Fracture Table(Pop) *	
Oxygen Masks with Regulator *	
Venesection Tray *	
Fan/Cooler/Heater *	
Tubelights/Bulb for Adequate Lighting *	
Operation Theatre	
Operating Table*	
Autoclave*	
Operating Theatre Lights, Shadowless*	
Suction Apparatus*	
Automist(Operation Theatre Fumigator)*	
Ventilator, Adult	
Anaesthetic M/C (Boyles With/Without Flotec)*	
Pulse Oximeter*	
Cardiac Monitor*	
Defibrillator	
Phototherapy Unit	
Neonatal Resuscitation Unit	
Emergency Operating Theatre	
Emergency Light/Generator Facilities	
Boyles Apparatus Hydraulic Operation Theatre Table	
Air Conditioner	
Portable Mobile X-Ray Machines in Operation Theatre along with Dark Room	
OPD	
Doctor Chair & Table*	
Examination Table with Steps & Curtain*	
Washbasin with running water facility*	
Patient Stool*	
Attendant Chair	
X-Ray View Box	
Bio-Medical Waste Bin*	
Casualty	
Glow sign board indicating 'Emergency Services Department'	
Ward well equipped with Fowler's Beds*	
Oxygen Cylinder with Accessories*	
Suction Apparatus Electric/Foot Operated*	
Emergency Tray, Ryles' tube/stomach tube*	

Tracheostomy Set*	
Ambu-Bag*	
Laryngoscope*	
Splints-Thomas Splint	
Bohler's Splint	
Cooler, Fan & Drinking Water*	
Treatment room cum minor operation theatre with all necessary instruments, equipments, trolleys, tables and trays	
Monitors*	
Defibrillator, Nebuliser with Accessories, Crash Cart, Resuscitation Equipment, Oxygen Cylinders with Flow Meter/Tubing/Catheter/Face Mask/Nasal Prongs, Suction Apparatus*	
Wheel Chairs & Stretcher Trolleys*	
Intensive Care Unit	
Extension of ICU with AC	
Defibrillators	
Ventilators	
Fowlers Beds	
Availability of Central Oxygen, Suction Machine	
Piped Gases, Infusion of Inotropic Support, Equipment for Maintenance of Body Temperature, Weighing Scale, Manpower for 24x7 monitoring, Emergency Crash Cart	
Generator	
Multi-sign Monitoring	
CSSD	
HP Horizontal Sterilisers (HPS)	
Fiber Optic Scopes	
Rubber Catheter	
AutoClave *	
Labour Room	
Labour Table*	
Infant Weighing Machine*	
Baby Resuscitation Kit*	
Mucus Aspirator*	
Suction Apparatus*	
Shadowless Lamp	
Medical Records	
Paper Based/ Hospital Information System *	
General Surgery	
PR examination tray with proctoscope and gloves*	
Kidney trays*	
Tongue depressor*	
X-ray view box*	
Pulse Oxymeter*	

Multi para monitor*	
Ventilators*	
Infusion pumps*	
Ophthalmoscopes*	
Glucometer*	
Laryngoscope*	
Endo-tracheal tubes*	
Ambu bag*	
Oxygen and Suction facility*	
Laparoscopic Equipment*	
Laparoscopic Equipment - Cautery Set, Electric *	
Laparoscopic Equipment - Cryo Cautery *	
Bipolar*	
Harmonic Scalpel*	
Light Source*	
ENT	
Headlight Mirror*	
Direct laryngoscopes*	
Nasal speculum*	
Tongue depressor*	
Laryngeal mirror*	
Nasopharyngeal mirrors*	
Aural speculum*	
Ear suction*	
Nasal suction*	
Suction Apparatus*	
Seigles speculum*	
Tuning fork*	
Otoscope*	
Bulls lamp*	
Head lamp*	
ENT examinations chair*	
Instrument Steriliser*	
(i) BP apparatus*	
(ii) Stethoscope.*	
Tonsillectomy and adenoidectomy sets*	
Sets for nasal bone fracture*	
Septoplasty set*	
Antrostomy set*	
Tracheostomy set*	
FESS set*	
Direct Laryngoscope set*	
Microlaryngoscopy set*	
Tympanoplasty*	
Mastoidectomy set*	

Staoedectomy set*	
(i) Oesophagoscopy set*	
(ii) Bronchoscopy set.*	
Operating Microscope*	
Pure Tone audiometer*	
Impedance audiometer*	
Temporal bone lab microscope*	
Mastoid set and micro motor with drill*	
Endoscopic equipment*	
Ophthalmology	
Snellens chart or drum*	
Trail set with frame*	
Near vision charts with different languages*	
Torch Light*	
(i) Ophthalmoscope*	
(ii) Retinoscope*	
Slit lamp*	
Applanation tonometer*	
Kerato meter*	
Indirect ophthalmoscope and a Gonioscope.*	
Operating Microscope*	
Cryo unit*	
Cataract set*	
Glaucoma set*	
Entropian set*	
Enucleation set*	
Squint set*	
O.T Table and O.T light*	
Micro Surgery Equipment*	
Optometry facility*	
Obstetrics & Gynaecology	
PS & PV examination tray *	
IUD tray *	
Weighing machine *	
Pap smear tray *	
Exam table with lithotomy facility table lamp. *	
OT table *	
OT light *	
High suction apparatus *	
Vaccum extractor etc. *	
Resuscitation tray *	
Cervical biopsy set *	
MTP set *	
D & C set *	
(i) Delivery set and Episiotomy set *	

(ii) Foetal Doppler	
(iii) Ophthalmoscope *	
(iv) Pulse Oxymeter *	
Abdominal hysterectomy set *	
Vaginal hysterectomy set *	
Tuboplasty set *	
Myomectomy set *	
Diagnostic laparoscopy set *	
Electro-cautery *	
CTG machine and supported by lab facilities for investigation. *	
Operating laparoscopy set *	
Hysteroscopy set *	
Rectoscope *	
Multi channel monitors *	
Ultrasound machine - should be registered under PC PNDT Act, 1994 *	
Wall Clock *	
Baby weighing machine *	
Baby resuscitation kit *	
Mucus aspirator *	
Suction apparatus along with set of catheter *	
Oxygen cylinder *	
(i) Episiotomy tray *	
(ii) venesection tray *	
Shadowless lamp *	
Forceps low *	
Foetal monitor *	
Vacuum extractor *	
Deep freeze or wooden box with lock and key *	
Oxygen suction *	
Cautery *	
(i) Adult weighing machine *	
(ii) Paediatrics weighing machine *	
Neonatal Resuscitation equipment with endo-tracheal tube (2 No) *	
Laryngoscope with neonatal blade *	
Infant feeding tube and trolley *	
Paediatric resuscitation Kit *	
Autoclave *	
All emergency drugs *	
Aluminium/plastic badges for identification baby and mother *	
(a) Phototherapy unit *	
(b) Warmer	
Ventilators *	

Orthopaedics	
Basic Instrumentation sets for fractures as per the surgical procedures to be performed*	
Large and small fragment external fixators *	
Portable X-Ray machine*	
C-arm image intensifier*	
Arthroscope*	
Ortho surgery equipment*	
CT Scan *	
MRI upto 0.3 tesla permanent magnet with laser camera, UPS,RF coils(5*7 mtrs=35)(Inhouse/ Tie up) *	
General Medicine	
Torch and hammer *	
CNS examination tray *	
Tuning fork *	
ECG Machine *	
X-ray view box*	
Examination tray with BP apparatus *	
Pulse Oxymeter *	
Multi para monitor *	
Ventilators *	
Infusion pumps *	
Ophthalmoscopes *	
Glucometer *	
Laryngoscope *	
Endo-tracheal tubes *	
Ambu bag *	
Oxygen and Suction facility*	
Paediatrics	
Paediatric weighing machine*	
Measure tape*	
Height and Weight scale*	
Suction Apparatus*	
Oxygen facility*	
Multi para monitors*	
Paediatric intubation set*	
Radiant Warmers*	
Phototherapy Units*	
Infusion pumps*	
Paediatric Ventilators*	
Defibrillator*	
Pulse Oxymeter*	
Radiant Heater,4kw	
Incubators	
Open Care Units	
Syringe Pumps*	

Chest Diseases & Respiratory Medicine (Pulmonology)	
Peak flow meters*	
Nebulisers*	
ICD facility*	
Pleural biopsy needles*	
Pulse oxymeters*	
Fibre optic bronchoscopes*	
Rigid bronchoscopes*	
PFT machines with facility for spirometry*	
Lung volume and diffusion capacity and blood gas machine*	
Oxygen facility*	
Suction Facility*	
ECG*	
Ventilators*	
Infusion pumps*	
Syringe Pumps*	
Bronchoscopy*	
Spirometry*	
Crash Cart with Emergency Medicines*	
Multipara Monitors*	
Pulse Oxymeter*	
Defibrillator*	
Radiation Oncology	
Conventional X-ray unit*	
Mobile x-ray units*	
Computer Tomography *	
Mammography*	
Brachytherapy set-up*	
Teletherapy set-up*	
Dosimetry system*	
Radiation protection setup*	
Linear Accelerator,*	
Magnetic Resonance Imaging(MRI)*	
Cobalt*	
Rapid arc*	
Cardio Thorasic Surgery	
CT Scan(Inhouse/ Tie up) *	
MRI(Inhouse/ Tie up) *	
Angiography facilities*	
Stress test*	
Echo-cardiography*	
Cardiac monitor*	
ACT machine*	
Heart lung machines*	

Intra aortic balloon pumps*	
Catherisation equipment*	
Infusion pumps*	
Angioplasty equipment*	
Blood gas and Electrolyte analyzers*	
Defibrillator *	
Temporary pacing*	
Critical equipment*	
Multipara Monitors*	
Pulse Oxymeter*	
ECG*	
Ventilators*	
IABP*	
2D ECHO*	
Syringe Pumps*	
Paediatric Surgery	
Basic resuscitation equipment*	
Nebuliser*	
Incubators*	
Phototherapy units*	
Open Care system*	
Infusion pumps*	
Syringe pump*	
(i) CPAP facility*	
(ii) Ventilator facility*	
Suction Apparatus*	
Cysto-scope*	
Rigid bronchoscope*	
Oesophagaldialators*	
Paediatric sigmoidoscope*	
Defibrillator*	
Pulse oxymeter*	
Resuscitation equipment*	
Multipara Monitors*	
Genitourinary Surgery	
The necessary OT equipment *	
Dialysis machines	
C-ARM *	
Endoscopic equipment *	
ESWL facility *	
Neuro Surgery	
EEG Machine*	
Evoked potentials*	
CT*	
MRI*	

Hi-end diagnostic facilities*	
Operating microscope *	
Micro surgical instruments sets.*	
Oxygen facility*	
Suction Facility*	
Crash Cart with Emergency Medicines*	
Multipara Monitors*	
Pulse Oxymeter*	
Defibrillator*	
Infusion pumps*	
Syringe Pumps*	
Ventilators*	
ENMG*	
Angio CT Facility*	
Surgical Oncology	
Conventional X-ray unit*	
Mobile x-ray units*	
Computer Tomography *	
Mammography*	
Brachytherapy set-up*	
Teletherapy set-up*	
Dosimetry system*	
Radiation protection setup*	
Linear Accelerator,*	
Magnetic Resonance Imaging(MRI)*	
Cobalt*	
Rapid arc*	
Burns, Plastic & Reconstructive Surgery	
O.T Table*	
O.T Light*	
Suction Apparatus*	
Anaesthesia machine*	
Operating microscope*	
Skin grafting machine*	
Skin cutters and micro-Surgery instruments*.	
Oxygen facility*	
Suction Facility*	
Crash Cart with Emergency Medicines*	
Multipara Monitors*	
Pulse Oxymeter*	
Cardiology	
CT Scan(Inhouse/ Tie up) *	
MRI(Inhouse/ Tie up) *	
Angiography facilities*	
Stress test*	

Echo-cardiography*	
Cardiac monitor*	
ACT machine*	
Heart lung machines*	
Intra aortic balloon pumps*	
Catherisation equipment*	
Infusion pumps*	
Angioplasty equipment*	
Blood gas and Electrolyte analyzers*	
Defibrillator *	
Temporary pacing*	
Critical equipment*	
Multipara Monitors*	
Pulse Oxymeter*	
ECG*	
Ventilators*	
IABP*	
2D ECHO*	
Syringe Pumps*	
Nephrology	
Dialysis machines *	
CRRT	
Neurology	
EEG Machine*	
Evoked potentials*	
CT*	
MRI*	
Hi-end diagnostic facilities*	
Operating microscope *	
Micro surgical instruments sets.*	
Oxygen facility*	
Suction Facility*	
Crash Cart with Emergency Medicines*	
Multipara Monitors*	
Pulse Oxymeter*	
Defibrillator*	
Infusion pumps*	
Syringe Pumps*	
Ventilators*	
ENMG*	
Angio CT Facility*	
Medical Oncology	
Conventional X-ray unit*	
Mobile x-ray units*	
Computer Tomography *	

Mammography*	
Brachytherapy set-up*	
Teletherapy set-up*	
Dosimetry system*	
Radiation protection setup*	
Linear Accelerator,*	
Magnetic Resonance Imaging(MRI)*	
Cobalt*	
Rapid arc*	
Critical Care	
Torch and hammer *	
CNS examination tray *	
Tuning fork *	
ECG Machine *	
X-ray view box*	
Examination tray with BP apparatus *	
Pulse Oxymeter *	
Multi para monitor *	
Ventilators *	
Infusion pumps *	
Ophthalmoscopes *	
Glucometer *	
Laryngoscope *	
Endo-tracheal tubes *	
Ambu bag *	
Oxygen and Suction facility*	
Operating microscope*	
Skeeter drill for Cochleostomy*	
Benair micro motor*	
Facial nerve monitor*	
Two sets of micro ear surgery instruments *	
Laser Co2 Lumens surti touch*	
Audiology equipment*	
i) Pure tone audimeter*	
ii) Free field equipment*	
iii) Impedance audiometer*	
iv) Oto-Acoustic emission audiometer*	
v) ABR with Auditory Steady state response audiometer*	
vi) Dedicated Computer System with internet facility*	
vii) Digital Camera*	
viii) Printer, Scanner etc*	
ix) Visible speech instruments with latest software for imparting the audio verbal therapy*	
Neonatology	
Basic resuscitation equipment*	

Nebuliser*	
Incubators*	
Phototherapy units*	
Open Care system*	
Infusion pumps*	
Syringe pump*	
(i) CPAP facility*	
(ii) Ventilator facility*	
Suction Apparatus*	
Cysto-scope*	
Rigid bronchoscope*	
Oesophagaldialators*	
Paediatric sigmoidoscope*	
Defibrillator*	
Pulse oxymeter*	
Resuscitation equipment*	
Multipara Monitors*	
Polytrauma	
Basic Instrumentation sets for fractures as per the surgical procedures to be performed*	
Large and small fragment external fixators *	
Portable X-Ray machine*	
C-arm image intensifier*	
Arthroscope*	
Ortho surgery equipment*	
CT Scan *	
MRI up to 0.3 tesla permanent magnet with laser camera, UPS,RF coils(5*7 mtrs=35)*	
Dental Surgery	
Doctor's chair and table*	
Reception table and chair*	
Visitors chairs*	
X-ray Unit*	
dental chairs*	
Blastfurnace, *	
centrifugal casting machine *	
Dental lab equipment*	

G. General Service

Facility Details	In-House/Tie-Up	Distance (Km)*	Details
Reception and Billing			
Laboratory Services	Yes	Yes	Yes
Stores			
Wards			

Diagnostic Centres - Radiology (Basic)	Yes	Yes	
Environment, Sanitation and Water supply	Yes		
Sterilisation	Yes		Yes
Emergency First aid			
Dental Clinic			
Linen and Laundry	Yes	Yes	
Physiotherapy	Yes	Yes	
Blood Bank	Yes	Yes	
Patient Attendant Facility	Yes		
Diet and Kitchen Facility	Yes	Yes	
Pharmacy	Yes	Yes	
Ambulance Services	Yes	Yes	
Medical gases and Manifold room			
Power Back-up			
Air-Condition System			
Basic Signages			
Waiting area with Public utilities			
HMIS Solution Deployed			

H. Add Manpower

Type of Medical Expertise*	
Type of Expertise*	
Name*	
Registration Number*	
University*	
Email Id*	
Mobile No*	
Experience (Years)*	
Specialisation*	
Registration Certificate*	
Declaration	

I. Manpower Checklist

General	
Managers	
Accountant	
Receptionist	
Supervisor	
Security Personnel	
Maintenance Staff	
Wards	
Duty Medical Officer Round the Clock*	
Nursing Staff in General Wards*	

Nursing Staff ICU*	
Nursing Staff POW*	
Helpers*	
One Female Nursing Orderly or one Male Nursing Orderly*	
Sweepers *	
Operation Theatre	
Duty Medical Officers as OT Assistants during routine 8 hours*	
OT Staff nurses available round the clock *	
Female Nursing Orderly for operation theatre*	
Male Nursing Orderly for operation theatre*	
Diagnostic Centre - Radiology (Basic)	
Radiologist /Gynaecologist	
Round the clock X-Ray Technicians	
Diagnostic Centre - Radiology (Advanced)	
Radiologist /Gynaecologist	
Round the clock X-Ray Technicians	
Diagnostic Centre - Clinical Laboratory and Diagnostics - Small	
Technical Persons to perform the Tests	
Diagnostic Centre - Clinical Laboratory and Diagnostics - Medium	
Radiologist, Allopathic doctor	
Diagnostic Centre - Clinical Laboratory and Diagnostics - Large	
Radiologist, MD Pathology/Biochemistry/ Micro Biology	
OPD	
Receptionist	
Male Nursing Orderly for Medical OPD	
Male Nursing Orderly for Surgical OPD	
Female Nursing Orderly for Obstetrics and Gynaecology OPD*	
Male Nursing Orderly	
Female Nursing Orderly*	
Staff Nurse*	
R.M.O*	
Paramedicals	
Physiotherapy	
General Physicians	
Attenders	
Sweepers	
Receptionist and Administrative Incharge	
Orthopaedic Surgeon and Plastic Surgeon	
Physiotherapists	
Assistants to Physiotherapists	
Occupational Therapist	
Speech Therapist as a part time	
Orthotic and Prosthetic Engineers	
Medical Social Worker	
Neuro Surgeon and Neuro Physician	

Casualty	
Separate Medical Officer (CMO) available round the clock*	
Continuous availability of D.M.O (Indoor MO) during night hours*	
Trained Staff posted in Emergency Department.*	
Nursing Staff availability round the clock*	
ICU	
Med.Officer *	
Nursing Staff *	
Blood Bank	
Round the clock availability of Trained Staff	
CSSD	
Trained Staff Nurse *	
Labour Room	
Duty Medical Officers one in each Shift	
Qualified Nurses one in 8hr Shift	
Female Nursing Orderly for Labour Room	
Sweeper for Labour Room	
Linen and Laundry	
Linen Keeper *	
Stores	
Store Keeper *	
Training	
Qualified Staff *	
Telecom	
PBX and Telephone Operator *	
Nursing Staff	
Nursing Staff in General Wards*	
Nursing Staff in Female Wards*	
Nursing Staff POW*	
Other Staff	
Helpers *	
Sweepers *	
General Surgery	
Round the clock/On Call General Surgeon (MD/ DNB (Gen.surgery))*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Support Specialities Available (General Medicine, Paediatrics)*	
Ophthalmology	
Round the clock/On Call Surgeon trained in Vitro-Retinal, Orthoptics & Paediatrics Ophthalmology are desirable (MS / PG Diploma (DO) / DNB(Oph.))*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	

Obstetrics & Gynaecology	
Round the clock/On Call OBG Specialist (MD/ PG Diploma (DGO)/ DNB(OBG) with laparoscopic experience)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock/On Call Paediatrician Specialist (DCH / DNB (Paed.))*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in Labour Room 4/Shift (Gen.Nursing)*	
Additional OT Nurse in Shifts*	
FNO for OBG OP*	
FNO for Labour Room*	
Sweeper for Labour & OT*	
Orthopaedics	
Round the clock/On Call Orthopaedic Surgeon (MS / DNB (ortho) / PG Diploma (D ortho.))*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Dental Surgery	
Qualified B.D.S Doctors*	
Qualified M.D.S Doctors (Specialisation: a) Endodontics b) Oral and Maxillofacial Surgery c) Oral Medicine and Radiology d) Oral Pathology e) Orthodontics f) Paedodontics g) Periodontology h) Prosthodontics) Qualified M.D.S Doctors (Specialisation: a) Endodontics b) Oral and Maxillofacial Surgery c) Oral Medicine and Radiology d) Oral Pathology e) Orthodontics f) Paedodontics g) Periodontology h) Prosthodontics) Qualified M.D.S Doctors (Specialisation: a) Endodontics b) Oral and Maxillofacial Surgery c) Oral Medicine and Radiology d) Oral Pathology e) Orthodontics f) Paedodontics g) Periodontology h) Prosthodontics) *	
Paramedical Staff*	
Qualified Nurses*	
Qualified Dental Technicians*	
General Medicine	
Round the clock/On Call Physician (MD (Gen. Medicine/DNB)*	

Round the clock MBBS Duty Doctors*	
Round the clock/On Call Anaesthetist in shifts (MD (Gen. Medicine/DNB))*	
Qualified & Trained Nurse in ICU (Gen.Nursing)*	
Ward Boys in ICU*	
Paediatrics	
Round the clock/On Call Paediatrician Specialist (MD/ PG Diploma (DCH)/ DNB (Paed.))*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in ICU & PICU (Gen.Nursing)*	
Ward Boys in ICU & PICU*	
Pulmonology	
Round the clock/On Call Chest Physician (MD Chest diseases / equivalent or DTCD)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in RICU (Gen.Nursing)*	
Ward Boys in RICU*	
Radiation Oncology	
Round the clock/On Call Oncologist (DM / Mch)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in ICU & SICU (Gen.Nursing)*	
Ward Boys in ICU & SICU*	
Cardio Thoracic Surgery	
Round the clock/On Call Cardiologist (DM(Cardiology)) *	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in ICU & SICU (Gen.Nursing)*	
Ward Boys in ICU & SICU*	
Paediatric Surgery	
Round the clock/On Call Paediatric Surgeon (Mch or equivalent) *	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock/On Call Paediatrician (MD(Paed.) / D.Ch) *	
Qualified & Trained Nurse in NICU & PICU (Gen.Nursing) *	
Ward boys in NICU & PICU *	
Genitourinary Surgery	
Round the clock/On Call Urologist (Urologist M.ch)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Physician Support*	
Neuro Surgery	
Round the clock/On Call Neuro Surgeon (Mch or equivalent)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in Neuro ICU (Gen.Nursing)*	

Ward boys in Neuro ICU*	
Surgical Oncology	
Round the clock/On Call Oncologist (DM / Mch)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in ICU & SICU (Gen.Nursing)*	
Ward Boys in ICU & SICU*	
Plastic Surgery	
Round the clock/On Call Plastic Surgeon (DM / Mch)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Support Service of General Surgeon (MS / DNB(Gen. Surg))*	
Cardiology	
Round the clock/On Call Cardiologist (CT Surgeon (M.ch or equeleant)) *	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Nephrology	
Round the clock/On Call Nephrologist (DM or equivalent) *	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	
Physician Support *	
Neurology	
Round the clock/On Call Neurologist (DM or equivalent and Mch or equivalent)) *	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in Neuro ICU (Gen.Nursing) *	
Ward boys in Neuro ICU *	
Medical Oncology	
Round the clock/On Call Oncologist (DM / Mch)*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in ICU & SICU (Gen.Nursing)*	
Ward Boys in ICU & SICU*	
Critical Care	
Verbal Rehabilitation teach well versed in audio verbal therapy techniques and software used in such methods (Master degree in Audiology and/ speech, language, Language Pathology from recognised institution)*	
Adequate number of AV teachers to impart AV therapy training	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	

Personal programming systems for mapping and programming approved types of Cochlear*	
Round the clock/On Call Physician (MD Gen. Medicine/DNB)*	
Round the clock MBBS Duty Doctors*	
Round the clock Anaesthetist in Shifts (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Qualified & Trained Nurse in ICU (Gen. Nursing)*	
Ward Boys in ICU*	
Round the clock/On Call ENT surgeon (MS / D.L.O / DNB (ENT))*	
Round the clock/On Call Anaesthetist specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock MBBS Duty Doctors*	
Audiologist/Speech Pathologist (Master degree in Audiology and Speech, language, Language Pathology from Recognised Institution)*	
Neonatology	
Round the clock/On Call Neonatologist (Mchor equivalent)*	
Round the clock/On Call Paediatric Surgeon (Mchor equivalent)*	
Round the clock/On Call Ophthalmologist (MS / PG Diploma (DO) / DNB(Oph.))*	
Round the clock/On Call Anaesthetist specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock/On Call Paediatrician*	
Qualified & Trained Nurse in NICU & PICU (Gen.Nursing)*	
Ward Boys in NICU & PICU*	
Polytrauma	
Round the clock/On Call Orthopaedic Surgeon (MS / DNB (ortho) / PG Diploma (D ortho.))*	
Round the clock/On Call Anaesthetist Specialist (MD (Anae.)/ PG Diploma (DA)/ DNB)*	
Round the clock/On Call Neurosurgeon*	
Round the clock/On Call General Surgery specialist*	
Round the clock/On Call Vascular Surgeon*	
Round the clock/On Call Cardiothoracic Surgeon*	
Round the clock MBBS Duty Doctors*	
Qualified & Trained Nurse in SICU (Gen.Nursing)*	
Ward Boys in SICU*	

Annexure 2 List of Fields fillable on Rohini Portal during Hospital Registration

1. Name of Hospital/ Facility

2. Contact Details

Addresss-1	
Address-2	
Telephone No	
Mobile No	
Email ID	
Website Link	
Is hospital part of a group of Hospital/Corporate?	
Is the Hospital part of a Network of Hospital ?	
Address Coordinates (Latitude and longitude)	

3. Identity Details

PAN No	
TAN No	
TIN No	
Hospital Reg. No	
Date of Reg.	

4. Upload Documents

Hospital/ Facility Reg. Certificate	
Address Proof (Electricity/Telephone Bill)	

5. Facilities

No of Beds	
Facility	
Type of room & Tariff Details	
Facility Type	

6. Doctors

S.No	Name	MCI Registration	IMA Registration	Specialisation	Email	Phone No	Ext. No

7. Empanelment (Insurance Companies and TPAs)**8. Hospital Contacts**

S.No	Contact Person	Department	Designation	Mobile No	Phone No	Email ID

9. Certification & Accreditation

Accreditations

S.No	Accreditations Agency Name	Agency/Entity Logo	Effective Date

Certifications

S.No	ISO	Super Brand

10. Awards/Accolades

Hospital Grading Awards

NABH	
IMA	
Insurer/TPAs	

11. Hospital Awards

S. No	Name of the award	Award conferring Company/Entity	Year

Annexure 3 Quality and Patient's Safety Parameters

Q. No.	Detailed parameters	Evidence Required	Method of Assessment
1	All the services being provided by AB – PMJAY Empanelled Hospitals, patient rights and responsibilities are clearly defined & displayed in prominent places in understandable language.	a) Scope of service is clearly defined and displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) Scope of service is display is bilingual language(one local and another Hindi or English) c) Staff aware of scope of services	Direct observation & Staff interview
2	Hospital has displayed IEC pertaining to Ayushman Bharat at prominent place	a) The banner or poster of AB-PMJAY is displayed at prominent place (e.g. Hospital entrance, Registration area, Waiting area, etc.) b) The banner or poster of AB-PMJAY is visible to patient or visitors c) Staff aware about the AB-PMJAY	Direct observation & Staff interview
3	The initial assessment by doctors for in-patients is documented within 24 hours or earlier and the Patient record file have care and treatment orders which is signed, named, timed and dated by the concerned doctor.	See minimum 5 in-patients files of existing (admitted) patient record and check for: a) Availability of Initial assessment form b) Initial assessment form filled by concerned personal c) Time of admission, Time of initial assessment , Initial assessment start and completion time. d) Treatment orders are signed, named, timed and dated by the concerned doctor	Record review & Staff interview
4	The results of the diagnostic (Laboratory, Radiology, etc.) tests made available within defined time frame and critical results intimated to the concerned personnel immediately.	a) Time frame of diagnostic results are displayed in diagnostic department and followed. b) See minimum five cases of Critical value and check for: i) Critical result value identification time and informed time to concerned personnel. ii) Appropriate action taken by the concerned person for the critical result.	Direct observation, Record review, Patient interview & Staff interview
5	Events during cardio-pulmonary resuscitation are recorded and mock drills conducted at regular interval; sequence of CPR in pictorial manner should be displayed.	a) Policy for cardio-pulmonary resuscitation b) CPR process flow chart displayed in patient care area c) Staff aware of steps in cardio-pulmonary resuscitation d) Documentation of Regular mock drill conducted, variations observed in each drill and CAPA taken by respective personnel's.	Direct observation, record review & Staff interview
6	Informed consent after duly explaining the information on risks involved, benefits, alternatives for the procedures etc. by the concerned Doctor who will	a) SOP developed for taking the informed consent from patient or patient relatives. b) See minimum 5 in-patients files of previous month and check availability of: i) Clearly defined information on risks	Direct observation, Record review, Patient

	perform the requisite procedure in an understandable language	involved, benefits, alternatives for the procedures by surgeon who will perform the requisite procedure in an understandable language. ii) Informed consent is duly signed by patient or patient relatives and countersigned by concerned surgeon. iii) Post operative notes by concerned surgeon.	interview & Staff interview
7	Regular and periodic monitoring of anaesthesia components like recording of heart rate, cardiac rhythm, respiratory rate, blood pressure, oxygen saturation, airway security and patency and level of anaesthesia should be done.	See minimum 5 post-operative files of previous month and check for: a) Availability of completely filled Pre-anaesthesia, during anaesthesia and post-anaesthesia form in each patient file. b) Pre-anaesthesia consent is duly signed by patient or patient relatives and countersigned by anaesthetists in each patient file.. c) Complete documentation (e.g. Recording of heart rate, cardiac rhythm, respiratory rate, BP, oxygen saturation, airway security recorded) in each patient file.	Record review & Staff interview
8	WHO checklist for prevention of adverse events like wrong site, wrong patient and wrong surgery is being filled for every surgical procedure	See minimum 5 post-operative files of previous month and check : a) Availability of WHO safety checklist. b) WHO safety checklist is filled and signed by anaesthetist(before induction of anaesthesia), surgeon(before skin incision) and OT incharge(before patient leaves OT)	Record review & Staff interview
9	Documented procedure for management of medication are defined and implemented e.g. Sound alike and look alike medications are stored separately.	a) Defined list of sound alike and look alike medications b) Display of the sound alike and look alike medications list in all patient-care area c) Sound alike and look alike medications are stored separately in pharmacy and all patient-care area	Direct observation, Record review & Staff interview
10	Listing and storage of High risk medications to be done & orders should be verified before their dispensing.	a) The list of High risk medications are available b) Updated legal licence available if narcotics are stored and used. c) The high risk medications are stored separately in secure environment (double lock). d) Check patient file for documentation verification.	Direct observation, Record review & Staff interview
11	Verification of dosage, route, timing and expiry date before administering the medication should be done.	a) Defined SOP for process of administration of medication b) Check minimum 5 in-patients files of previous month and look for implemented process as defined in SOPs (dosage, route, timing and expiry date before administering the medication) c) Medication orders are clear, legible, dated, named and signed by the concerned doctor.	Direct observation, Record review & Staff interview

12	Adverse drug events are collected, analysed by the treating doctor and practices are modified (if necessary) to reduce the same.	a) Clearly defined policy for the adverse drug events. b) Adverse drug events are reported to concerned authority and record is available b) Corrective and preventive action taken for Adverse drug events.	Record review & Staff interview
13	The hospital infection control committee is constituted and functional with defined surveillance method for tracking and analysing Hospital acquired infections.	a) Availability of infection control committee formation letter with list of members. b) List of identified high risk areas. c) Defined SOP for tracking and analysing infection rates. d) Minutes of the meeting of infection control committee. e) Corrective and preventive action taken to prevent infection.	Record review & Staff interview
14	All the health care providers should have easy accessibility to the hand washing facility in all patient care areas. Hand hygiene steps to be displayed at each hand washing facility.	a) Hand washing facility available in all patient care areas b) Staff aware about the hand hygiene practices and follows the steps of handwashing (WHO handwashing steps). c) Work instruction displayed in all handwashing points at all patient care areas d) Hand hygiene audit and CAPA done regularly.	Direct observation, Record review & Staff interview
15	Staff members should be provided with the adequate and appropriate pre and post exposure prophylaxis	a) The Vaccination (Inj. TT, Hepatitis – B, Typhoid) and medical checkup record available of all concerned staff members b) Hospital provided Personal protective equipment to concerned staff. c) Staff uses Personal protective equipment while conducting any procedure/activity. d) Display of Post exposure prophylaxis chart in all patient care areas	Direct observation, Record review & Staff interview
16	The proper implementation and regular monitoring of Bio-Medical waste segregation and collection in all the patient care areas of the hospital. Staff should be trained in handling the Bio-Medical waste and provided with all personal protective measure.	a) Updated license available for Bio-Medical Waste Management practice as per BMW Rule 2016 b) SOP defined for the process of BMW as per Pollution control guidelines. c) Staff follows the SOP. d) Waste management bins available and BMW guideline chart is displayed in all patient care area e) Personal protective measures (e.g. gloves, mask, apron, gum boots, heavy duty rubber gloves, etc.) are used by all categories of staff handling Bio-Medical Waste. f) Infection control committee visits common biomedical treatment facility.	Direct observation, Record review & Staff interview
17	There is a defined mechanism for regular updating of the licenses / registration / certifications and MOUs.	a) SOP developed with defined responsibility and timeline of regular updating the licences / registration / certifications b) See the relevant statutory documents for: Mandatory licenses availability as per HEM portal -Building and Infrastructure:	Record review

		i) Building plan approval ii) Fire department clearance certificate iii) Pollution control board certificate iv) Lift licence -Registration and Certificate: v) Hospital registration certificate vi) PCPNDT act registration vii) AERB viii) TLD badge -Services: ix) Pharmacy license/ MOU x) Blood bank license/ MOU xi) Ambulance license/ MOU	
18	Safe exit plan for fire and non-fire emergencies should be documented and ensure the awareness amongst the hospital staff .Fire Mock drills should be conducted at least twice in a year.	a) SOP defined and implemented for safe exit plan in case of fire and non-fire emergencies. b) Signages displayed of do's and don't's in case of fire c) Display of fire exit plan in all patient care areas. c) Record of Mockdrill's conducted and CAPA done	Direct observation, Record review & Staff interview.
19	The services provided by the medical professionals and nursing staff should be in line with their qualification, training and registration.	See minimum 5 personal files of staffs (e.g. Consultant RMO & Nurses, etc.) and check for their qualification, training and privileging a) Medical professionals are granted privileges to admit and care of patients in consonance with their qualification, training, experience and registration. b) Medical professionals admit and care for patients as per their privileging. c) Nursing staff is granted privileges in consonance with their qualification, training, experience and registration. d) Nursing professional care for patients as per their privileging. e) System developed for updating the personal files of staff.	Record review & Staff interview
20	Up to date and chronological details of the patient care should be available in the medical record including discharge summary	a) SOP defined for the process of keeping medical record file of discharge patient, MLC and Death case b) Staff is aware and follows the process defined in SOP c) See minimum 5 files from medical record (e.g. Surgery, Medicine, MLC, Death, LAMA, etc.) and check the chronological account of patient care. i) Availability of checklist for maintaining records in chronological order d) Medical record audit with corrective and preventive action.	Record review & Staff interview

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