

## Medical Staffing



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In recent years, the landscape of medical coding systems has experienced significant transformations, reshaping how healthcare providers document clinical services and procedures. These changes have profound implications for reimbursement rates, affecting both healthcare institutions and practitioners.

Medical coding is a critical component in the healthcare revenue cycle, serving as a universal language that translates patient encounters into standardized codes. These codes are used by insurance companies to determine reimbursement amounts for services rendered. Qualified professionals in medical staffing contribute to better regulatory compliance **staffing agency for medical assistant** health administration. The International Classification of Diseases (ICD) and Current Procedural Terminology (CPT) codes are among the most widely used systems in this process. As medical practices evolve and new technologies emerge, these coding systems must be updated regularly to ensure accuracy and comprehensiveness.

One of the most notable recent changes was the transition from ICD-9 to ICD-10, which expanded the number of available codes significantly. This shift was designed to provide more specificity and granularity in documenting patient diagnoses. However, it also introduced complexity into the coding process, requiring extensive training for coders and adjustments in billing practices. For many healthcare providers, this transition period resulted in temporary disruptions to cash flow due to delays or denials in claims processing as insurers adapted their systems to accommodate the new code set.

Another significant development is the regular updates to CPT codes that reflect advancements in medical technology and procedural techniques. Each year, new CPT codes are released while outdated ones are revised or retired altogether. These updates aim to capture emerging trends in medicine such as telehealth services, which saw accelerated adoption during the COVID-19 pandemic. While these updates potentially enhance reimbursement opportunities by acknowledging contemporary practices, they also demand ongoing education for medical professionals who must stay abreast of these changes.

The impact of coding changes on reimbursement rates cannot be understated. Accurate coding is essential not only for compliance but also for maximizing revenue potential. Incorrect or outdated coding can lead to claim denials or underpayments by payers, negatively impacting a provider's financial health. Conversely, precise application of current codes facilitates smoother claims processing and ensures appropriate compensation for services provided.

To mitigate risks associated with these transitions and optimize reimbursement rates, healthcare organizations often invest in robust training programs for their staff alongside advanced software solutions that aid in accurate code selection and documentation compliance.

In conclusion, while changes in medical coding systems present challenges due to increased complexity and learning curves involved with new code sets like ICD-10 or annual CPT updates; they also offer opportunities through improved specificity that aligns with modern medical practices thereby optimizing reimbursement outcomes when executed correctly. Therefore staying informed about ongoing developments within this realm remains crucial for all stakeholders involved-from administrators overseeing billing departments down through individual practitioners dedicated towards delivering quality care without compromise on fiscal sustainability.

The healthcare industry is a complex ecosystem, where coding plays a pivotal role in determining reimbursement rates. Coding changes can have significant implications on the financial health of healthcare providers and the accessibility of services for patients. Understanding these impacts requires a nuanced examination of how coding modifications intersect with billing practices and reimbursement systems.

At its core, medical coding involves translating diagnoses, procedures, and services into universal alphanumeric codes. These codes are used by insurance companies to determine how much they will reimburse healthcare providers for their services. Changes in coding can stem from updates to the International Classification of Diseases (ICD) or adjustments to Current Procedural Terminology (CPT) codes, among other sources. Each change carries potential repercussions for reimbursement rates.

One critical aspect of coding changes is how they affect the accuracy and specificity with which patient encounters are documented. More precise codes allow for better reflection of the severity and complexity of conditions treated, which can lead to appropriate adjustments in reimbursement levels. Conversely, if new codes fail to capture these nuances effectively, providers may face challenges in receiving adequate compensation for their services.

Moreover, coding changes often require substantial adjustments within healthcare organizations. They may necessitate additional training for medical coders and billing staff to ensure compliance with new standards. This transition period can be fraught with risks; mistakes during initial implementation might result in claim denials or delays, affecting cash flow and disrupting service delivery.

The impact on reimbursement rates also varies across different specialties and settings. Some areas may benefit from increased reimbursement due to more accurate representation of complex cases, while others might experience reductions if previous codes were more favorable financially. The shift towards value-based care further complicates this landscape as it intertwines quality metrics with payment structures.

Furthermore, regulatory bodies frequently update coding frameworks to curb fraudulent practices or inefficiencies within the system. While these intentions aim at improving transparency and accountability, they can inadvertently introduce burdensome administrative tasks that strain resources without corresponding increases in revenue.

In conclusion, the impact of coding changes on reimbursement rates is multifaceted and far-reaching. It underscores the importance of adaptability within healthcare organizations to navigate evolving landscapes without compromising service quality or financial viability. By staying informed about upcoming changes and investing in continuous education for staff involved in billing processes, providers can better position themselves amidst ongoing shifts in medical coding practices. Ultimately, striking a balance between accurate documentation requirements and fair compensation remains crucial not only for sustaining operations but also for ensuring patient access to high-quality care across diverse healthcare settings.

## **Social Sites**



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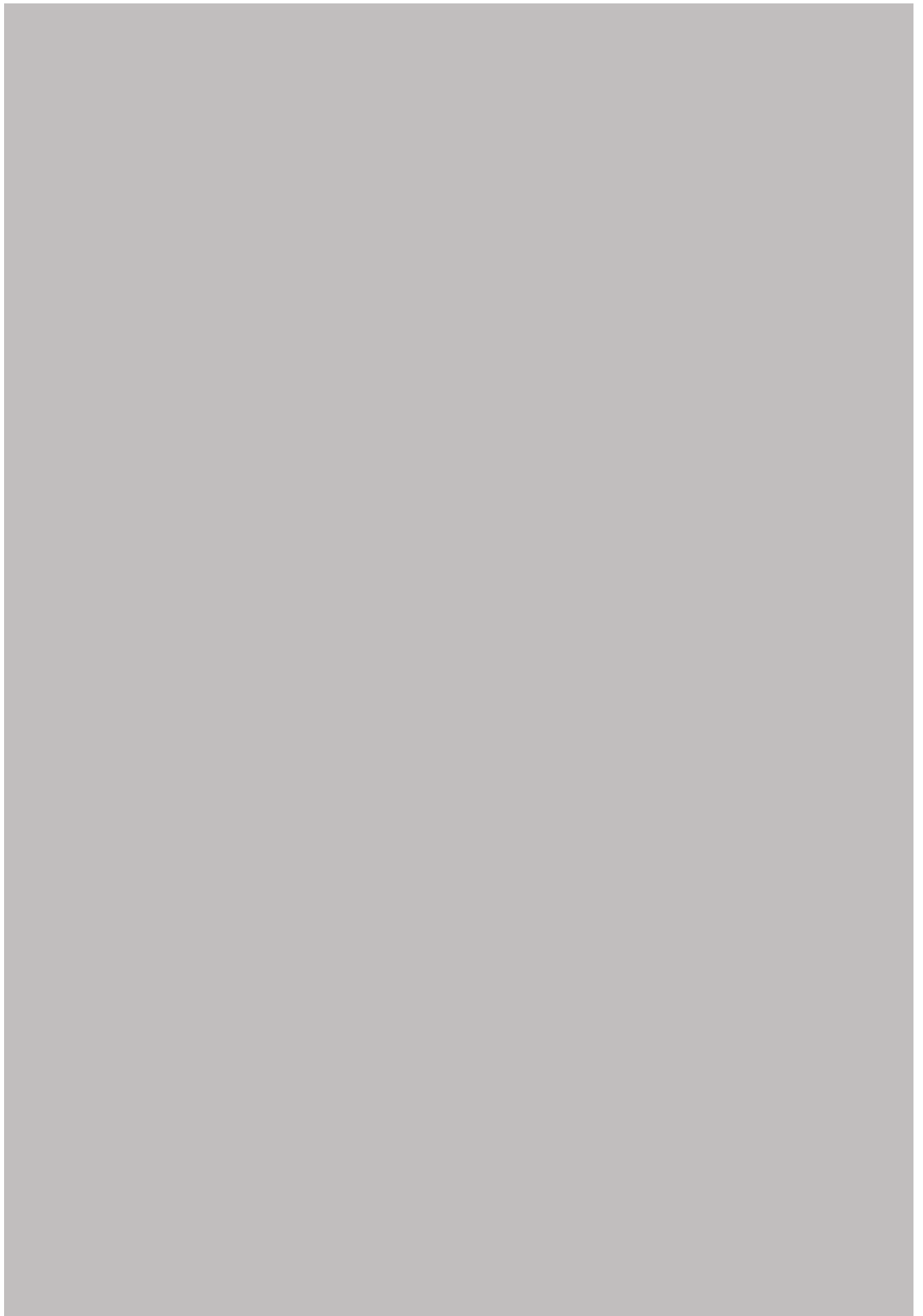
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# Key Changes and Additions to the Latest ICD-10-CM Code Set

The healthcare industry is an intricate web of services, providers, regulations, and reimbursements. Among these complexities lies the crucial aspect of medical coding, which serves as the backbone for billing and reimbursement processes. As the healthcare landscape evolves, so too do the coding systems that underpin it. The transition and adjustments in medical coding present a myriad of challenges for healthcare providers, particularly concerning their impact on reimbursement rates.

Medical coding is a dynamic field that requires constant updates to reflect new treatments, technologies, and diagnoses. These updates are necessary to ensure accurate representation of medical services rendered. However, each adjustment brings with it a period of adaptation for healthcare providers who must swiftly integrate these changes into their billing practices.

One significant challenge faced by healthcare providers due to coding adjustments is the learning curve associated with new codes. When coding systems such as ICD (International Classification of Diseases) or CPT (Current Procedural Terminology) undergo revisions, healthcare professionals need extensive training to understand and apply these changes correctly. This process demands time and resources that smaller practices may find particularly burdensome.

Moreover, inaccurate or outdated coding can lead to claim denials or delayed payments from insurers. Coding errors can occur more frequently during periods of transition when staff are still familiarizing themselves with new codes. Such disruptions can have a direct impact on cash flow for healthcare providers who rely on timely reimbursements to maintain operations.

In addition to internal challenges within practices, external pressures also mount as insurers adjust their policies in response to coding changes. Reimbursement rates may be recalibrated based on updated codes, affecting how much providers receive for specific services. The financial implications are significant; lower reimbursement rates can strain budgets and

potentially influence the scope or quality of care provided.

To mitigate these challenges, many healthcare organizations invest in comprehensive training programs for their staff and adopt advanced software solutions designed to streamline the coding process. Staying proactive by keeping abreast of upcoming changes through continuous education is vital for minimizing disruptions.

In conclusion, while adjustments in medical coding are essential for reflecting advancements in medicine accurately, they pose substantial hurdles for healthcare providers-particularly concerning reimbursement rates. Balancing the need for up-to-date knowledge with operational efficiency requires strategic planning and investment but ultimately ensures that accurate billing supports both provider sustainability and patient care continuity.



# Impact of Updates on Healthcare Providers and Coders

Adapting to new coding standards in the healthcare sector is a challenging yet crucial task, especially when considering their impact on reimbursement rates. As medical coding evolves to better capture the complexities of modern healthcare, organizations must adopt strategies that ensure both compliance and financial stability. Effective adaptation requires a multifaceted approach, focusing on education, technology integration, and continuous evaluation.

First and foremost, education is paramount. Healthcare providers and administrative staff must be thoroughly educated about new coding standards such as updates to ICD codes or CPT changes. Comprehensive training programs should be implemented to help staff understand not only the technicalities of the new codes but also their implications for billing and reimbursement. Regular workshops and seminars can provide ongoing education, ensuring that all team members remain current with any amendments or refinements in coding practices.

In addition to education, leveraging technology plays a critical role in effective adaptation. Advanced software solutions can automate much of the coding process, reducing human error and increasing efficiency. These systems often include updated databases that reflect the latest coding standards, which can assist coders in making accurate selections quickly. Furthermore, these tools can provide analytics on reimbursement patterns, helping organizations identify discrepancies or areas for improvement.

Effective communication between departments is another key strategy for handling changes in coding standards. Creating cross-functional teams that include members from clinical services, billing departments, and IT ensures that all aspects of patient care and revenue cycle management are aligned with current standards. This collaborative approach facilitates seamless transitions when changes occur.

Continuous evaluation of processes is essential to sustain long-term success under new coding regimes. Organizations should regularly audit their coding practices to identify errors or trends that could negatively affect reimbursement rates. By analyzing these audits, healthcare providers can pinpoint specific areas where additional training may be needed or where procedural adjustments could enhance accuracy.

Lastly, engaging with external experts such as consultants or professional associations can provide valuable insights into best practices for adapting to new standards. These experts can offer guidance based on industry-wide experiences and benchmark data, helping organizations navigate complex changes more effectively.

In conclusion, while adapting to new coding standards poses significant challenges due to its direct impact on reimbursement rates, a strategic approach that emphasizes education, technology integration, interdepartmental communication, continuous evaluation, and external expertise can greatly mitigate these challenges. By adopting these strategies proactively rather than reactively adjusting after issues arise—healthcare organizations not only safeguard their financial health but also enhance overall operational efficiency in delivering patient care.

# Strategies for Staying Informed About Code Changes

The healthcare industry is a complex landscape where even subtle changes can have significant ramifications. One such area of complexity is the reimbursement rate, which is heavily influenced by medical coding practices. Understanding how coding changes impact these rates requires examining real-world case studies that highlight the intricate interplay between policy adjustments and financial outcomes.

One notable example of reimbursement rate changes due to coding updates can be observed in the transition from ICD-9 to ICD-10 coding systems. This shift was not merely a numerical update but represented a fundamental transformation in medical classification, expanding codes from 13,000 to over 68,000. The goal was to improve accuracy and detail in

documenting patient diagnoses and procedures. However, this change had substantial effects on reimbursement processes.

Take, for instance, a mid-sized hospital that struggled with initial implementation costs associated with training staff and upgrading IT systems for ICD-10 compliance. Initially, there was anxiety regarding potential disruptions in cash flow due to coding errors or delays in claims processing. However, once the staff became adept at using the new codes, the hospital experienced improved documentation quality that led to more accurate billing and fewer claim denials. Consequently, this enhanced precision positively impacted their reimbursement rates.

Another case involved outpatient clinics that saw variations in reimbursement rates when specific procedure codes were revised under Current Procedural Terminology (CPT) updates. A dermatology clinic noticed a significant decrease in reimbursements for certain skin lesion removals after new CPT guidelines reclassified these procedures into less lucrative categories. To mitigate this impact, the clinic invested in thorough training sessions for coders and billing staff to ensure they fully understood the nuances of updated procedural definitions. By doing so, they successfully optimized their billing strategies and stabilized their revenue streams despite initial setbacks.

Moreover, surgical centers faced challenges when Medicare introduced new bundled payment models aimed at reducing costs while maintaining care quality. Coding changes played a crucial role as they required precise mapping of services provided during episodes of care into bundled payments rather than individual service charges. For some centers, this transition led to temporary reductions in revenue as they adapted their operational workflows and documentation practices accordingly.

These examples underscore how critical it is for healthcare providers to stay informed about coding revisions and proactively adjust their billing practices. Regular training sessions for medical coders and collaboration with payers can help ensure compliance with current standards while optimizing reimbursement potential.

In conclusion, real-world examples demonstrate that while coding changes can initially disrupt financial operations within healthcare facilities, strategic adaptation ultimately paves the way for improved accuracy and efficiency in billing processes-leading to better alignment with payer expectations and potentially favorable adjustments in reimbursement rates over time. As healthcare continues its evolution toward value-based care models emphasizing quality outcomes over volume-based services rendered; mastering these intricacies becomes increasingly vital for sustainable success across diverse clinical settings.

# Challenges and Solutions in Adapting to New Codes

The landscape of medical coding and reimbursement is in a constant state of evolution, driven by advancements in healthcare and changes in regulatory frameworks. As we look towards the future, it is crucial to understand the impact that coding changes have on reimbursement rates, as these adjustments hold significant implications for healthcare providers, insurers, and patients alike.

Medical coding serves as the backbone of the billing process in healthcare, translating complex medical services into standardized codes used for reimbursement. This system ensures consistency and facilitates communication between healthcare providers and payers. However, with ongoing updates to coding systems such as ICD-10-CM/PCS (International Classification of Diseases) and CPT (Current Procedural Terminology), the potential for shifts in reimbursement rates becomes apparent.

One key factor influencing future trends is the transition towards value-based care. This model emphasizes patient outcomes over volume of services rendered; thus, coding changes often reflect this shift by including more detailed codes that capture quality metrics. For instance, new codes might encompass measures related to patient safety or chronic disease management. As a result, providers who excel under these criteria may witness favorable adjustments in their reimbursement rates.

Additionally, technological advancements are playing a pivotal role in reshaping medical coding practices. Artificial intelligence (AI) and machine learning are being increasingly integrated into coding processes to enhance accuracy and efficiency. These technologies can quickly adapt to code updates and help identify patterns that might affect reimbursement rates positively or negatively. Consequently, organizations investing in AI-driven solutions could experience more stable financial outcomes amidst frequent coding alterations.



However, the constant evolution of medical codes also presents challenges that can impact reimbursement rates unfavorably if not managed properly. Healthcare providers must invest time and resources into training staff on new codes and ensuring compliance with updated regulations. Failure to do so can lead to incorrect billing practices or undercoding-both of which can result in reduced reimbursements or even penalties.

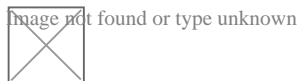
Another concern is how disparities in technology adoption across different healthcare settings may create inequalities in capturing accurate data for fair reimbursements. Smaller practices with limited access to advanced tools might struggle compared to larger institutions capable of swiftly adapting their systems to new requirements.

Looking ahead, collaboration among stakeholders will be essential for navigating these complexities successfully while maintaining equitable access across diverse populations within our healthcare system. Policy makers need input from both clinicians providing care at ground level as well as insurers processing claims based on coded information when crafting policies that determine future directions regarding how code modifications affect reimbursements.

In conclusion, the dynamic nature of medical coding necessitates vigilance from all parties involved due its profound influence on reimbursement rates-a major determinant shaping operational sustainability within health services globally today-and undoubtedly tomorrow too! By embracing innovations like AI alongside fostering collaborative dialogues among industry players we'll better prepare ourselves collectively face forthcoming challenges head-on ensuring optimal outcomes everyone concerned about quality affordable accessible care delivery going forward!

## About overhead

**Overhead** may be:



Look up **overhead** in Wiktionary, the free dictionary.

- Overhead (business), the ongoing operating costs of running a business
- Engineering overhead, ancillary design features required by a component of a device
  - Overhead (computing), ancillary computation required by an algorithm or program
  - Protocol overhead, additional bandwidth used by a communications protocol



- Line code or encoding overhead, additional bandwidth required for physical line transmission
- Overhead information, for telecommunication systems
- File system overhead, storage or other consideration required by a file system that is not directly related to data. For example, in tape data storage, the separator between one file and the next is overhead.
- Any physical object situated, or action occurring above:
  - Overhead line, for power transmission
  - Overhead cable, for signal transmission
  - Overhead projector, a display system
  - Overhead storage, for example overhead storage bins, racks, shelves, cabinets or track systems in aircraft, trains or buildings
- Overhead cam, a mechanical device
- Overhead join, in air traffic control
- Overhead press, an upper-body weight training exercise in
- Overhead crane or bridge crane, a type of crane sliding on two parallel rails

## See also

[edit]

- Overkill (disambiguation)

## Disambiguation icon

This disambiguation page lists articles associated with the title **Overhead**.

If an internal link led you here, you may wish to change the link to point directly to the intended article.

## About patient

For the state of being, see Patience. For other uses, see Patient (disambiguation).

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Part of a series on Patients

**Patients**

**Concepts**

- Doctor-patient relationship
- Medical ethics
- Patient participation
- Patient-reported outcome
- Patient safety

**Consent**

- Informed consent
- Adherence
- Informal coercion
- Motivational interviewing
- Involuntary treatment

### Rights

- Patients' rights
- Pregnant patients' rights
- Disability rights movement
- Patient's Charter
- Medical law

### Approaches

- Patient advocacy
- Patient-centered care
- Patient and public involvement

### Abuse

- Patient abuse
- Elder abuse

### Medical sociology

- Sick role

A **patient** is any recipient of health care services that are performed by healthcare professionals. The patient is most often ill or injured and in need of treatment by a physician, nurse, optometrist, dentist, veterinarian, or other health care provider.

### Etymology

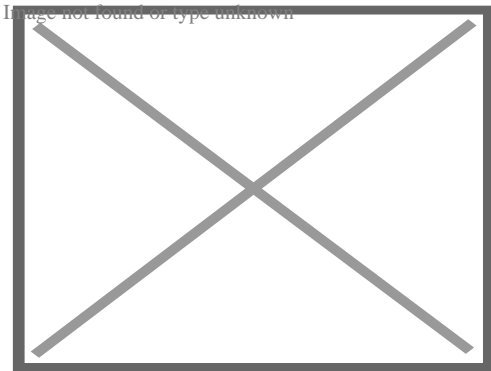
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The word patient originally meant 'one who suffers'. This English noun comes from the Latin word *patiens*, the present participle of the deponent verb, *patior*, meaning 'I am suffering', and akin to the Greek verb πάσχειν (*paskhein* 'to suffer') and its cognate noun πάθος (*pathos*).

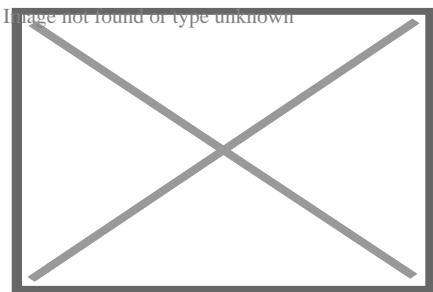
This language has been construed as meaning that the role of patients is to passively accept and tolerate the suffering and treatments prescribed by the healthcare providers, without engaging in shared decision-making about their care.<sup>[1]</sup>

## Outpatients and inpatients

[edit]



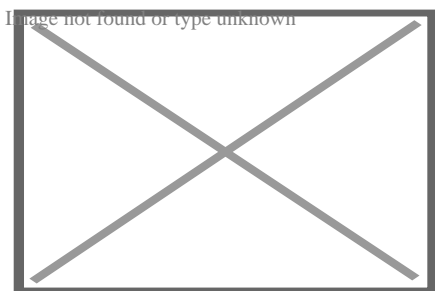
Patients at the Red Cross Hospital in Tampere, Finland during the 1918 Finnish Civil War



Receptionist in Kenya attending to an outpatient

An **outpatient** (or **out-patient**) is a patient who attends an outpatient clinic with no plan to stay beyond the duration of the visit. Even if the patient will not be formally admitted with a note as an outpatient, their attendance is still registered, and the provider will usually give a note explaining the reason for the visit, tests, or procedure/surgery, which should include the names and titles of the participating personnel, the patient's name and date of birth, signature of informed consent, estimated pre-and post-service time for history and exam (before and after), any anesthesia, medications or future treatment plans needed, and estimated time of discharge absent any (further) complications. Treatment provided in this fashion is called ambulatory care. Sometimes surgery is performed without the need for a formal hospital admission or an overnight stay, and this is called outpatient surgery or day surgery, which has many benefits including lowered healthcare cost, reducing the amount of medication prescribed, and using the physician's or surgeon's time more efficiently. Outpatient surgery is suited best for more healthy patients undergoing minor or intermediate procedures (limited urinary-tract, eye, or ear, nose, and throat procedures and procedures involving superficial skin and the extremities). More procedures are being performed in a surgeon's office, termed *office-based surgery*,

rather than in a hospital-based operating room.



A mother spends days sitting with her son, a hospital patient in Mali

An **inpatient** (or **in-patient**), on the other hand, is "admitted" to stay in a hospital overnight or for an indeterminate time, usually, several days or weeks, though in some extreme cases, such as with coma or persistent vegetative state, patients can stay in hospitals for years, sometimes until death. Treatment provided in this fashion is called inpatient care. The admission to the hospital involves the production of an admission note. The leaving of the hospital is officially termed *discharge*, and involves a corresponding discharge note, and sometimes an assessment process to consider ongoing needs. In the English National Health Service this may take the form of "Discharge to Assess" - where the assessment takes place after the patient has gone home.<sup>[2]</sup>

Misdiagnosis is the leading cause of medical error in outpatient facilities. When the U.S. Institute of Medicine's groundbreaking 1999 report, *To Err Is Human*, found up to 98,000 hospital patients die from preventable medical errors in the U.S. each year,<sup>[3]</sup> early efforts focused on inpatient safety.<sup>[4]</sup> While patient safety efforts have focused on inpatient hospital settings for more than a decade, medical errors are even more likely to happen in a doctor's office or outpatient clinic or center.<sup>[citation needed]</sup>

## Day patient

[edit]

A **day patient** (or **day-patient**) is a patient who is using the full range of services of a hospital or clinic but is not expected to stay the night. The term was originally used by psychiatric hospital services using of this patient type to care for people needing support to make the transition from in-patient to out-patient care. However, the term is now also heavily used for people attending hospitals for day surgery.

## Alternative terminology

[edit]

Because of concerns such as dignity, human rights and political correctness, the term "patient" is not always used to refer to a person receiving health care. Other terms that are sometimes used include **health consumer**, **healthcare consumer**, **customer** or **client**. However, such terminology may be offensive to those receiving public health care, as it implies a business relationship.

In veterinary medicine, the **client** is the owner or guardian of the patient. These may be used by governmental agencies, insurance companies, patient groups, or health care facilities. Individuals who use or have used psychiatric services may alternatively refer to themselves as consumers, users, or survivors.

In nursing homes and assisted living facilities, the term **resident** is generally used in lieu of *patient*.<sup>[5]</sup> Similarly, those receiving home health care are called *clients*.

## Patient-centered healthcare

[edit]

See also: Patient participation

The doctor–patient relationship has sometimes been characterized as silencing the voice of patients.<sup>[6]</sup> It is now widely agreed that putting patients at the centre of healthcare<sup>[7]</sup> by trying to provide a consistent, informative and respectful service to patients will improve both outcomes and patient satisfaction.<sup>[8]</sup>

When patients are not at the centre of healthcare, when institutional procedures and targets eclipse local concerns, then patient neglect is possible.<sup>[9]</sup> Incidents, such as the Stafford Hospital scandal, Winterbourne View hospital abuse scandal and the Veterans Health Administration controversy of 2014 have shown the dangers of prioritizing cost control over the patient experience.<sup>[10]</sup> Investigations into these and other scandals have recommended that healthcare systems put patient experience at the center, and especially that patients themselves are heard loud and clear within health services.<sup>[11]</sup>

There are many reasons for why health services should listen more to patients. Patients spend more time in healthcare services than regulators or quality controllers, and can recognize problems such as service delays, poor hygiene, and poor conduct.<sup>[12]</sup> Patients are particularly good at identifying soft problems, such as attitudes, communication, and 'caring neglect',<sup>[9]</sup> that are difficult to capture with institutional monitoring.<sup>[13]</sup>

One important way in which patients can be placed at the centre of healthcare is for health services to be more open about patient complaints.<sup>[14]</sup> Each year many hundreds of thousands of patients complain about the care they have received, and

these complaints contain valuable information for any health services which want to learn about and improve patient experience.[<sup>15</sup>]

## See also

[edit]

- Casualty
- e-Patient
- Mature minor doctrine
- Nurse-client relationship
- Patient abuse
- Patient advocacy
- Patient empowerment
- Patients' Bill of Rights
- Radiological protection of patients
- Therapeutic inertia
- Virtual patient
- Patient UK

## References

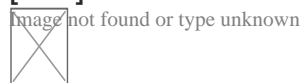
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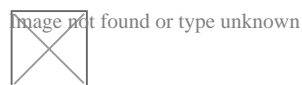
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## External links

[edit]



Wikimedia Commons has media related to ***Patients***.



Look up ***patient*** in Wiktionary, the free dictionary.

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review article with views on the meaning of the words "good doctor" vs. "good patient"
- "Time Magazine's Dr. Scott Haig Proves that Patients Need to Be Googlers!" – Mary Shomons response to the Time Magazine article "When the Patient is a Googler"

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Articles about hospitals

History of hospitals, Hospital network, Category:Hospitals

### **Common hospital components**

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- Hospitalist
- Intensive care unit
- Nocturnist
- On-call room
- Operating theater
- Orderly
- Patients
- Pharmacy
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- Asclepeion (Greece)
- Bimaristan (Islamic)
- Cottage hospital (England)
- Hôtel-Dieu (France)
- Valetudinaria (Roman)
- Vaishya lying in houses (India)
- Xenodochium (Middle Ages)

### **Archaic forms**



<b>Geographic service area</b>	<ul style="list-style-type: none"> <li>○ Base hospital (Australia)</li> <li>○ Community hospital</li> <li>○ General hospital</li> <li>○ Regional hospital or District hospital</li> <li>○ Municipal hospital</li> <li>○ Day hospital</li> </ul>
<b>Complexity of services</b>	<ul style="list-style-type: none"> <li>○ Secondary hospital</li> <li>○ Tertiary referral hospital</li> <li>○ Teaching hospital</li> <li>○ Specialty hospital</li> <li>○ Hospital ship</li> <li>○ Hospital train</li> </ul>
<b>Unique physical traits</b>	<ul style="list-style-type: none"> <li>○ Mobile hospital</li> <li>○ Underground hospital</li> <li>○ Virtual Hospital</li> <li>○ Military hospital</li> <li>○ Combat support hospital</li> </ul>
<b>Limited class of patients</b>	<ul style="list-style-type: none"> <li>○ Field hospital</li> <li>○ Prison hospital</li> <li>○ Veterans medical facilities</li> <li>○ Women's hospital</li> <li>○ Charitable hospital</li> <li>○ For-profit hospital</li> <li>○ Non-profit hospital</li> </ul>
<b>Funding</b>	<ul style="list-style-type: none"> <li>○ State hospital</li> <li>○ Private hospital</li> <li>○ Public hospital</li> <li>○ Voluntary hospital</li> <li>○ Defunct</li> <li>○ Cancer</li> <li>○ Children's hospital</li> <li>○ Eye hospital</li> <li>○ Fever hospital</li> </ul>
<b>Condition treated</b>	<ul style="list-style-type: none"> <li>○ Leper colony</li> <li>○ Lock hospital</li> <li>○ Maternity hospital</li> <li>○ Psychiatric hospital</li> <li>○ Rehabilitation hospital</li> <li>○ Trauma center</li> <li>○ Veterinary hospital</li> </ul>

**Century established**

- 5th
- 6th
- 7th
- 8th
- 9th
- 10th
- 11th
- 12th
- 13th
- 14th
- 15th
- 16th
- 17th
- 18th
- 19th
- 20th
- 21st

Lists of hospitals in: Africa, Asia, Europe, North America, Oceania, South America

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