

# Open Heart Surgery Survey

Parts A-C for 1/1/2006-12/31/2006

## Part A: General Information

Georgia Department of Community Health

**1. Identification:**

**Due Date: April 13, 2007**

Year: 2006

Facility UID	<input type="text"/>	UID:	
a. Facility Name	<input type="text"/>	b. County	<input type="text"/>
c. Street Address	<input type="text"/>	d. City	<input type="text"/>
f. Mail Address	<input type="text"/>	e. Street Zip	<input type="text"/>
		g. City	<input type="text"/>
i. Medicaid Provider Number	<input type="text"/>	h. Mail Zip	<input type="text"/>
		j. Medicare Provider Number	<input type="text"/>

**2. Report Period:**

Report data for the full 12-month period, January 1, 2006 through December 31, 2006 (365 days). Do not use a different report period.

Check the box to the right if your facility was NOT operational for the entire year.

If your facility was NOT operational for the entire year, provide the dates the facility was operational below:

## Part B: Survey Contact Information

Person authorized to respond to inquiries about the responses to this survey:

Name	<input type="text"/>	Title	<input type="text"/>
Telephone	<input type="text"/>	Fax	<input type="text"/>
E-mail	<input type="text"/>		

## Part C: Utilization Data

1. Report the total number of OPEN HEART surgery operations performed during the report period by age and type of operation. DO NOT include any closed heart surgeries or cardiac catheterization procedures.

	Number by Age		Row Total
	Ages 0-14	Ages 15+	
a. Coronary bypass	0	0	0
b. Coronary bypass plus valves	0	0	0
c. Aortic valve replacement	0	0	0
d. Mitral valve replacement	0	0	0
e. Heart transplant	0	0	0
f. Atrial septal defect	0	0	0
g. Ventricular septal defect	0	0	0
h. Tetralogy of fallot	0	0	0
i. Other (Specify)	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Total</b>	<b>0</b>	<b>0</b>	<b>Grand Total</b>

**Part C: Utilization Data (continued)**

2. Report the total number of CLOSED HEART surgery operations performed during the report year by age and type of operation. DO NOT include any open heart surgeries or procedures performed by cardiac catheterization.

Type of Closed Heart Surgery Operation	Number by Age		Row Total
	Ages 0-14	Ages 15+	
a. Coronary bypass	0	0	0
b. Coarctation of the aorta	0	0	0
c. Closure of patent ductus arteriosus, age >28 days, by CHS	0	0	0
d. Closure of patent ductus arteriosus, age <28 days, by CHS	0	0	0
e. Palliative shunts for cyanotic heart disease	0	0	0
f. Other (Specify)	0	0	0
	0	0	0
	0	0	0
<b>Total</b>	<b>0</b>	<b>0</b>	<b>0</b>

3. During the report period, how many coronary angioplasties performed at your hospital resulted in immediate emergency open heart surgery operations? (If necessary, estimate)

Check if Estimated

Please Note: The totals reported in Questions 4 and 5 below must balance to the total reported in Part F (Patient Origin).

4. Please report the number of unduplicated open-heart surgery patients your facility served during the report period using the following race and ethnicity categories.

Patients by Race/Ethnicity							Total
American Indian/ Alaska Native	Asian	Black OR African American	Hispanic OR Latino	Hawaiian OR Pacific Islander	White	Multi-Racial	
Number of Patients	0	0	0	0	0	0	0

5. GENDER: Please report the number of open-heart surgery patients by gender served during the report period.

	Male	Female	Total
Number of Patients	0	0	0

# Open Heart Surgery Survey

Parts D-G

for 1/1/2006-12/31/2006

UID:

## Georgia Department of Community Health

Facility UID   
 Facility Name

Year:  
 UID:

### Part D: Financials and Average Charges

- For the 2005 report period, report the average total hospital charge, length of stay, and number of cases from admissions to discharge, excluding Medicare outliers, for each of the following DRGs.

Important: See instructions

Selected DRGs:	Average		Number of Cases	
	Total Hospital Charge	Length of Stay (in days)	Included in Calculation of Averages	Actual Hospital Total
a. DRG 103: Heart Transplant				
b. DRG 104: Cardiac Valve Procedures with Cardiac Catheterization				
c. DRG 105: Cardiac Valve Procedures without Cardiac Catheterization				
d. DRG 107: Coronary Bypass with Cardiac Catheterization				
e. DRG 109: Coronary Bypass without Cardiac Catheterization				

- Please report the total number of unduplicated open heart surgery patients and operations by primary payment source. Please report Peachcare For Kids patients under Third-Party.

	Primary Payment Source			
	Medicare	Medicaid	Third-Party (including Peachcare)	Self-Pay
Number of Open Heart Surgery Patients (unduplicated)				
Number of Operations				

- Please report the total charges for open heart surgeries provided during the report period.

**Total Charges**

- Please provide the actual reimbursement received for charges for open heart surgeries provided during the report period.

**Actual Reimbursement**

- Please report the total uncompensated charges for open heart surgeries for patients that are indigent or covered by charity care services. Also, report the number of patients.

**Total Uncompensated Charges**

**Total Uncompensated Patients**

5. Please report the Adjusted Gross Revenue for Open Heart Surgery Services during the report period.

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<b>Adjusted Gross Revenue</b>

**Part E: Peer Review**

- 1. Check the box to the right if your program/facility participates in an external or national peer review and outcomes reporting system?

If you indicated yes above, please provide the name(s) of the peer review/outcomes reporting organization(s) below:

- 2. How many community education programs did your program/facility participated in during the reporting period.

**Part F: Patient Origin**

**Please report the number of open heart surgery patients by county and age category. The grand totals must agree with the calculated totals of open heart operations by race and gender found in Part C, Questions 4 and 5. To delete a row, press Esc to clear data entry errors. Then click in the margin to the left of the county name and press the delete key.**

(Please see the instructions for further information.)

Grand Total Pediatric

Grand Total Adult

**Part G: Comments**

Please enter below any comments and suggestions that you have about this survey.

Comments:

**NOTE: You must go to the Signature Form and sign your survey before submitting it. The survey will not be deemed complete without an authorized signature.**

# Annual Open Heart Surgery Services Survey

for 1/1/2006-12/31/2006

UID:

## Signature Form

*Georgia Department of Community Health*

### **YOU MUST CHECK FOR ERRORS BEFORE COMPLETING THE SIGNATURE SECTION**

In order to ensure the Signature Form will accept an authorized signature you must first click the "View Error Messages" button. This button will produce a report detailing any missing data items that are required or balances that do not agree but are required to be in balance. The Signature Form WILL NOT accept an authorized signature until each item on the Data Validation Report is corrected. After correcting errors, please click the "View Error Messages" button again to make sure that all errors have been cleared.

### Electronic Signature

Please note that the survey WILL NOT BE ACCEPTED without the authorized signature of the Chief Executive Officer or Executive Director (principal officer) of the facility. The signature can be completed only AFTER all survey data has been finalized. By law, the signatory is attesting under penalty of law that the information is accurate and complete.

I state, certify and attest that to the best of my knowledge upon conducting due diligence to assure the accuracy and completeness of all data, and based upon my affirmative review of the entire completed survey, this completed survey contains no untrue statement, or inaccurate data, nor omits requested material information or data. I further state, certify and attest that I have reviewed the entire contents of the completed survey with all appropriate staff of the facility. I understand that inaccurate, incomplete or omitted data could lead to sanctions against me or my facility. I further understand that a typed version of my name is being accepted as my original signature pursuant to the Georgia Electronic Records and Signature Act.

Authorized Signature:

Date:

Title:

Comments:

### **Unresolved Data Issues**

Please explain any unresolved data issues in the comments box.