Single-Specialty Ambulatory Surgery Facility Demonstration Project

DRAFT Annual Evaluation DRAFT

Instructions: No later than _____ return one completed copy of this evaluation form to the Medical Facilities Planning Branch and one to the Certificate of Need Section, Division of Health Services Regulation.

Evaluation is for (circle the appropriate year):

Year 1 Year 2 Year 3 Year 4 Year 5

Reporting Period: _____ through _____
(Month/Day/Year) (Month/Day/Year)

Facility Information

Facility Name: _____
CON Project I.D. #: _____ Surgical Specialty: _____
Date of initial license: _____ Date of initial accreditation: _____
Accrediting body: _____

Care to Self-Pay and Medicaid Patients

Pursuant to the material representations made in your application and the conditions imposed on your certificate, the facility is required to demonstrate that the Medicare allowable amount for self-pay and Medicaid surgical cases minus all revenue collected from self-pay and Medicaid surgical cases was at least *seven percent of the total revenue* collected for all surgical cases performed in the facility. Complete the attached Form A (Revenue and Expense Statement) and Form B (7% Worksheet) and attach to this report.

Report to Statewide Data Processor

Pursuant to the material representations made in your application and the conditions imposed on your certificate, the facility is required to submit utilization and payment data to the statewide data processor as required by G.S. 131E-214.2. Did the facility submit utilization and payment data to the statewide data processor during the reporting period? ____ Provide supporting documentation.

Surgical Safety

Pursuant to the material representations made in your application and the conditions imposed on your certificate, the facility is required to complete a Surgical Safety Checklist before each surgery is performed. What was the percentage of surgeries for which a Surgical Safety Checklist was actually completed? _____ % Provide supporting documentation.

Patient Outcomes

1. Pursuant to the material representations made in your application and the conditions imposed on your certificate, the facility is required to develop a system to measure and report patient outcomes. Attach a detailed description of the system used by the facility during the reporting period.

   Note: At a minimum, patient outcome measures *must* include: wound infection rate; number and percentage of post-operative infections; number and percentage of post-procedure complications; number and percentage of readmissions; and the number and percentage of medication errors.

2. Provide the patient outcome results for each patient outcome measure used during the reporting period.

Interoperability with Other Providers

Pursuant to the material representations made in your application and the conditions imposed on your certificate, the facility is required to describe the system used to enhance communication and ease data collection (e.g., electronic medical records). Attach a detailed description of the system used by the facility during the reporting period.

Open Access to Physicians

1. Did you represent in your application that the facility would provide open access for physicians? _____ Yes _____ No
2. If you answered yes, attach a detailed description of the facility's policy.
3. How many non-owner affiliated physicians performed surgery at the facility during the reporting period? _____

Physician Responsibilities

1. How many physicians, both owner and non-owner, were affiliated with the facility during the reporting period? _____
2. How many physicians affiliated with the facility established or maintained hospital staff privileges with at least one hospital during the reporting period? _____
3. How many physicians affiliated with the facility began or continued to meet Emergency Department coverage responsibilities with at least one hospital? _____
4. Complete the attached Physician Responsibilities form.

The undersigned hereby assures and certifies that the information included in this evaluation form and all attachments is correct to the best of my knowledge and belief.

Signature: _____ Date: _____

Print Name and Title _____