

# Kentucky Health Survey Registry

## Welcome

Good morning!

This application supports the entry and tracking of survey information relating to the health care utilization and service.

**Please Note: 2019 was not a leap year and reported data should account for 365 days.**

License #:  \*

Password:  \*

Re-enter Password:  \*

## Contact Information

For KY Health Survey program support, please contact:

**Cabinet for Health and Family Services**  
**275 East Main St. 4 WE**  
**Frankfort KY 40621**

Contacts for survey.

Survey	Contact	Phone #	eMail Address
Ambulatory Surgery II	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Chemical Dependency	Elizabeth Tutt	(502) 564-7940 X 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Home Health II	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Hospice	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Hospital	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Long Term Care	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Megavoltage Radiation (Linear Accelerator)	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Magnetic Resonance Imaging	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Private Duty Nursing	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Positron Emission Tomography	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>
Psychiatric Residential Treatment Facility	Elizabeth Tutt	(502) 564-7940 x 3156	<a href="mailto:ElizabethA.Tutt@ky.gov">ElizabethA.Tutt@ky.gov</a>

# Survey Registration

## Registration Information

**License #:** 123456  
**Facility:** Test Production Sites  
**Street 1:**  \*  
**Street 2:**   
**City:**  \*  
**State:**  \*  
**Zip:**  \*-   
**County:**  \* Required if KY address

## Available Survey(s) for Current Survey Year

- If a survey does not appear for completion, please contact the Office of Health Data Analytics at (502) 564-7940. Required reporting includes; Hospitals, Ambulatory Surgery, Magnetic Resonance Imaging, Megavoltage Radiation, Positron Emission Tomography, Home Health, Hospice, Long Term Care, Chemical Dependency, Private Duty Nursing and Psychiatric Residential Treatment Facilities. If a service is conducted under a different license number from a Hospital then the survey will be provided under that specific number. Select current survey under Survey Completion below. Input survey data and submit to state for each survey below.
- Survey deadline March 30.

**Please Note: 2019 was not a leap year and reported data should account for 365 days.**

### Facility's Survey(s)

Year	Complete Date	Survey Completion	Equipment	Blank Downloadable
2019		<u>Ambulatory Surgery II</u>		
2019		<u>Chemical Dependency</u>		
2019		<u>Home Health II</u>		
2019		<u>Hospice</u>		
2019		<u>Hospital</u>		
2019		<u>Long Term Care</u>		
2019		<u>Magnetic Resonance Imaging</u>	<u>Equip for MRI</u>	
2019		<u>Megavoltage Radiation (Linear Accelerator)</u>		
2019		<u>Positron Emission Tomography</u>		
2019		<u>Private Duty Nursing</u>		
2019		<u>Psychiatric Residential Treatment Facility</u>		

## Available Survey(s) for Prior Survey Year(s)

# Survey Registration

## Respondent Information

**Identification #:** 123456

**Facility:** Test Production Sites

**Survey:** ASC2

**Survey Year:** 2019 ▼

**Respondent First Name:**  \*

**Respondent Last Name:**  \*

**Respondent Phone:**  \*

**Respondent eMail:**  \*

**Administrator First Name:**  \*

**Administrator Last Name:**  \*

**Administrator Phone:**  \*

**Administrator eMail:**  \*

**Save**

**Continue**

# 2019 Instructions for Survey

## Ambulatory Surgery II

This survey is for the reporting period: January 1, 2019 through December 31, 2019.

**INTRODUCTION:** The printable version of the survey is only for your convenience in completing the survey on paper before submitting the data online. Surveys are due March 30, 2020. This survey is for the period January 1, 2019 through December 31, 2019.

The accuracy and completeness of the data reported in this survey are essential to the process of health planning in Kentucky. It also represents the data requirements as set forth in 900 KAR 6:125. All items must be complete and accurate before this survey will be considered acceptable.

All survey extension requests must be approved by the designated survey administrator.

**PLEASE READ ALL INSTRUCTIONS CAREFULLY AND THOROUGHLY.** Compare this survey to surveys previously submitted for consistency and comparability.

You are responsible for the accuracy of the data reported in this survey. Failure to complete and correct the indicated parts of the survey will result in your facility being reported to the Office of Inspector General for a possible licensure deficiency. Retain a copy of the completed survey for your files.

If there are any questions concerning the preparation of this survey, please contact survey administrator Elizabeth Tutt at (502) 564-7940 or email [ElizabethA.Tutt@ky.gov](mailto:ElizabethA.Tutt@ky.gov). The published KY Annual Survey Reports may be viewed at: <https://chfs.ky.gov/agencies/ohda/Pages/annualreports.aspx>.

**DEFINITIONS:** In all instances, unless otherwise specified, the terms used in this survey are the same as those found in the American Hospital Association AHA Hospital.

The Ambulatory Surgical Services Survey has been updated to include data collection for Procedure Rooms. Section I is to include only data for an Ambulatory OR. Section II is to include data for surgical procedures that were performed only in a Procedure Room. Do not duplicate data. Certificate of Need (CON) at this time only uses Ambulatory OR data.

Include only Ambulatory Surgical Operations that have been performed in a sterile operating room in Section I and indicate the number of ambulatory surgery operations performed by major service category.

Include only Ambulatory Surgical Procedures that have been performed in a procedure room that is not considered sterile in Section II and indicate the number of ambulatory surgical procedures performed by major service category.

**Continue**

## Survey Administrator Information

Elizabeth Tutt  
Cabinet for Health and Family Services  
(502) 564-7940 x 3156  
[ElizabethA.Tutt@ky.gov](mailto:ElizabethA.Tutt@ky.gov)

## 2019 Ambulatory Surgery II Survey

### Section I: Ambulatory Surgery Data - Operating Room's

#### A. Ambulatory Surgical Operations (excluding heart)

**Identification #:** 123456

**Facility:** Test Production Sites

- Defined as discrete patient encounters, whether major or minor, performed only in the operating room(s). A surgical operation can involve one or more surgical procedures, but is still considered only one operation. Unless specific procedures are asked for, operations should be reported. Do not include injections.
- Sec I: A-E Should not include procedure room data. Section I is for Certified Sterile OR data only.
- Sec 1: B1 - Exclusive means rooms only used as outpatient. The non-exclusive combined use inpatient and outpatient rooms are on the hospital survey.

\* Endoscopic Surgery should include but not limited to the following; Laparoscopy, Thoracoscopy, Rhinoscopy, Otoscopy, Cystoscopy and Colonoscopy. Only include those that are invasive and performed in an ambulatory OR.

**1. Orthopedic surgery**

**2. Plastic Surgery**

**3. ENT Surgery**

**4. Ophthalmological Surgery**

**5. Urologic Surgery**

**6. Gynecological Surgery**

**7. Endoscopic Surgery (not included above 1 - 6) \***

**8. All Other Surgery**

**Total Ambulatory Surgery Operations**

**Calculate**

#### B. Utilization - Capacity

\* Number of current operating rooms for your facility (if the actual number varies, please provide an explanation)

**1. Number of Ambulatory Operating Rooms (Exclusive Ambulatory use), Excluding Cystoscopy Rooms**

**2. Number of Cystoscopy Rooms**

**3. Number of Patients Served during the Reporting Period**

**4. Total number of Hours/Typical Week Your Facility was Open (Hrs surgery staffed)**

#### C. Service Time

**1. Total Surgical Hours (REPORT IN WHOLE HOURS)**

**2. Average clean-up time between operations (REPORT IN WHOLE MINUTES)**

#### D. Non-surgical Procedures

**All Non-surgical procedures Include any procedure in an operating room, which is not classified by your facility as surgical to be non-surgical.**

#### E. Pain Management

**Number of pain management cases performed in an ambulatory OR. (Please list types of pain management procedures in comment box.)**

#### Comment

of 1000

**Save**

## 2019 Ambulatory Surgery II Survey

### Section II: Procedure Room Data

#### A. Ambulatory Procedure (excluding heart)

**Identification #:** 123456

**Facility:** Test Production Sites

- Defined as discrete patient encounters, whether major or minor, performed only in the procedure room(s). A surgical procedure can involve one or more procedures, but is still considered only one operation. Unless specific procedures are asked for, the number of operations should be reported. Do not include injections.
- Sec II: A - E should include procedure room data only.
- Exclusive means rooms only used as a non-sterile Procedure Room. These are not the rooms in Section I.

\* Endoscopic Surgery should include but not be limited to the following; Laparoscopy, Thoracoscopy, Rhinoscopy, Otoscopy, Cystoscopy and Colonoscopy. Only include those that are performed in a procedure room.

<b>1. Orthopedic Surgical Procedure</b>	<input type="text" value="0"/>
<b>2. Plastic Surgical Procedure</b>	<input type="text" value="0"/>
<b>3. ENT Surgical Procedure</b>	<input type="text" value="0"/>
<b>4. Ophthalmological Surgical Procedure</b>	<input type="text" value="0"/>
<b>5. Urologic Surgical Procedure</b>	<input type="text" value="0"/>
<b>6. Gynecological Surgical Procedure</b>	<input type="text" value="0"/>
<b>7. Endoscopic Surgical Procedure (not included above 1-6)*</b>	<input type="text" value="0"/>
<b>8. All Other Surgical Procedure</b>	<input type="text" value="0"/>
<b>Total Ambulatory Surgical Procedure</b>	<input type="text" value="0"/> <input type="button" value="Calculate"/>

#### B. Utilization - Capacity

<b>1. Number of Ambulatory Procedure Rooms,(exclusive procedure room use). Excluding Cystoscopy Rooms as of December 31 (exclusive outpatient Rooms)</b>	<input type="text" value="0"/>
<b>2. Number of Endoscopy Rooms (not included in Number of Ambulatory Procedure Rooms.)</b>	<input type="text" value="0"/>
<b>3. Number of Patients Served in a procedure room during the Reporting Period</b>	<input type="text" value="0"/>
<b>4. Total number of hours/typical week the procedure room was operational?</b>	<input type="text" value="0"/>

#### C. Service Time

<b>1. Total Procedure Hours (REPORT IN WHOLE HOURS)</b>	<input type="text" value="0"/>
<b>2. Average clean-up time between procedures (REPORT IN WHOLE MINUTES)</b>	<input type="text" value="0"/>

#### D. Procedures

<b>All non-surgical procedures performed in a procedure room. Include any procedure in an procedure room, which is not classified by your facility as surgical to be non-surgical.</b>	<input type="text" value="0"/>
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#### E. Pain Management

<b>Number of Pain management cases performed in procedure room. (Please list types of pain management procedures in the comment box.)</b>	<input type="text" value="0"/>
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#### Comment

of 1000

# Ambulatory Surgery II Survey for 2019

## Survey Data Verification

Thank you for completing the survey.

On behalf of the administration of Test Production Sites, I certify that the information contained in this report is complete and accurate. After reviewing the information contained in this report, I hereby submit it as an official record of the facility's activity in compliance with 900 KAR 6:125.

**\*Only verify once the survey is completed.\***

Once data is complete, verification notices will be emailed to the state and to your facility's respondent and administrator. If the respondent or administrator does not receive this confirmation it is likely that their email address was not included or had a typo in the registration section of this survey. In this case, please contact the Office of Health Data Analytics, so this can be corrected.

**Respondent Name:**  
**Administrator Name:**  
**Original Completion Date:**

By clicking this button you are indicating that this survey is complete. You will not be able to change any of the data.

**Verify and Submit to State**

**Print**

## Incomplete Survey(s)

Facility's Survey(s)

Year	Survey	Equipment	Printable Survey
2019	<u>Ambulatory Surgery II</u>		Print Ambulatory Surgery II
2019	<u>Chemical Dependency</u>		Print Chemical Dependency
2019	<u>Home Health II</u>		Print Home Health II
2019	<u>Hospice</u>		Print Hospice
2019	<u>Hospital</u>		Print Hospital
2019	<u>Long Term Care</u>		Print Long Term Care
2019	<u>Magnetic Resonance Imaging</u>	<u>Equip for MRI</u>	Print Magnetic Resonance Imaging
2019	<u>Megavoltage Radiation (Linear Accelerator)</u>		Print Megavoltage Radiation (Linear Accelerator)
2019	<u>Positron Emission Tomography</u>		Print Positron Emission Tomography
2019	<u>Private Duty Nursing</u>		Print Private Duty Nursing
2019	<u>Psychiatric Residential Treatment Facility</u>		Print Psychiatric Residential Treatment Facility