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National Hospital Discharge Survey Facility Questionnaire Part A: Initial Confirmation and Telephone Screen

Screening Call *(Speak with the Public Affairs Office or the CEO's office)*

Hello. My name is _____ from the Research Triangle Institute (RTI). I am calling on behalf of the National Center for Health Statistics of the Centers for Disease Control and Prevention. Your hospital has been selected to participate in a National Survey for the redesign of the National Hospital Discharge Survey, the longest continuing survey of inpatient care in the United States. To determine your eligibility, we need to obtain some information about your hospital. I would like to begin by verifying our records.

1. Is the following name, address and telephone number of this hospital correct? (Read name and address from label below.)

Label with name and address.

If name, address or telephone number is different, please provide new information below.

Hospital name: _____

Address: _____

City, State & ZIP Code: _____

Telephone number: _____

2. Is this hospital a (Read service type from label below) hospital?

Label with service type.

If the service type is different from above, please record new service type below.

Type of service: _____

If different service type is not one of the selected types for the NHDS (see list of excluded service types), then thank the person for his/her time and end the telephone interview.

3a. Is this a federally-owned hospital?

- Yes --- **Thank the person for his/her time and end the telephone interview.**
- No --- Go to Q. 3b

b. Does this hospital have six beds or more?

- Yes --- Go to Q. 3c
- No --- **Thank the person for his/her time and end the telephone interview.**

c. Does this hospital have inpatients?

- Yes --- Go to Q. 3d
- No --- **Thank the person for his/her time and end the telephone interview.**

d. Is this hospital currently licensed by the State?

- Yes
- No --- **Thank the person for his/her time and end the telephone interview.**

4. We want to send some information about the NHDS to an appropriate person in your hospital. Who would this be and what is his/her contact information?

Name: _____

Title: _____

Address: _____

City, State and ZIP Code: _____

Telephone number: _____

E-mail: _____

This is the end of the questions.Thank you for your time today!

National Hospital Discharge Survey Facility Questionnaire

Part B: Interview with Hospital Executive

Section I. Introduction

Thank you for taking the time to speak with us today. As you know, we would like to talk with you about participating in a National Survey to redesign the National Hospital Discharge Survey (NHDS). We are from RTI International, and have been contracted by the Centers for Disease Control and Prevention's National Center for Health Statistics to facilitate this important endeavor.

Perhaps we could all introduce ourselves before we get started. I am Name/Title/Institution.

You should have received a package in the mail prior to this visit that contained the following materials:

- Introduction letter from Dr. Edward Sondik, Director of the National Center for Health Statistics (NCHS)
- NHDS folder containing a description of the NCHS, the NHDS and its purpose
- Frequently Asked Questions related to this National Survey

We have additional materials for you today.

- CDC/NCHS IRB Approval Letter
- Patient Sampling Plan
- RTI's Data Safeguarding Plan
- Facility Questionnaire
- List of Data Abstraction Elements
- Journal Article
- 2005 Advance Data Report

We would like to discuss each of these with you or the appropriate parties during our time today.

Background on the NCHS and the NHDS

The National Center for Health Statistics (NCHS) is responsible for a family of surveys that are designed to measure utilization of the health care delivery system, and are used for a variety of purposes in the public and private sector. A key component in the suite of surveys is the National Hospital Discharge Survey (NHDS). First conducted in 1965, the NHDS has been an important source of information on inpatient utilization in short-stay non-federal hospitals in the United States for many users. Although the NHDS focuses specifically on hospital inpatient care, it fits in a broader portfolio of surveys covering outpatient care, emergency room care, nursing home care, home health and hospice care, and ambulatory surgery center care. Your hospital may in fact participate in one or more of these studies, but RTI is not privy to that information.

About the NHDS: The NHDS produces national estimates of the use of non-federal short-stay U.S. hospitals. The survey provides information on:

- Diagnoses and major surgical and diagnostic procedures

- Lengths of stay
- Patterns of use of care in hospitals of different size and ownership and in various regions of the country.
- Patient characteristics

These data are publicly available for researchers in federal and state governments, hospitals, academia, and other institutions. The public use files do not allow identification of hospitals or patients. They are used for public health and to inform health care policy and research.

Although the NHDS has served the country well for over 40 years, NCHS has redesigned the NHDS for 2010 to better reflect current healthcare concerns, address current policy questions and improve the surveys' clinical relevance. We would like to request your assistance in the redesigned NHDS. NCHS sought input regarding issues that our health care system will face in the future (e.g., 20 years) from clinicians, researchers, insurers, policy makers, and others - in hospitals, government and academic institutions. Based on the input NCHS determined the data elements to be included in this National Survey and created the facility questionnaire and a PC Tool used to abstract patient information.

The redesigned NHDS is informed by the results of a pilot study and a pretest. RTI and NCHS have developed a final well-defined set of field procedures that will allow for consistent data collection from a national sample of hospitals.

Data to be Collected

The National Survey will collect data in the following categories:

- Discharge diagnoses and surgical and diagnostic procedures
- Clinical variables, such as laboratory results
- Protected health information, such as name, address, last 4 digits of SSN and demographics, such as race and gender
- Charges and actual payment
- Medications taken upon admission and prescribed at discharge
- Limited disease specific modules

Confidentiality

Because we will be collecting protected health information (PHI) in this survey, we recognize the hospital's legal obligations to protect PHI and would like to discuss the guarantee of confidentiality that CDC-NCHS provides to hospitals participating in the NHDS National Survey.

First let's discuss Health Insurance Portability and Accountability Act (HIPAA) issues. HIPAA and its Privacy Rule ensure the privacy of study participants. HIPAA permits protected health information (PHI) disclosures without written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes. The Centers for Disease Control and Prevention (CDC), including the National Center for Health Statistics, is an authorized public health entity. RTI, as a contractor for the NCHS is considered to be a public health entity under the Privacy Rule with respect to the activities RTI will conduct related to the National Survey. This study has been reviewed and approved by the NCHS Institutional Review Board (IRB). The IRB has examined the issues of PHI and the methods RTI and the NCHS will use to protect this information. You are permitted by law to rely on the NCHS IRB review and approval.

The second primary topic of interest is how patient and facility information will be used. Information on patients and facilities will be used only for statistical purposes as required by the Public Health Service Act and the Confidential Information Protection and Statistical Efficiency Act (CIPSEA). All published data and documents will be presented in such a way that no individual facility or patient can be identified. Any identifiable information will be held confidential and will be used only by NCHS staff, contractors or agents, only when necessary and with strict controls and will not be disclosed to anyone else without the consent of your facility. Data will be used for statistical purposes only. Under CIPSEA, the penalties for willful disclosure of confidential statistical information (considered a class E felony) are imprisonment for up to 5 years, a fine of \$250,000, or both.

Process and Timeline

The process and timeline we will follow will consist of the following steps:

- 1) We will discuss any questions that the staff has about the sampling plan we provided.
- 2) Your designated staff will pull records after records have been sampled.
- 3) RTI abstractors will come on site for up to 2 days to abstract the 10 records.
- 4) We will debrief you while on site at the end of the 2 day RTI abstraction process.

Before we begin

Do you have any questions based on what we have talked about above?

- Yes → Record questions below
- No

Record Questions:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

We would like now to proceed with conducting the NHDS in your hospital. Does your hospital agree to participate?

- Hospital agrees to participate → Skip to Section II**
- Hospital objects to participating → Go to Q. 1 below**

The questions below are to be completed only if a hospital refuses to participate in the NHDS. The hospital may outline more than one of the following concerns. The skip pattern assumes that only one is articulated. If more than one concern is raised, please follow the questions for each concern raised by the hospital.

1. What concerns do you have about participating in the Survey?

- Our financial situation does not permit us to dedicate time to this effort.
- We are concerned about collecting PHI and will need to review this with our IRB and/or privacy officer.
- We have too many other priorities at this point in time.
- Other → Please specify: _____

2. Can we provide you or someone of your choice with any written documentation, such as the HIPPA law, and its exemption provisions?

- Yes → Hospital contact person: _____
Specify materials requested: _____

- No _____

We are disappointed that we will not be able to work further with your hospital but we very much appreciate the time you spent with us today.

This is the end of the questions . . . Thank you for your time today!

Section II. Administrative Information

The information below, in numbers 1-3, needs to be completed before the point person interview. This information should be validated during the interview process. Numbers 4-5 should be completed, if information is available, before the interview. Otherwise, complete during the interview.

1. Hospital Name:

2. NHDS Hospital Number:

3. CEO/ Administrator Name:

4a. Primary (Point Person) Contact:

b. E-mail:

c. Telephone Number:

d. Pager / Cell phone:

e. Fax:

f. Room number:

g. Address: Street:

City:

State:

ZIP Code:

5a. Assistant's Name:

5b. Assistant's E-mail:

5c. Assistant's Phone:

6. Hospital Personnel Present During Interview ---*This information is to be completed at the interview.*

| Name | Title | Telephone Number | E-mail |
|------|-------|------------------|--------|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Section III. Hospital Health Care System Information

1. Is this hospital a subsidiary of a larger company or part of a hospital network?

Yes → Please indicate the name of the larger company / hospital network

No

2. Are other hospitals covered under your state license?

Yes → Please list name(s) of hospitals: _____

No

3. When this hospital reports utilization information to the State, State hospital association, or a third-party vendor, does it include information solely on this facility or in combination with another facility?

Includes information solely on this facility

In combination with another facility → Please list the other hospitals with which this hospital's discharge data are combined.

4. Grid below to be completed from questions 2 and 3 by interviewer. This grid is for the use of the interviewer. It is not to be asked of the hospital.

Instructions:

- 1) *Using the hospitals listed as answers to questions 2 above, please list each hospital in the space at the top of each column. Please be sure that the hospital that you are at is listed in the column heading space for hospital #1. Also, to the extent that the hospitals in the column headings and row headings are the same list the hospitals in the same order in the column and row headings.*
- 2) *Using the hospitals listed as answers to question 3 above, please list each hospital in the space at the left of each row. Please be sure that the hospital that you are currently at is listed in the row heading space for hospital # 1.*
- 3) *Find the intersection on the chart of the last hospital listed (the highest numbered hospital) in the rows and the last hospital listed in the columns (the highest number hospital).*
- 4) *This intersection will indicate the hospitals from which data should be collected. This set of hospitals will be used in Question 6 to help determine the set of hospitals from which data should be collected.*

| Interviewer to list hospitals from question 2 in column headings → | Hospital #1 | Hospital # 2 | Hospital # 3 | Hospital # 4 |
|--|----------------------|-------------------------------------|-------------------------------------|-------------------------------------|
| Interviewer to list hospitals from Question 3 in Row headings ↓ | | | | |
| Hospital # 1 | Hospital # 1 Only | Hospital # 1 Only | Hospital # 1 Only | Hospital # 1 Only |
| Hospitals # 2 | Hospital # 1 Only | Hospital # 1 and Hospital # 2 | Hospital # 1 and Hospital # 2 | Hospital # 1 and Hospital # 2 |
| Hospital # 3 | Hospital # 1 Only | Hospital # 1 and Hospital # 2 | Hospitals # 1,2, and 3 | Hospitals # 1,2, and 3 |
| Hospital # 4 | Hospital # 1 Only | Hospital # 1 and Hospital # 2 | Hospitals # 1,2, and 3 | Hospitals # 1,2,3 and 4 |

5. Are there **units** within this hospital that are covered by a separate state license or for which discharges are reported separately?

- Yes → Please list the units of the hospital: _____
- No

6a. How many hospitals are covered by your medical records department?

_____ Number of hospitals

b. Can your hospital generate a discharge list that **includes only** the hospitals determined from the intersection of the grid above but **excludes** the units listed in Question 5?

- Yes
- No → Which hospitals will the data for the patient list that can be provided represent? _____
- Don't know

7a. Can facility level information be provided for this hospital alone?

- Yes → *Skip to Section IV.*
- No
- Don't know

b. Please list the names of the other hospitals that will be included in the facility level information:

Section IV. General Demographics

1. What is the number of currently staffed:

Total beds: _____

Estimate: Yes No

Bassinets: _____

Estimate: Yes No

Skilled or Intermediate Nursing Beds: _____

Estimate: Yes No

2. What is the primary service type of this hospital?

Mark (X) only one.

- | | |
|--|---|
| <input type="checkbox"/> General Acute Care | <input type="checkbox"/> Children's Hospital |
| <input type="checkbox"/> Surgical | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Long term care acute | <input type="checkbox"/> Obstetrics & gynecology |
| <input type="checkbox"/> Eye, ear, nose and throat | <input type="checkbox"/> Alcohol/drug dependency only |
| <input type="checkbox"/> Psychiatric only facility | <input type="checkbox"/> Rehabilitation only facility |
| <input type="checkbox"/> Heart | <input type="checkbox"/> Orthopedic |
| <input type="checkbox"/> Other → Please specify: _____ | |

3. Do you anticipate any significant changes in your discharge volume in the coming year (for example, opening a cardiac wing or closing a birthing center)?

- Yes → Please explain _____
 No

Section V. Record Sampling and Identification

Before we proceed with the next set of questions, I would like to explain a little bit about the plan for selecting the particular discharges from your hospital whose information will be collected for the survey. The discharges that we select from this hospital will be entered into a database with discharges from all the other hospitals that participate in the survey. In order to use these discharges to make national estimates of hospital utilization, it is very important that the particular discharges we select from each hospital have a known chance of being included in the sample. In order to do this, we need to collect information from you about the types and number of inpatients you have in your discharge listing. Ideally, we would like to have your hospital create separate listings of discharges that include inpatients with certain characteristics. Our goal is to be able to have 5 separate listings, with each discharge included in one and only one listing. The 5 separate listings we would like are: (1) observation status cases who were not admitted as inpatients, (2) normal newborn infants, (3) patients with acute myocardial infarction, (4) patients discharged dead, but not in groups 1, 2, or 3 above, and (5) all other discharges not included in groups 1, 2, 3, or 4.

So, in order to find out whether your hospital can create the 5 listings from your master list of discharges, I would like to ask a few questions about your patient mix and the type of descriptive information you have about your patients on your discharge lists.

1. Are there particular types of patients that your hospital does NOT have?

Mark (X) all that apply

- Obstetrics (i.e., labor and delivery)
- Pediatrics
- Adult Acute Myocardial Infarction cases
- Observation status cases
- Other → Please specify: _____

2. Can your hospital produce a list of inpatient discharges by the following categories?

Mark (X) for one answer in each category

| Category | Yes | No | Unknown |
|---|--------------------------|--------------------------|--------------------------|
| ICD-9-CM principal diagnosis code | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specific ICD-9-CM diagnosis code among all listed diagnoses codes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ICD-9-CM principal procedure code | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Specific ICD-9-CM procedure code among all listed procedure codes | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge status (<i>deaths, etc.</i>) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Observation status | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. Based on your response to Q2 above, which of the following separate discharge listings (i.e., strata) that do not overlap can your hospital create from a list of all your inpatient discharges?

Mark (X) all that apply

- Observation status patients (who are not later admitted as inpatients)
- Normal newborn infants (V30-V39 codes for births, having no additional diagnoses)
- Discharges with Acute Myocardial Infarction (any-listed diagnosis ICD9-CM code of 410, AMI)
- Inpatients discharged dead, excluding the 3 categories above
- All other discharges, excluding the 4 categories above

- Check here if it is not possible to create any of these strata from your discharge list.

4. If your hospital accepts patients into observation status, in which of the following databases may these patients be found?

Mark (X) all that apply

- Inpatient discharges
- Outpatient visits
- Emergency department visits
- Ambulatory surgery visits
- Other → Please specify: _____

5a. Is it possible for your hospital to separate observation status cases that resulted in inpatient admission from those that did not convert to inpatient admissions?

- Yes---Go to Q 4b.
- No---Skip to Q. 5

5b. Is there an administrative code used to identify those cases?

- Yes → What is the code? _____
- No

5. How many months do you retain information in your hospital computer system on-site for each of the following?

- Clinical systems _____ months
- Laboratory systems _____ months
- Billing / financial systems _____ months

6a. Is the medical record numbering system used in this hospital serial, unit or some other system? *In a **serial** numbering system the patient receives a new number on each admission and each medical chart is filed under its own number. In a **unit** numbering system the patient receives a number on the first hospital admission and retains this number on for all subsequent admissions. In a **serial-unit** numbering system the patient receives a new number on each admission, but all previous medical record charts are brought forward and filed under the number of the most recent admission.*

- Serial
- Unit
- Serial-unit
- Other → Please describe: _____

6b. Besides inpatients does your medical record numbering system include?

| Category | Yes | No | Unknown | Don't have these types of patients |
|--|--------------------------|--------------------------|--------------------------|------------------------------------|
| Outpatients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ambulatory surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for sleep studies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for other (please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6c. Can your hospital generate a discharge list of inpatients that **excludes** the following patients?

*For each "No" response, please ask part "d" below.

| Category | Yes | No* | Unknown | Don't have these types of patients |
|--|--------------------------|--------------------------|--------------------------|------------------------------------|
| Outpatients | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Ambulatory surgery | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for dialysis | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for sleep studies | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Less than 24 hour stay for other (please specify): _____ | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

6d. Is there any way to distinguish these encounters from other inpatient discharges?

Yes → How?

No

Section VI. Data Sources

1. Do you have a policy and related standards that allow your nurses to "**chart by exception**"? *Charting by exception (CBE) is a system for documenting exceptions to normal illness or disease progression, using a shorthand method of charting what is usual and normal. Staff make check marks or write their initials in certain places on the CBE flow sheets.*

- Yes
- No

2a. Can the UB-04 data for your hospital be printed?

- Yes → Skip to Q.3.
- No

b. In what format is the UB-04 available?

- Paper

- Electronic
- Other → Please specify: _____

3a. Is the UB-04 processed by a third party vendor?

- Hospital --- Skip to Q. 4.
- Third party vendor

b. Does your hospital receive the processed UB-04 back from the third party vendor?

- Yes
- No

c. Will your hospital or the third party vendor be printing the UB-04 form for this study?

- Hospital
- Vendor

4. How many days after the end of a month is the UB-04 completed for all discharges in that month and your hospital would be able to generate a list of discharged patients by ICD-9 code for that month?

_____ Number of days

5a. What percent of payments are received two months after discharge?

_____ %

b. What percent of payments are received three months after discharge?

_____ %

6. If a patient is treated at this hospital as an acute inpatient up to 30 days *before* this hospital stay (index admission) or up to 30 days *after* discharge, please provide details about where the information may be obtained for the categories below.

Directions: For each category mark (X) all that apply.

| Where is the best place to find: ↓ | Medical record | Billing | Other→ Please specify |
|--|----------------|---------|-----------------------|
| Admission date & discharge date | | | |
| Encounter type (<i>ED, OPD, Admission</i>) | | | |
| Principal procedure & principal diagnosis | | | |
| DRG | | | |

Section VII. Financial and Billing Information

1. What identifying information for each payment needs to be provided, so that actual payment information can be linked to clinical systems and medical records?

Mark (X) all that apply.

- Admission date
- Discharge date
- Patient name
- Social Security number
- Medical record number
- Insurance ID number
- Encounter number/account number/admission number
- Other → Please specify: _____

Section VIII. Infectious Diseases -- *This section should be asked of the Clinical Microbiology Laboratory staff or Director of Infection Control*

One of our goals is to estimate the number of bloodstream infections among hospitalized patients. To accomplish that, we would like to ask some questions about your system for keeping records of laboratory test results performed for the patients in this hospital.

1. Are results of blood cultures maintained as part of a computerized database?

Yes → How long are they kept on site?

_____ months

_____ years

No → *Skip to Q. 3a.*

2. Can information within the database be manipulated to produce a list of positive blood cultures that contains each of the following data items associated with each culture?

Mark (X) one for each data item.

| Data item | Yes | No | Unknown |
|--|--------------------------|--------------------------|--------------------------|
| Date specimen collected | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Type of organism identified | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Medical record number for patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Discharge/encounter/billing/visit number for patient | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

3. If lab results are not accessible through electronic format, can your hospital provide a paper listing of all positive blood cultures with culture date and organism, by patient id?

Yes

No

Don't know

□

Section IX. Institutional Review Board *This section is optional. Use only if needed.*

We will be collecting protected health information (PHI) in this survey. We recognize the hospital's legal obligations to protect PHI and would like to discuss the guarantee of confidentiality that NCHS provide to hospitals participating in the National Hospital Discharge Survey.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its Privacy Rule ensure the privacy of the study participants. HIPAA permits Protected Health Information (PHI) disclosures without written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes. The Centers for Disease Control and Prevention (CDC), including the National Center for Health Statistics within CDC, is an authorized public health entity. The National Hospital Discharge Survey (NHDS) data collection plan has been reviewed and approved by the National Center for Health Statistics (NCHS)/Centers for Disease Control's (CDC) Research Ethics Review Board (IRB). The IRB approval notification was included in the informational packet given to you. They have particularly examined the issues of PHI and the methods NCHS will use to protect this information. You are permitted by law to rely on a CDC IRB review and approval.

Information on patients and facilities obtained in this study will be used only for statistical purposes as required by the Public Health Service Act. Published documents resulting from this study will be presented in such a way that no individual facility or patient can be identified. Under section 308(d) of the Public Health Service Act [42 USC 242m (d)], the only persons to be granted access privileges to the protected health information after collection will be staff of NCHS and its contractors who have (a) been authorized to work with the file, (b) signed the Nondisclosure Statement in the NCHS Staff Manual on Confidentiality and (c) have seen the NCHS Confidentiality Videotape. In addition, the Confidential Information Protection and Statistical Efficiency Act (CIPSEA), passed in 2002, provides additional protection of all statistical data collected under a pledge of confidentiality. Under CIPSEA, the penalties for willful disclosure of confidential statistical information (considered a class E felony) are imprisonment for up to 5 years, a fine of \$250,000, or both.

1. Will your hospital need to clear participation for the NHDS through your Institutional Review Board (IRB)?

- Yes
- No → *Skip to Section X.*
- Don't know

2a. Would a representative from your hospital be interested in speaking with the CDC/NCHS IRB to better understand the protection they provide?

- Yes → Please provide name, telephone number and email address:

- No

b. Can we provide you or someone of your choice with any written documentation such as the HIPAA law and its exemption provisions?

Yes → Please provide name, telephone number and email address:

Please specify materials requested:

No

3. How often does the hospital's IRB convene?

Once a week

Once a month

Every three months

As needed

Other → Please specify: _____

4. Will your hospital accept the materials presented to the CDC/NCHS IRB or will separate materials need to be prepared?

Accept NCHS materials

Separate materials need to be prepared (Please provide a copy of these materials)

5. Does your IRB require an in-house Principal Investigator (PI)?

Yes

No

6. Who should RTI contact about IRB issues? Please provide name, telephone number and email address. _____

Section X. Key Contacts

Inpatient Data

| | | | |
|---|---------|---------|---------------|
| Sampling | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| Medical Record Abstraction | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| Facility Form | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| Infection Control Department | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| Laboratory | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| Financial/Billing | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| IT/Other Data in Electronic Form | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |
| | | | |
| IRB | Name: | Title: | Phone Number: |
| | E-mail: | Room #: | |

Section XI. Closing

Thank you for your time today. This has been very helpful to us. The RTI abstractor will be

_____.

He/she would like to return on approximately _____ (date) to abstract the 10 records.

Would this date be all right with you? We will discuss these dates with the abstractor and confirm with you within a couple days.

We are extremely appreciative of your willingness to work with us and the CDC/NCHS in this survey. It is through efforts of hospitals such as this one that we are able to provide data to the country to help improve the health and healthcare of our nation.

NATIONAL HOSPITAL DISCHARGE SURVEY REDESIGN

Part C: Hospital Facility Information Form

Thank you for participating in the National Hospital Discharge Survey. The information collected will be invaluable to policymakers, researchers and all who provide patient care in America's hospitals and healthcare systems.

The first section of this questionnaire (questions 1 and 2) collects basic hospital and key contact information. The second section (questions 3-7) is similar to the American Hospital Association (AHA) annual survey, and largely utilizes AHA definitions. The third section (questions 8-22) asks for information that is not generally part of the AHA survey, for example, more detailed information on staffing, health information technology, and payment. If you have questions as you complete this form, please contact Ms. Sharon Campolucci of Research Triangle Institute at (770) 407-4905.

PLEASE RETURN FORM TO YOUR RTI CONTACT: _____

1. Hospital Information (pre-printed label)

American Hospital Association Number:

NHDS Number:

Legal Name:

Address:

City:

State:

ZIP Code:

Phone:

() - -

Fax:

() - -

2. Person Completing This Form

Name:

Title:

E-mail:

Dept.

Address:

Phone:

() - -

Fax:

() - -

Hospital Demographics

3. Please provide the hospital utilization statistics below for **calendar year 2010**. If the statistics provided below are not for calendar year 2010, please indicate the 12 month period provided: _____

a. Was this facility open as of 01/01/2010?

Yes

No → When did your hospital open _____?

b. Total number of **acute inpatient** admissions: _____

c. Total number of inpatient days: _____ days

- d. Average length of stay (all acute inpatients): _____ days
- e. Total number of live births: _____
- f. Number of operating rooms: _____
- g. Number of surgeries **inpatient**: _____
- h. Number of surgeries **outpatient**: _____
- i. Number of emergency department visits: _____
- j. Number of outpatient visits (excluding emergency department) : _____

4. What is the ownership type of this hospital?

Please mark (X) only one.

- Non-Profit, not religious order affiliated
- Non-Profit, religious order affiliated
- Government
- Proprietary
- Other → Please specify: _____

5. Is this a primary teaching hospital for a medical school?

- Yes
- No

6. Is this a critical access hospital?

- Yes
- No

Clinical Capabilities and Services

7. For each type of clinical capability and service listed below, please mark (X) whether your hospital provides the service.

| Clinical Capabilities and Services | AHA 2010 survey question # | Service Provided In This Hospital | |
|---|----------------------------|-----------------------------------|--------------------------|
| | | Provided | Not Provided |
| Airborne infection isolation room (specify number of rooms)_____ rooms. | 21 | <input type="checkbox"/> | <input type="checkbox"/> |
| Cardiology and cardiac surgery services | 32 | | |
| • Adult cardiac catheterization | N/A | <input type="checkbox"/> | <input type="checkbox"/> |
| • Adult interventional cardiac catheterization | 32c | <input type="checkbox"/> | <input type="checkbox"/> |
| • Adult cardiac surgery | 32e | <input type="checkbox"/> | <input type="checkbox"/> |
| End of life services | 45 | | |
| • Hospice program | 45a | <input type="checkbox"/> | <input type="checkbox"/> |
| • Palliative care program | N/A | <input type="checkbox"/> | <input type="checkbox"/> |
| Paid patient representative services (Organized hospital services providing paid personnel through whom patients and staff can seek solutions to institutional problems affecting the delivery of high quality care and services) | N/A | <input type="checkbox"/> | <input type="checkbox"/> |
| Wound management team | N/A | <input type="checkbox"/> | <input type="checkbox"/> |
| Dedicated geriatric inpatient team | N/A | <input type="checkbox"/> | <input type="checkbox"/> |

Health Information Technology

8. Does your hospital use electronic MEDICAL RECORDS for inpatients (not including billing records)?

- Yes, all electronic
- Yes, part paper and part electronic
- No
- Don't know

9. For each of the computerized capabilities below, please indicate whether your hospital has the capability for inpatient wards, does not have the capability, or you do have the capability but the function is turned off such that is not used.

| | Hospital Inpatient Wards | | | |
|--|--------------------------|--------------------------|--------------------------|--------------------------|
| | Yes | No | Don't Know | Turned off |
| 9a. Patient demographic information? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, does this include patient problem list? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9b. Orders for prescriptions? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are there warnings of drug interactions or contraindications provided? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes to Q. 9b, are prescriptions sent electronically to the pharmacy? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9c. Orders for tests? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are orders sent electronically? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9d. Viewing lab results? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are out of range levels highlighted? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

| | | | | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 9e. Viewing imaging results? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are electronic images returned? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9f. Clinical notes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, do they include medical history and follow up notes? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9g. Reminders for guideline-based interventions and/or screening tests? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9h. Public health reporting? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| If yes, are notifiable diseases sent electronically? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

10. From which of the following hospital units can inpatient electronic medical records be accessed?

Please mark (X) all that apply.

Inpatie Wards **ICU** **ED** **Obs Unit** **Outpatient**

- ICU
- ED
- Observation Unit
- Outpatient

11. Does your coding staff use electronic coding software?

- Yes → Please write the name of the vendor: _____
- No

Financial information

12. Please indicate the distribution of total revenue received from patient care from the following sources for **calendar year 2010**.

| | Percent Total Revenue from Patient Care |
|-----------------------|--|
| Medicare | |
| Medicaid/SCHIP | |
| Private/Commercial | |
| Patient payments | |
| TRICARE | |
| Workers' Compensation | |
| Other Government | |
| Other: _____ | |
| TOTAL | 100% |

13. What was the amount of your hospital's uncompensated care in 2010?

\$ _____ Uncompensated care in 2010

14. What percentage of your hospital's revenue came from Medicaid and Medicare Disproportionate Share Program in 2010?

a. %_____ Medicaid Disproportionate Share Program in 2010

b. %_____ Medicare Disproportionate Share Program in 2010

Emergency Department and Special Hospital Units

15a. Does your hospital have an Emergency Department?

- Yes
- No → *Skip to Q. 16.*

b. Is the Emergency Department staffed 24 hours per day?

- Yes
- No

c. Does this hospital have a dedicated Pediatric or Psychiatric Emergency Services Area?

| | Yes | No |
|--|--------------------------|--------------------------|
| Dedicated Pediatric Emergency Service Area | <input type="checkbox"/> | <input type="checkbox"/> |
| Dedicated Psychiatric Emergency Service Area | <input type="checkbox"/> | <input type="checkbox"/> |

d. What is the trauma level rating of the Emergency Department and hospital?

For each column, please mark (X) only one box.

| | Adult | Pediatrics |
|---------------|--------------------------|--------------------------|
| None | <input type="checkbox"/> | <input type="checkbox"/> |
| Level I | <input type="checkbox"/> | <input type="checkbox"/> |
| Level II | <input type="checkbox"/> | <input type="checkbox"/> |
| Level III | <input type="checkbox"/> | <input type="checkbox"/> |
| Level IV | <input type="checkbox"/> | <input type="checkbox"/> |
| Level V | <input type="checkbox"/> | <input type="checkbox"/> |
| Other/Unknown | <input type="checkbox"/> | <input type="checkbox"/> |

16. What is the level of care provided by your Neonatal Intensive Care Unit?

Please mark (X) only one.

- I
- II
- III
- IV
- V
- No neonatal intensive care unit

17. Does your hospital have a dedicated observation unit?

- Yes → _____ Number of beds
- No
- Don't know

18. Does your hospital have a dedicated cardiac intensive care unit?

- Yes → What is the number of currently staffed beds? (Beds that are licensed and physically available for which staff is on hand to attend to the patient who occupies the bed. Staffed beds includes those that are occupied and those that are vacant.)

_____ Currently staffed beds

- No
- Don't know

Staffing

19. We are also interested in finding out about **hospitalists** (physicians whose primary professional focus is the general medical care of hospitalized inpatients), excluding physicians who work in Intensive Care unit(s).

a. Does your hospital employ hospitalists (*exclude physicians who work only in Intensive Care Units*)?

- Yes
- No → Skip to Q. 20.
- Don't know

b. Please indicate the services where hospitalists work and the number of hospitalist full-time equivalents (FTEs) that the hospital has for each of the services during calendar year 2010. *A person working 40 hours/week constitutes one FTE. A person working 20 hours/week would be 0.5 FTE. Please exclude physicians who work only in the Intensive Care Unit(s).*

| Service | Current number of hospitalist FTEs |
|----------------------------|------------------------------------|
| Internal medicine | |
| Surgery | |
| Pediatrics | |
| Other: Specify | |
| Other: Specify | |
| Other: Specify | |
| Other: Specify | |
| Total hospitalists: | |

c. Please list the total number of FTEs of each type of employee that is employed per month in the following inpatient areas for calendar year 2010. A person working 40 hours/week constitutes one FTE. A person working 20 hours/week would be 0.5 FTE. *Please do not leave boxes blank. Put in N/A if it does not apply.*

| Area | Registered Nurses | Licensed Practical Nurse | Nurse Aides |
|--|-------------------|--------------------------|-------------|
| Total inpatient care | | | |
| Total contract/agency for inpatient care | | | |

Thank you for your participation!!! Please return completed facility questionnaire, including the section on Infectious Disease, to your RTI contact.

Infectious Diseases →→ Please forward the section below to the Director of Clinical Microbiology Laboratory or the Infection Control Department

Instructions

Please provide below cumulative susceptibility data from clinical microbiology laboratory for the time period January 1, 2009, through December 31, 2009. These data should be reported in a similar fashion as the Clinical Laboratory Standards Institute (CLSI) M39 Guidelines.

Please check one box: to indicate the time period for which you are providing data:

- January 1, 2009 through December 31, 2009 (**PREFERRED**)
- Some other time period. What time period? _____

These data should reflect organisms tested for all inpatient areas of the hospital (includes intensive care unit and other inpatient areas). For each organism listed, provide the total number of organisms tested by the laboratory in column 1. In column 2, enter the number of tested organisms that were **susceptible** to the antimicrobial listed in the header.

If possible, please restrict information to inpatients only. Please check the box to indicate the population represented by these data.

- Data reported are for all patients, inpatient and outpatient
- Data reported are for inpatients only
- Data are reported for some other population. Please describe the population the data represent. _____

| Gram Negative Aerobes | Imipenem or Meropenem | | | |
|--------------------------|------------------------|--------------------------------|----|---------------------------|
| | a. Total number tested | b. Total number susceptible | OR | c. Percent susceptible |
| Acinetobacter spp. | | | | |
| <i>P. aeruginosa</i> | | | | |

| Gram Positive Aerobes | Clindamycin | | | |
|--------------------------|------------------------|--------------------------------|----|---------------------------|
| | a. Total number tested | b. Total number susceptible | OR | c. Percent susceptible |
| <i>S. aureus</i> (MRSA) | | | | |
| <i>S. aureus</i> (MSSA) | | | | |

Thank you for your participation. →→ Please return this section to your hospital contact:
