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

INSTRUCTIONS: *Initiate call to verify hospital name and address, identify Chief Executive Officer (CEO) conduct the eligibility screener, and set up the mailing.*

Hello. My name is _____ . I am calling on behalf of the National Center for Health Statistics of the Centers for Disease Control and Prevention. {Hospital name} has been selected to participate in the National Hospital Discharge Survey.

1. I'd like to verify the information I have. Is this {hospital name} at {*give full address including ZIP Code*}?

   Hospital name: _____

   Address: _____

   City, State & ZIP Code: _____

   Telephone number: _____

2. My records show that {hospital name} is a {*read service type from label below*} hospital, is that correct?

   Type of service: _____

   INSTRUCTION*: If the different service type is on the list of out-of-scope hospitals below, thank the person for his/her time and end the telephone interview.*

Out-of-Scope Hospitals

Hospital unit of an institution (prison, college infirmary, etc.)
Hospital unit of an institution for mental retardation
Children's hospital unit of an institution
Institution for mental retardation

3. This hospital has inpatients, correct?

☐ Yes
☐ No → *Thank the person for his/her time and end the telephone interview.*
☐ Don't know → **Who would be the best person to contact to get this information? May I have his/her telephone number? Can you connect me?**

Name: _____

Telephone Number: (___) _____

4. Are there 6 or more hospital beds staffed for inpatient use, not including bassinets?

☐ 6 or more → Skip *to Q. 4.*
☐ Fewer than 6 → *Thank the person for his/her time and end the telephone interview.*
☐ Don't know → **Who would be the best person to contact to get this information? May I have his/her telephone number? Can you connect me?**

Name: _____

Telephone Number: (___) _____

5. Is the hospital currently licensed by the State?

☐ Yes
☐ No → *Thank the person for his/her time and end the telephone interview.*
☐ Don't know → **Who would be the best person to contact to get this information? May I have his/her telephone number? Can you connect me?**

Name: _____

Telephone Number: (___) _____

6. Is this a federally-owned hospital?

☐ Yes → *Thank the person for his/her time and end the telephone interview.*
☐ No
☐ Don't know → **Who would be the best person to contact to get this information? May I have their telephone number? Can you connect me?**

Name: _____

Telephone Number: (___) _____

We want to send some information about participation in the National Hospital Discharge Survey to a hospital official who is in the position to agree to participate for the hospital. In most cases this would be the Chief Executive Officer (CEO).

7. Can you give me the name and title of the person you think would be the appropriate person to send this information?

Name: _____

Title: _____

8. Is he/she at this same address?

Address: _____

City, State and ZIP Code: _____

9. Can you give me his/her telephone number and email address?

Telephone number: _____

E-mail:_____

Thank you for all your help!

National Hospital Discharge Survey Facility Questionnaire
Part B: Interview with Hospital Official

Section I. Introduction

Hello. My name is _____. I am calling on behalf of the National Center for Health Statistics, a part of the Centers for Disease Control and Prevention. Several days ago we sent you a FedEx package containing materials that described the National Hospital Discharge Survey

1. Did you receive the package we sent?

☐ Yes
☐ No → **In that event, I will be sure to have one of our packages sent out to you right away.** *Record Mailing Address to be used to send a new study package via FedEx and schedule another time to call back within three days, if they are unable or unwilling to continue at this time.*

Name: _____

Job Title: _____

Hospital Name: _____

Hospital Street Address: _____

City, State & ZIP Code: _____

Date and Time of Next Scheduled Telephone Call: ___/___/___ __ __: __ __ am or pm

E-mail:_____

Great! {Hospital name} was selected to participate in the National Hospital Discharge Survey (NHDS). The survey is conducted by the National Center for Health Statistics, Centers for Disease Control and Prevention (part of the U.S. Department of Health and Human Services).

Beginning in 2011, we are asking selected hospitals to electronically submit data from the UB-04 claims on all discharged inpatients or observation patients seen at the hospital. Discharge data reports follow the national uniform billing data element specifications and any additional state-required data elements.

In subsequent years, your hospital may be asked to participate is special studies in addition to the NHDS and beginning in 2013, the NHDS will become the National Hospital Care Survey and expand to include data collection from the Emergency and Outpatient Departments and Ambulatory Surgery Centers. At this time we are only collecting data from inpatients from administrative claims.

By law, your sharing of this information is voluntary, and will have no effect on patient's rights.

We are offering the hospital $500 initially to set up the processes and procedures to transmit these data to NCHS. At the end of each year of data collection, your hospital will receive an additional $500 for its participation.

In the packet of materials there is a brochure entitled "Strictly Confidential" that explains how NCHS protects the data we collect. Your participation is voluntary, and all information will be kept strictly confidential. The data we collect will be used only for research and statistical purposes. Reports on the study will not contain any information that identifies a particular hospital or patient.

Because we will be collecting patient identifiers in this survey and we recognize the hospital's obligations to protect patient confidentiality, we would like to assure you that we have taken all of the required actions needed to operate in compliance with both the Public Health Service Act and the Health Insurance Portability and Accountability Act (HIPAA).

This study has been reviewed and approved by the NCHS Institutional Review Board (IRB). You are permitted by law to rely on the NCHS IRB review and approval. The IRB has examined the issues of patient identifiers and the methods we will use to protect this information. The approval letter from NCHS' IRB is included in your packet.

2. Do you have any questions about the information in the packet you received or concerns about what I have discussed so far?

   ☐ Yes → *Record major topics below*
   ☐ No

List in short phrases the type of questions posed. Use the FAQ to try to address each one. Refer to the written materials, if possible.

1._____ 5._____

2._____ 6._____

3._____ 7._____

4._____ 8._____

3. Can we count on your hospital's participation in the NHDS?

Do not read these responses out loud; instead; check the option that best captures the hospital official's response.

☐ Yes, the hospital agrees to participate

Thank you! Your participation will be very helpful!

☐ Needs more information → *Determine if you can provide any further information or written documentation to help alleviate any stated concern(s). Schedule a date and time to call back within three days:*

___/___/___ __ __ : __ __ am or pm

→ *Thank the hospital official for his/her time and repeat the date and time of your next scheduled call.*

☐ No, hospital official declines to participate → *Do not read these responses out loud; instead; check the option that best captures the hospital executive's reason for refusal*

☐ Confidentiality concerns
☐ The hospital's financial situation does not permit it to dedicate time to this effort.
☐ The hospital has too many other priorities at this time.
☐ Other → Please specify: _____

Try to address these concerns using the FAQs.
Try to identify someone else in the organization who may be able to approve participation.
Emphasize that the study will be done at the convenience of the hospital staff.

→ *Thank the hospital official for his/her time.*

I have a few additional questions about your hospital and then I will need to speak to someone from the hospital who will be our Primary Contact and will be responsible for submitting data to the National Hospital Discharge Survey.

Do you have time to answer a few more questions or is there someone else I should speak with?

Who would be the best person to contact? May I have his/her telephone number?

Name: _____

Telephone Number: (___)_____

National Hospital Discharge Survey Facility Questionnaire
Part C: Hospital Primary Contact Interview

Hospital ID#: _____

Hello. My name is _____ and I am a representative for the National Hospital Discharge Survey. {CEO's name} recommended that I call you. As you may know, {hospital name} is participating in the National Hospital Discharge Survey conducted by the National Center for Health Statistics of the Centers for Disease Control and Prevention. NHDS collects information from hospitals about inpatient care by collecting the Uniform Bill UB-04. We greatly appreciate your participation in the NHDS.

The main purpose of my call today is to ask a few questions about your hospital and set up an appointment begin the process of transmitting claims data in the form of the UB-04 to NCHS.

***Instructions**: If you are given other contact information, write his/her name and contact information below and on the Hospital Contact Form.*

Name: _____ Date: ___/___/___ __ __: __ __ am or pm

Section I. Hospital 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 or hospital network*:
_____
☐ No
☐ Don't Know

2. Are other hospitals covered under your state license?

☐ Yes → *Please list name(s) of hospitals*:
_____
__
☐ No
☐ Don't Know

3. When this hospital submits data to the State or the State hospital association, does it include information solely on this facility or in combination with another facility(ies)?

☐ Solely on this facility
☐ Combination with another facility → *Please provide the name of the other facility*:
_____
☐ Don't know

4. What is the number of currently staffed beds? Please let me know if the number you provide is an estimate or the actual figure:

Total beds: _____ ☐ Estimate ☐ Actual Figure

Bassinets: _____ ☐ Estimate ☐ Actual Figure

Skilled or Intermediate Nursing Beds: _____ ☐ Estimate ☐ Actual Figure

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

Do not read responses; instead, mark (X) next to the response given. Only one response can be selected, so you will need to verify the closest choice if more than one option is provided.

☐ General Acute Care
☐ Surgical
☐ Long term care acute
☐ Eye, ear, nose and throat
☐ Psychiatric only facility
☐ Heart
☐ Children's Hospital
☐ Cancer
☐ Obstetrics & gynecology
☐ Alcohol/drug dependency only
☐ Rehabilitation only facility
☐ Orthopedic
☐ Other → Please specify: _____

6. 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 II. Data Transfer

7. Is it possible for your staff to electronically transmit the claims data for discharges from your hospital?

☐ Yes
☐ No → *Make arrangements to find out how you can get the data*
☐ Don't know → *Make arrangements to find out who to talk to.*

8. Will the data you provide us include only discharges from your hospital?

☐ Yes
☐ No → *Please provide name(s) of hospital(s)also included in the lists*:
_____

9. Is it possible to identify the discharges from your hospital as opposed to discharges from another hospital?

☐ Yes
☐ No

10. Will the data you provide us include observation status cases that did not result in an inpatient admission?

☐ Yes
☐ No → *Is there another way we can electronically get the data on observation cases*:_____

11. Is it possible to identify observation status cases that did not result in inpatient admission from the rest of the discharges?

☐ Yes
☐ No

12. Will the data you provide us only include inpatient discharges and exclude all outpatients?

☐ Yes
☐ No
☐ Don't know
☐ N/A—Does not have this type of patient

13. Is there any way to distinguish outpatients from other inpatients?

☐ Yes → How? _____
☐ No

14. Will the data you provide us only include inpatient discharges and exclude patients that had only ambulatory surgery?

☐ Yes
☐ No
☐ Don't know
☐ N/A—Does not have this type of patient

15. Is there any way to distinguish patients that had only ambulatory surgery from other inpatients?

☐ Yes → How? _____
☐ No

16.Will the data you provide us only include inpatient discharges and exclude patients that had less than a 24 hour stay for purposes of dialysis, sleep studies, or other case types?

☐ Yes → What cases? _____
→ *Skip to Q. 18*
☐ No
☐ Don't know
☐ N/A—Does not have this type of patient

17. Is there any way to distinguish these types of less 24 hour stays from other inpatients?

☐ Yes → **How?** _____
☐ No

This next question relates to reimbursement to your hospital for its participation in the survey. Your hospital will receive a one time set up fee of $500 and additional $500 for every year of participation in the survey.

18. Can you tell me to whom the checks should be sent?

☐ Yes → Name: _____

Address: _____

City/State/Zip Code: _____

Telephone Number: (___)_____

E-mail: _____

☐ No → **Is there someone else that I should speak with about getting this information?**

Name: _____

Telephone Number: (___)_____

E-mail: _____

Section III. Concluding Remarks

As we discussed earlier, the next step is for you or your IT department to create test files to submit the data.

I very much appreciate your willingness to help us and will talk to you again on {supplies date from above}.

Hospital Contact Form

Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	
Name:	Title:	Phone Number:
E-mail:	Room #:	

OMB No. 0920-0212: Approval expires 10/31/2011

Hospital Number: _____ (Office use only)

NATIONAL HOSPITAL DISCHARGE SURVEY
Part D: Facility Questionnaire

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

If you have questions as you complete this form, please **contact TBD**. Once this questionnaire is completed, please put it in the FedEx envelope provided and send it back to Social and Scientific Systems (SSS), 8757 Georgia Avenue, Silver Spring, MD 20910.

1. Hospital Information (*pre-printed label)*

Legal Name:

Address:

City: State: __ __ ZIP Code: __ __ __ __ __

Telephone: (__ __ __) __ __ __ - __ __ __ __ Fax: (__ __ __) __ __ __ - __ __ __ __

2. Person Completing This Form

Name: _____

Title: _____

E-mail: _____

Dept. Address: _____

Telephone: (____)____-_____ Fax: (____)____-_____

3. Is the information provided on this questionnaire only for the hospital named on the above label?

☐ Yes
☐ No → Please provide names of hospitals also included: _____

Hospital Demographics

4. Please provide the hospital utilization statistics below for **calendar year 2010**. If 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. Average length of stay (all acute inpatients): _____days

d. Total number of live births:_____

5. 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: _____

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

☐ Yes
☐ No

7. Is this a critical access hospital?

☐ Yes
☐ No

Health Information Technology

8. Does your hospital <u>use</u> electronic medical records (EMR) or electronic health records (EHR) system? Do not include billing record systems.

☐ Yes, all electronic
☐ Yes, part paper and part electronic
☐ No → *Skip to Q.11*
☐ Don't know → *Skip to Q.11*

9. In which year did you install your EMR/EHR system? Year: _____

10. What is the name of you current EMR/EHR system? **CHECK ONLY ONE BOX. IF OTHER IS CHECKED, PLEASE SPECIFY THE NAME.**

☐ Allscripts	☐ eClinicalWorks	☐ GE/Centricity	☐ NextGen	☐13 Practice Fusion
☐ Cerner	☐ Epic	☐Greenway	☐ Sage	☐14 Other_____
☐ CHARTCARE	☐ eMDs	Medical	☐ SOAPware	☐15 Unknown
		☐MED3000		

11. Are there plans for installing a new EMR/EHR system within the next 18 months?

☐ Yes
☐ No
☐ Maybe
☐ Unknown

12. If orders for prescriptions or lab tests are submitted electronically, who submits them? **CHECK ALL THAT APPLY.**

☐ Prescribing practitioner
☐ Other
☐ Prescriptions and lab test orders not submitted electronically
☐ Unknown

13. Please indicate whether your hospital inpatient departments <u>have</u> each of <u>the computerized capabilities</u> listed below. **CHECK NO MORE THAN ONE BOX PER ROW**. Does the reporting location <u>have</u> a computerized system for:

	Hospital Inpatient Wards			
	Yes	Yes, but turned off or not used	No	Unknown
13a. Recording patient history and demographic information?	☐	☐	☐	☐
13a1. If yes, does this include patient problem list?	☐	☐	☐	☐
13b. Recording clinical notes?	☐	☐	☐	☐
13b1. If yes, do they include a comprehensive list of the patient's medications and allergies?	☐	☐	☐	☐
13c. Ordering prescriptions?	☐	☐	☐	☐
13c1. If yes, are prescriptions sent electronically to the pharmacy?	☐	☐	☐	☐
13c2. If yes, are warnings of drug interactions or contraindications provided?	☐	☐	☐	☐
13d. Providing reminders for guideline-based intervention or screening tests?	☐	☐	☐	☐
13e. Ordering for lab tests?	☐	☐	☐	☐
13e1. If yes, are orders sent electronically?	☐	☐	☐	☐
13f. Providing standard order sets related to a particular	☐	☐	☐	☐

condition or procedure?				
13g. Viewing lab results?	☐	☐	☐	☐
13g1. If yes, are results incorporated into EMR/EHR?	☐	☐	☐	☐
13h. Viewing imaging results?	☐	☐	☐	☐
13i. Viewing data on quality of care measures?	☐	☐	☐	☐
13j. Electronic reporting to immunization registries?	☐	☐	☐	☐
13k. Public health reporting?	☐	☐	☐	☐
13k1. If yes, are notifiable diseases sent electronically?	☐	☐	☐	☐
13l. Providing patients with clinical summaries for each visit?	☐	☐	☐	☐
13m. Exchanging secure messages with patients?	☐	☐	☐	☐

14. Can inpatient electronic medical records be accessed from the following hospital units?

	Yes	No	Unknown
a. Intensive Care Unit	☐	☐	☐
b. Emergency Department	☐	☐	☐
c. Observation Unit	☐	☐	☐
d. Outpatient	☐	☐	☐

15a. Beginning in 2011, Medicare and Medicaid will offer incentives to hospitals that have demonstrated "meaningful use of health IT". Are there plans to apply for Medicare or Medicaid incentive payments for meaningful use of health IT?

☐ Yes, we intend to apply → *go to Q.15b*
☐ Uncertain whether we will apply → *Skip to Q.16*
☐ No, we will not apply → *Skip to Q. 16*

15b. In which year do you expect to apply for the meaningful use payments?

☐ 2011
☐ 2012
☐ After 2012
☐ Unknown

Financial information

16. What percent of your patient care revenue for **calendar year 2010** came from the following?

1. Medicare _____ %
1. Medicaid/CHIP _____ %
2. Private insurance _____ %
3. Patient payments _____ %
4. Other (including charity, research, CHAMPUS, VA, etc.) _____ %

TOTAL 100%

17. 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

Outpatient and Emergency Departments and Special Hospital Units

18. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?

☐ Yes → Number of beds _____
☐ No – *Skip to Q. 20.*
☐ Don't know – *Skip to Q. 20.*

19. Does this OPD include physician services?

☐ Yes
☐ No
☐ Don't know

20. Does this hospital have an Ambulatory Surgery Center (ASC)?
ACS locations include a general or main operating room, dedicated ambulatory surgery room, satellite operating room, cystoscopy room, endoscopy room, cardiac catheterization lab, laser procedures room, and a pain block room.

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

21a. Does your hospital have an Emergency Department?

☐ Yes → Number of beds _____
☐ No – *Skip to Q.22.*
☐ Don't know – *Skip to Q. 22.*

21b. Is the Emergency Department staffed 24 hours per day?

☐ Yes
☐ No
☐ Don't know

22. Does this hospital have a dedicated Pediatric Emergency Services Area?

☐ Yes
☐ No
☐ Don't know

23. Does this hospital have a dedicated Psychiatric Emergency Services Area?

☐ Yes
☐ No
☐ Don't know

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

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

	None	Level I	Level II	Level III	Level IV	Level V	Other/Unknown
Adult trauma	☐	☐	☐	☐	☐	☐	☐
Pediatric trauma	☐	☐	☐	☐	☐	☐	☐

25. Does your hospital have a Neonatal Intensive Care Unit (NICU)?

☐ Yes
☐ No -- *Skip to Q. 27.*
☐ Don't know -- *Skip to Q. 27.*

26. What is the level of care provided by your NICU?
Please mark (X) only one.

☐ I
☐ II
☐ III
☐ IV
☐ V
☐ Don't know

27. Does your hospital have an Intensive Care Unit (ICU) other than the NICU?

☐ Yes
☐ No
☐ Don't know

28. Does your hospital have a dedicated observation unit?

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

Staffing

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).

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

☐ Yes
☐ No
☐ Don't know

Thank you for your participation!

Please return your completed facility questionnaire in the provided FedEx envelope!