**Attachment I**: Initial Hospital Intake Questionnaire

## NHCS Initial Hospital Intake Questionnaire

OMB No. 0920-0212: Approval expires: XX/XX/20XX

Notice - Public reporting burden for this collection of information is estimated to average 1 hour, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-24, Atlanta, GA 30333, ATTN: PRA (0920-0212).

Assurances of Confidentiality –All information which would permit identification of any individual, a practice, or an establishment will be held confidential, will be used only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

### Initial Confirmation and Telephone Screen Call (Part A)

1. I'd like to verify the information I have.

   a) Hospital name: _____
   b) Address: _____
   c) City, State and zip code: _____
   d) Telephone number: _____

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

   ☐ Yes → *Skip to Q3.*
   ☐ No

   2a. What is the type of service? _____

*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. Otherwise continue with Q3.*

**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

**Attachment I**: Initial Hospital Intake Questionnaire

3. Is the hospital currently licensed by the State?

   ☐ Yes → *Skip to Q4.*
   ☐ No → *Thank the person for their time and end interview.*
   ☐ Don't know

   3a. Who would be the best person to contact to get this information?
   Name:_____
   Telephone: _____

4. Is this a federally-owned hospital?

   ☐ Yes → *Thank the person for their time and end interview.*
   ☐ No → *Skip to Q5.*
   ☐ Don't know

   4a. Who would be the best person to contact to get this information?
   Name:_____
   Telephone: _____

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

   ☐ Yes → *Skip to Q5b.*
   ☐ No → *Thank the person for their time and end interview.*
   ☐ Don't know

   5a. Who would be the best person to contact to get this information?
   Name:_____
   Telephone: _____

   5b. What is the number of currently staffed inpatient beds in this hospital, not including "newborn" bassinets?

   Total staffed inpatient beds: _____

   ☐ Don't know

   5c. Who would be the best person to contact to get this information?
   Name:_____

   Telephone: _____

6. We would like to send some information about participation in the National Hospital Care Survey to a hospital official who is in the position to agree to participate for the hospital.

   Can you give me the name and title of the person you think would be the appropriate person to send this information? The best person might be the CEO, Director of Quality Control/Assurance, HIM Director, Research Director or someone else. Who would you suggest, and may I have his/her name and title?

   Name:_____
   Title: _____
   Telephone:_____
   E-mail: _____

7. Is he/she at this same address?

   ☐ Yes → *Skip to Q8.*
   ☐ No

   *7a. Ask for appropriate address and record below*.
   Address: _____
   City, State and ZIP code: _____
   Telephone:_____
   E-mail: _____

Interview with hospital official (Part B)

**8.** Did you receive the information folder we sent?

☐ Yes → *Present further information on NHCS and then continue with Q9.*
☐ No

8a. In that event, I will be sure to have one of our packages sent 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 3 days, if the person is unable to unwilling to continue at this time. Otherwise address questions and present information on NHCS and then continue with Q9.*

Name: _____
Job title: _____
Hospital name: _____
Address: _____
City, State and ZIP code: _____
Telephone:_____
E-mail: _____

Date and time of next scheduled telephone call:

__ __ / __ __ / __ __ __ __
Day / Month / Year

__ __ : __ __ ___ A.M.
___ P.M.
Time

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

☐ Yes
☐ No → *Skip to Q10.*

9a. R*ecord major topics below. Use materials to try to address each one*.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____

**10.** Can we count on your hospital's participation in the NHCS?

- ☐ Yes → *Skip to Q10b.*
- ☐ Need more information → *Schedule a date and time to call back within 3 days and enter below* → *Thank interviewer for their time and repeat the date and time of the next scheduled contact.*

__ __ / __ __ / __ __ __ __
Day / Month / Year

__ __ : __ __ ___ A.M.
___ P.M.
Time

- ☐ No, hospital official declines to participate.

10a. What is the reason your hospital does not want to participate? *Do not read these responses out loud; instead; check the option that best captures the hospital executive's reason for refusal. Thank the official for their time and end interview.*

- ☐ 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 – specify _____

10b. Does your hospital require additional administrative or IRB approval?

- ☐ Yes
- ☐ No

**11.** 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 Care Survey. Who would be the best person to contact?

Name:_____

Phone: _____

E-mail: _____

Hospital Primary Contact Interview (Part C)

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

☐ Yes → 12a. What is the name of larger company or network? → *Skip to Q13.*

_____

☐ No → *Skip to Q13.*
☐ Don't know.

12b. Who would be the best person to contact to get this information?
Name:_____
Telephone: _____

**13.** Are other hospitals covered under your state license?

☐ No → *Skip to Q14.* ☐ Yes → 13a. *What* are the name(s) of the hospitals? → *Skip to Q14.*

_____

☐ Don't know

13b. Who would be the best person to contact to get this information?
Name:_____
Telephone: _____

**14.** When this hospital reports data to the State or to the hospital association is the information solely for this hospital or are other hospital(s) included in the data submission?

☐ Solely for this hospital

☐ Combined with another hospital

14a. What are the name(s) of the other hospital(s)?

_____

## Data Transfer

**15.** Is it possible for your staff to electronically transmit UB-04 administrative claims data for all patients from your hospital?

☐ Yes → *Skip to Q16.*
☐ No

15a. Can you electronically transmit claims for "Type of Bill" inpatient codes 011X and 012X?

☐ Yes → *Skip to Q15c.*
☐ No

15b. Can you provide printouts of the UB for <u>inpatient</u> codes 011X and 012X?

☐ Yes
☐ No

15c. Can you electronically transmit "Type of bill" <u>outpatient</u> codes 13X, 14X and 83X?

☐ Yes → *Skip to Q16.*
☐ No

15d. *If no to 15a and 15c, ask*: Can you provide any data electronically?

☐ Yes → What data can you provide?._____
☐ No → *refer to NCHS, and skip to Q19.*

**16.** In what format is your electronic data?

837I
837R
Excel
XML
ASCII
Other→ Specify :_____

**17.** Will the data you provide us include patients only from your hospital?

Yes → *Skip to Q18.*
No

17a. What are the name(s) of the other hospital(s) included?

_____.

17b. Is it possible to identify the records from your hospital as opposed to records from another hospital?

☐ Yes → 17c. How?
_____

☐ No

17d. What is the number of currently staffed inpatient beds for ALL the hospitals whose records you are sending, not including "newborn" bassinets?

Combined total staffed inpatient beds: _____

☐ Don't know

**18.** Will the data you will send include records for:

18a. Discharges who are paying their bills themselves (i.e., self-pay)

☐ Yes
☐ No
☐ Don't know

18b. Discharges who are charity patients

☐ Yes
☐ No
☐ Don't know

18c. Discharges to court or law enforcement (e.g., jail inmates or prisoners)

☐ Yes
☐ No
☐ Don't know

18d. Discharges of patients whose bills are not being paid by public or private insurance (e.g., patients participating in research studies, etc.)

☐ Yes
☐ No
☐ Don't know

**19.** Who will be the IT/data contact for the submission of your claims data and what is their contact information?
Name: _____

Telephone Number: (  ) _____

E-mail: _____

**Electronic Health Records (EHR)**

**20.** Are you able to electronically output patient level data from your EHR?

☐ Yes
☐ No → *Skip to Q22.*
☐ Don't know

20a. Can Inpatient data be electronically output?
☐ Yes
☐ No
☐ Don't know

20b. Can Outpatient/Ambulatory data be electronically output?
☐ Yes
☐ No
☐ Don't know

**21.** What data can you electronically output or export from your EHR?

☐ Patient summaries e.g., CCD (Continuity of Care Document) or CDA (Clinical Document Architecture)
☐ CQMs (Clinical Quality Measures)
☐ Other: Specify _____

**22.** We would also like to explore the possibility of retrieving medical records via remote access. Do you know if your hospital's electronic system can be accessed from the outside by entities not associated with the hospital?

☐ Yes
☐ Unsure

22a. *Schedule a date and time to call back within 3 days and enter below → Thank interviewer for their time and repeat the date and time of the next scheduled contact.*

__ __ / __ __ / __ __ __ __
Day / Month / Year

__ __ : __ __ ___ A.M.
___ P.M.

☐ No → *Skip to Payment Information section.*
☐ Unknown

22b. Who could provide this information?

Name:_____

Telephone Number: (_____)_____

E-mail: _____

**23.** Would your hospital be willing to allow CDC's contractor to obtain password access to your hospital's electronic health records system and load the charting software onto desktop computers at their headquarters? (We can provide you with a copy of the Data Security Plan which complies with all relevant laws, regulations, and policies governing the security of data and protection of confidentiality.)

Yes →*Skip to Q24.*
☐ Unsure

23a. *Schedule a date and time to call back within 3 days and enter below →Thank interviewer for their time and repeat the date and time of the next scheduled contact.*

__ __ / __ __ / __ __ __ __
Day / Month / Year

__ __ : __ __ ___ A.M.
___ P.M.

No →*Skip to Payment information section.*
Unknown

23b. Who could provide this information?

Name:_____

Telephone Number: (_____)_____

E-mail: _____

**24.** What system requirements are there to access the hospital remotely?

Any token (i.e., RSA SecurID)
IP restrictions
Other – Specify _____
Citrix

24a. Which version of Citrix is required? _____

**25.** If remote access is a possibility, who would be the IT contact to set up accounts for external access?

Name:_____

Telephone Number: (_____)_____

E-mail: _____

## Payment Information

This next question relates to reimbursement to your hospital for its participation in the survey. Your hospital will receive a onetime set up fee of $500 for the electronic data transmission and additional $500 for every year of participation in the inpatient component of the NHCS. Your hospital will receive $500 for participation in the ambulatory component of the NHCS.

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

Yes → *Enter information and then thank official for their time and end interview.*

Payee: _____
Attn: _____
Address: _____
Mail Stop: _____
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: _____

*Thank official for their time and end interview.*