

### NHCS Initial Hospital Intake Questionnaire

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#### Initial Confirmation and Telephone Screen Call

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 N: Initial Hospital Intake Questionnaire**

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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: \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

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: \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

**Interview with hospital official**

**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. *Record major topics below. Use materials to try to address each one.*

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

6) \_\_\_\_\_

7) \_\_\_\_\_

8) \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

**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: \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

**Hospital Primary Contact Interview**

**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 →  Yes → 13a. *What* are the name(s) of the hospitals? → *Skip to Q14.*

\_\_\_\_\_

*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)?

\_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

**Electronic Health Records (EHR)**

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

- Yes
- No → *Skip to Q17*
- Don't know

**15a.** Can Inpatient data be electronically output?

- Yes
- No
- Don't know

**15b.** Can Outpatient/Ambulatory data be electronically output?

- Yes
- No
- Don't know

**16.** 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 \_\_\_\_\_



**Attachment N: Initial Hospital Intake Questionnaire**

**Data Transfer**

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

Yes → *Skip to Q18.*

No



17a. Can you electronically transmit claims for “Type of Bill” inpatient codes 011X and 012X?

Yes → *Skip to Q17c.*

No



17b. Can you provide printouts of the UB for inpatient codes 011X and 012X?

Yes

No



17c. Can you electronically transmit “Type of bill” outpatient codes 13X, 14X and 83X?

Yes → *Skip to Q18.*

No



17d. *If no to 17a and 17c, ask:* Can you provide any data electronically?

Yes → What data can you provide? \_\_\_\_\_

No → *refer to NCHS, and skip to Q21.*

18. In what format is your electronic data?

837I

837R

Excel

XML

ASCII

Other → Specify : \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

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

Yes → *Skip to Q20.*

No



19a. What are the name(s) of the other hospital(s) included?

\_\_\_\_\_.

19b. Is it possible to identify the records from your hospital as opposed to records from another hospital?

Yes → 19c. How?

\_\_\_\_\_

No



19d. 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

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

20a. Discharges who are paying their bills themselves (i.e., self-pay)

Yes

No

Don't know

20b. Discharges who are charity patients

Yes

No

Don't know

20c. Discharges to court or law enforcement (e.g., jail inmates or prisoners)

Yes

No

Don't know

20d. 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

**Attachment N: Initial Hospital Intake Questionnaire**

20e. Discharges of patients whose bills are paid by workmen's compensation.

- Yes
- No
- Don't know

21. 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: \_\_\_\_\_

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: \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

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: \_\_\_\_\_

**Attachment N: Initial Hospital Intake Questionnaire**

**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.*