NHCS Initial Hospital Intake Questionnaire

Form Approved
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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.

3.

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

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 H: 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: _____

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. 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

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)?

_____

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 _____

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 <u>inpatient</u> codes 011X and 012X?

☐ Yes
☐ No

17c. Can you electronically transmit "Type of bill" <u>outpatient</u> 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 :_____

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

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: _____

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.