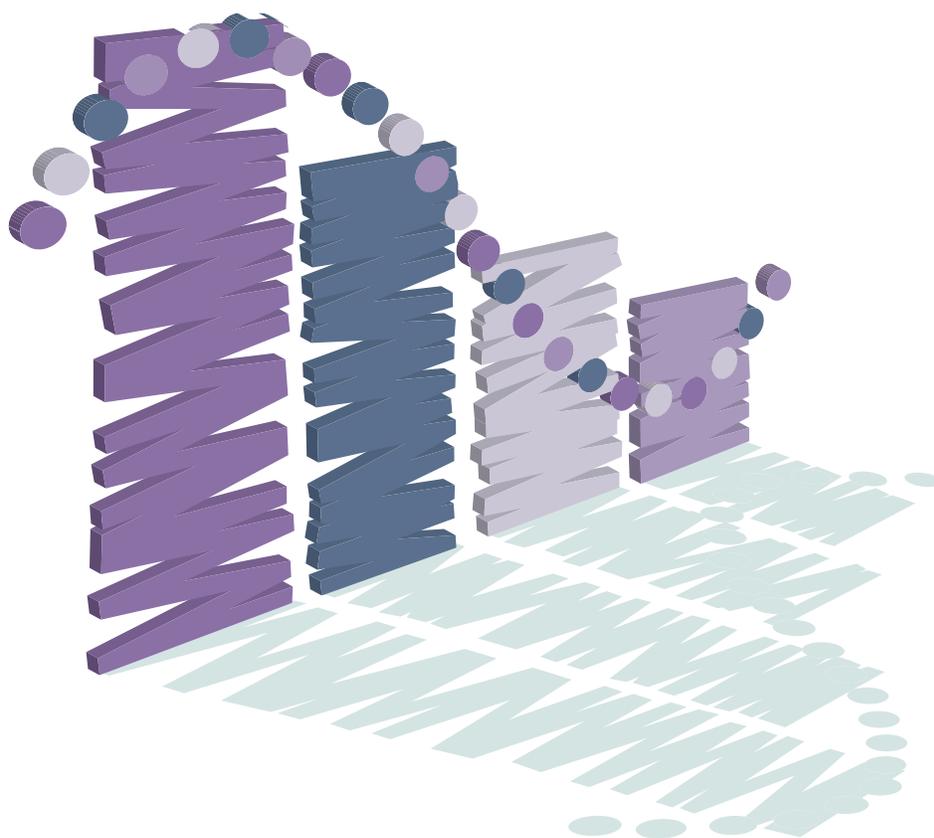


# Facility Questionnaire

# National Hospital

# Care Survey



*Sponsored by:*  
Centers for Disease Control and Prevention  
National Center for Health Statistics





Additional people completing form:

Name:

Title:

E-mail:

Dept. Address:

Phone:  -  -  Fax:  -  -

Name:

Title:

E-mail:

Dept. Address:

Phone:  -  -  Fax:  -  -

Name:

Title:

E-mail:

Dept. Address:

Phone:  -  -  Fax:  -  -

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

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:

|                      |                      |   |                      |                      |                      |                      |           |                      |                      |   |                      |                      |                      |                      |  |
|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|-----------|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|--|
| <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> | <b>TO</b> | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |  |
| MONTH                |                      |   | YEAR                 |                      |                      |                      |           |                      | MONTH                |   |                      | YEAR                 |                      |                      |  |

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

Yes

No → When did your hospital open?

|                      |                      |   |                      |                      |   |                      |                      |                      |                      |
|----------------------|----------------------|---|----------------------|----------------------|---|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | / | <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| DAY                  |                      |   | MONTH                |                      |   | YEAR                 |                      |                      |                      |

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

|                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| # ADMISSIONS         |                      |                      |                      |

c. Average length of stay (all acute inpatients):

|                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| # DAYS               |                      |                      |                      |

d. Total number of live births:

|                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| # LIVE BIRTHS        |                      |                      |                      |

5. What is the ownership type of this hospital? *Mark (X) only one box.*

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 use 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 question 11
- Don't know → skip to question 11

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

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

YEAR

10. What is the name of your current EMR/EHR system?

Mark (X) only one box. If **Other** is marked, please specify the name.

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Allscripts     | <input type="checkbox"/> eMDs             | <input type="checkbox"/> Sage            |
| <input type="checkbox"/> Cerner         | <input type="checkbox"/> GE/Centricity    | <input type="checkbox"/> SOAPware        |
| <input type="checkbox"/> CHARTCARE      | <input type="checkbox"/> Greenway Medical | <input type="checkbox"/> Practice Fusion |
| <input type="checkbox"/> eClinicalWorks | <input type="checkbox"/> MED3000          | <input type="checkbox"/> Other _____     |
| <input type="checkbox"/> Epic           | <input type="checkbox"/> NextGen          | <input type="checkbox"/> Unknown         |

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? Mark (X) all that apply.

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

13. Please indicate whether your hospital inpatient departments have each of the computerized capabilities listed below. *Mark (X) only 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                  |
| a. Recording patient history and demographic information?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| a1. <b>If yes</b> , does this include patient problem list?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Recording clinical notes?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| b1. <b>If yes</b> , do they include a comprehensive list of the patient's medications and allergies? | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Ordering prescriptions?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| c1. <b>If yes</b> , are prescriptions sent electronically to the pharmacy?                           | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| c2. <b>If yes</b> , are warnings of drug interactions or contraindications provided?                 | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Providing reminders for guideline-based intervention or screening tests?                          | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Ordering for lab tests?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| e1. <b>If yes</b> , are orders sent electronically?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Providing standard order sets related to a particular condition or procedure?                     | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Viewing lab results?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| g1. <b>If yes</b> , are results incorporated into EMR/EHR?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Viewing imaging results?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Viewing data on quality of care measures?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Electronic reporting to immunization registries?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| k. Public health reporting?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| k1. <b>If yes</b> , are notifiable diseases sent electronically?                                     | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| l. Providing patients with clinical summaries for each visit?  | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |
| m. Exchanging secure messages with patients?   | <input type="checkbox"/> | <input type="checkbox"/>        | <input type="checkbox"/> | <input type="checkbox"/> |

14. Can inpatient electronic medical records be accessed from the following hospital units?  
 Mark (X) only one box per row.

|                                   | Yes                      | No                       | Unknown                  |
|-----------------------------------|--------------------------|--------------------------|--------------------------|
| a. Intensive Care Unit            | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Emergency Department           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Observation Unit               | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Outpatient Departments:        |                          |                          |                          |
| i. Emergency Department           | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| ii. Outpatient Department         | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| iii. Ambulatory Surgery Locations | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

15. 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
- Uncertain whether we will apply
- No, we will not apply

15a. 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?

- a. Medicare \_\_\_\_\_ %
  - b. Medicaid/CHIP \_\_\_\_\_ %
  - c. Private insurance \_\_\_\_\_ %
  - d. Patient payments \_\_\_\_\_ %
  - e. 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 →
- No
- Don't know

|   |                                     |                      |                      |                      |
|---|-------------------------------------|----------------------|----------------------|----------------------|
| 18a. Number of beds                           | <input type="text"/>                | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|   | # BEDS                              |                      |                      |                      |
| 19. Does this OPD include physician services? |                                     |                      |                      |                      |
|   | <input type="checkbox"/> Yes        |                      |                      |                      |
|   | <input type="checkbox"/> No         |                      |                      |                      |
|   | <input type="checkbox"/> 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 → 20a. Number of beds
- |                      |                      |                      |                      |
|----------------------|----------------------|----------------------|----------------------|
| <input type="text"/> | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|----------------------|----------------------|----------------------|----------------------|
- # BEDS
- No
- Don't know

21. Does your hospital have an Emergency Department?

- Yes →
- No
- Don't know

|  |                                     |                      |                      |                      |
|--|-------------------------------------|----------------------|----------------------|----------------------|
| 21a. Number of beds  | <input type="text"/>                | <input type="text"/> | <input type="text"/> | <input type="text"/> |
|  | # BEDS                              |                      |                      |                      |
| 21b. Is the Emergency Department staffed 24 hours per day? |                                     |                      |                      |                      |
|  | <input type="checkbox"/> Yes        |                      |                      |                      |
|  | <input type="checkbox"/> No         |                      |                      |                      |
|  | <input type="checkbox"/> 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?  
*Mark (X) only one box per row.*

|                     | None                     | Level I                  | Level II                 | Level III                | Level IV                 | Level V                  | Other/<br>Unknown        |
|---------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| a. Adult trauma     | <input type="checkbox"/> |
| b. Pediatric trauma | <input type="checkbox"/> |

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

- Yes
- No
- Don't know

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 → 28a. Number of beds 

|  |  |  |  |
|--|--|--|--|
|  |  |  |  |
|--|--|--|--|

  
# 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.**