

MARC-33: Tobacco Pilot Studies

Data Collection Training

Presented by:
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Introduction

NIDA funded this R21 study to prepare sites for a multi-center RCT testing ED-initiated intervention(s) for tobacco:

- Study One: Qualitative study
- Study Two: Cohort study*
- Study Three: Healthcare provider survey*

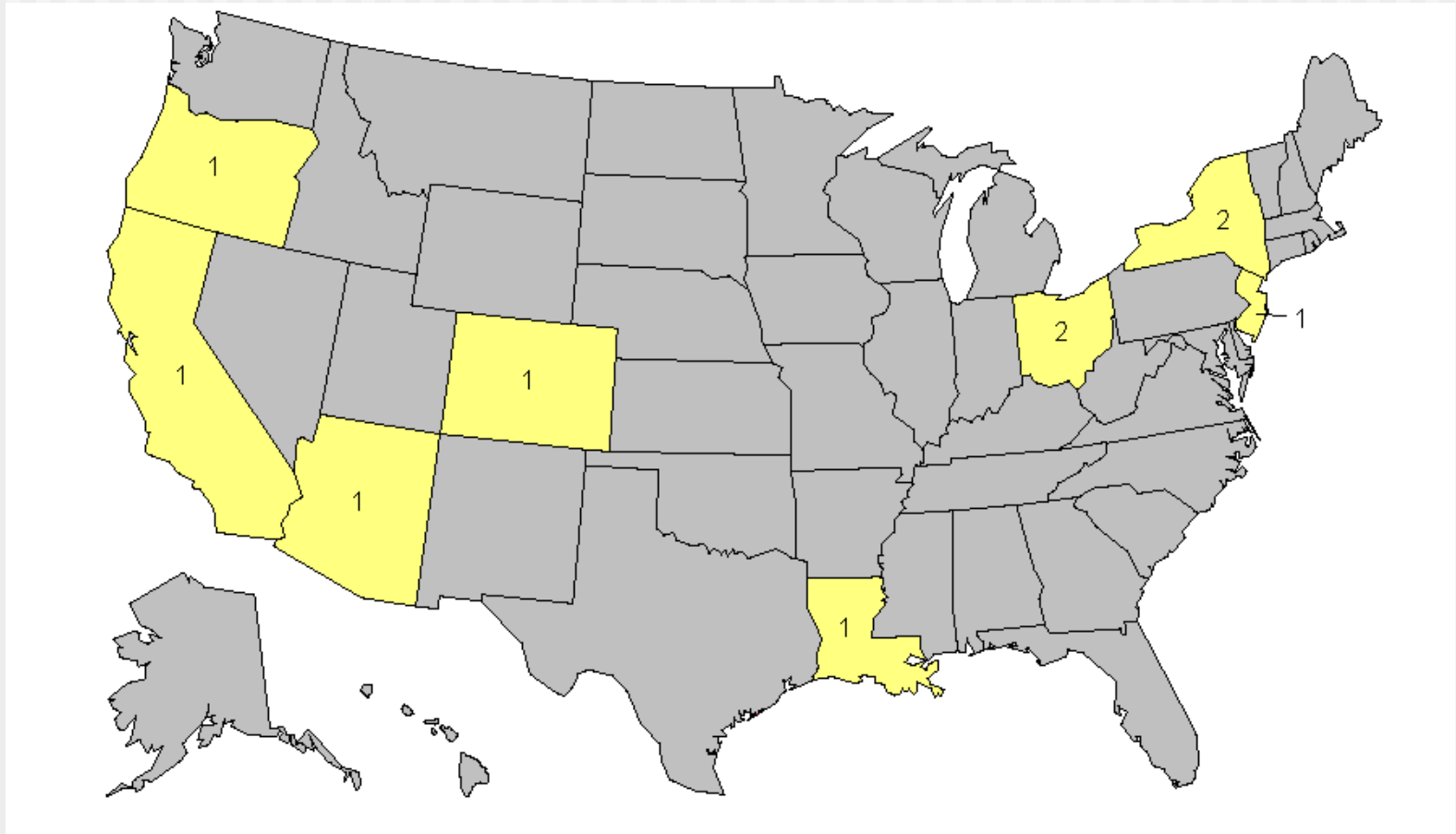
Objectives: Cohort Study

- To enroll 362 smokers at 10 sites and follow them for 6-months
- Establish baserates of change under treatment as usual
- Examine patient preferences re: ED-initiated treatments
- Examine predictors of change

Training Overview

- Cohort and HCP survey studies
- 1 to 2-hours teleconference training
- All staff should review the training manual prior to enrollment
- Resolve any questions
- Re-training as needed

Overview: Sites (n=10)



Sites

	Organization	City, State	Region	Site PI/Personnel
1	Cooper Health System	Camden, NJ	Middle Atlantic	Boudreaux, Edwin D, PhD
				Byrne, Nelson, PhD
2	Montefiore Medical Center	Bronx, NY	Middle Atlantic	Bernstein, Steven, MD
3	Metrohealth Medical Center	Cleveland, OH	East North Central	Cydulka, Rita, MD
				Federle, Heather, RN
4	Methodist Hospital	New York, NY	Middle Atlantic	Gaeta, Ted, MD
				Datillo, Paris, RN
5	Earl K. Long Medical Center	Baton Rouge, LA	West South Central	Perret, Nelson, MD
6	Loma Linda University Medical Center	Loma Linda, CA	Pacific	Lynch, Lea, MD
7	Summa Health System	Akron, OH	East North Central	Blanda, Michelle, MD
				Wilber, Scott, MD
8	University of Colorado Hospital	Denver, CO	Mountain	Adit Ginde, MD
9	Maricopa Medical Center	Phoenix, AZ	Mountain	Frank LoVecchio, DO
10	Oregon Health & Science Univ	Portland, OR	Pacific	Lowe, Bob, MD
				Choo, Esther, MD

Overview: Cohort Study

Three major data collection components:

1. A baseline survey during ED visit
2. Chart review
3. Follow-up telephone assessments
 - 14-days
 - 3-months
 - 6-months

Site Enrollment Targets

- Target baseline enrollment
N=36
- 14-day follow-up
N=33 (90%)
- 3-month follow-up
N=29 (80%)
- 6-month follow-up
N=25 (70%)

Baseline Enrollment

- Must staff ED from 9 AM to midnight
- Consecutive enrollment
- Stop once 36 completed subjects enrolled

Incomplete and Missing Data

- RA should immediately check all items for missing or unreliable responses
- If missing, ask subject for the answer
- If missing 10 or more items and unable to ask subject for answer, considered “incomplete”
- Does not count towards 36
- Complete chart review on incompletes
- Do not follow-up with incomplete subjects
- Submit to EMNet in same manner as complete forms, except clearly mark “Incomplete”
 - Record as “Incomplete” in Patient Registry

Patient Registry

- All patients who are registered in the ED from 9 AM to midnight
- Patient's full name, presentation time, age, sex, race/ethnicity, ED disposition, enrollment status, and, if they were not enrolled, the reason for such
- Names removed before sent to EMNet
- RAs will need to be very careful about recording name of all patients approached to reconcile with registry

Patient Registry (continued)

Much of the information will probably need to be obtained from the ED records (e.g., presentation time, length of stay, ZIP code)

Patient Registry (continued)

- Study ID #: 3-digit site # plus 3-digit patient # *[create this before sending data to Boston]*
- ED visit date: mm/dd/yy
- ED triage time: hh:mm
- Name Last name, First name and MI *[please delete this info before sending data to Boston]*
- Age: Age of patient at time of ED visit
- Sex: 1. Male 2. Female
- Race/ethnicity: 1. White 2. Black or African American 3. Asian 4. American Indian or Alaska Native [enter all that apply] 5. Native Hawaiian or Other Pacific Islander 6. Other 7. Hispanic or Latino origin 8. Not documented
- Insurance status: 1. Private (non-HMO) 2. Private HMO 3. Medicaid (non-HMO) 4. Medicaid (HMO) 5. Other Public 6. None
- Current home zip code: 5 digits. Assign 00000 if homeless/shelter; 77777 if home is outside the United States.
- ED disposition: 1. Sent home 2. Obsv 3. Admit reg 4. Admit ICU
5. AMA/LWT 6. Other
- ED length of stay: hh:mm

Patient Registry (continued)

- Enrollment status: 1. Enrolled 0. Not enrolled
- Reason not enrolled
 - 1 = patient not 18 years or over
 - 2 = language barrier (because of foreign language/lack of translator, physical inability to speak, hard-of-hearing patients)
 - 3 = altered mental status (this includes psych patients, dementia, Alzheimer's, hallucinations, drug or alcohol intoxication, disorientation, other mental illnesses)
 - 4 = agitated, hostile, violent, or abusive
 - 5 = too sick (including contact precautions, visual judgment, doctor/nurse advice, sleeping, sedated, determined too sick by combination of patient statement and RA observation) or too distressed (by physician's/nurse's determination; i.e. patient was a victim of domestic violence or assault, had a miscarriage, had a stroke, etc. and is in emotional distress because of the medical condition)
 - 6 = not a smoker
 - 7 = patient not able to be contacted for follow-up
 - 8 = refused (any sort of refusal to complete screener UNLESS language barrier, too distressed, or too sick)
 - 9 = missed (RA did not get to approach during patient's time in the ED)
 - 10 = other (please specify – e.g. left before seen, left without treatment (LWT), mental retardation)

Screening Criteria

- First set = is patient able to provide consent and engage in survey?
- Second set = is patient current smoker (daily or some days)?
- Third set = do we have a reasonable chance of follow-up?

Screening Form

Inclusion	
1. Is the patient less than 18 years old?	No ⁰ Yes ¹
2. Does the patient have an insurmountable language barrier (speak a language that the site does not have the capacity to assess for baseline and follow-up)?	No ⁰ Yes ¹
3. Patient has altered mental status? e.g., hallucinations, dementia, delirium, disorientation, unresponsive, intoxicated	No ⁰ Yes ¹
4. Patient is agitated, hostile, violent, or abusive?	No ⁰ Yes ¹
5. Patient is too ill to converse? e.g., intubation, vomiting, severe pain, sexual assault, crying	No ⁰ Yes ¹
If any “Yes,” STOP here.	

Screening Form (continued)

Smoking Screener		
6. Have you smoked at least 100 cigarettes (5 packs) in your life?		No ⁰ STOP! Yes ¹ Go to Q.7
7. Do you now smoke cigarettes every day, some days, or not at all?		
<input type="checkbox"/> Currently smokes every day	<input type="checkbox"/> Currently smokes some days	<input type="checkbox"/> Currently do not smoke
↓ Go to Contact Screener	↓ Go to Contact Screener	↓ <u>STOP!</u>
Contact Screener		
8. To participate, it is extremely important that we be able to reach you easily by phone. Do you have a phone that is <u>always</u> in service?		No ⁰ Yes ¹
9. Do you have a permanent address? (i.e., not homeless shelter, half-way house, nursing home, psychiatric treatment facility, correctional facility)		No ⁰ Yes ¹
10. Do you plan on staying where you currently live for the next 6 months?		No ⁰ Yes ¹
If all “Yes,” go to Enrollment Script.		

Informed Consent

- Make sure signatures, dates, and times are completed as required by site's IRB
- Make sure to put subject # on consent once patient has been enrolled
 - 3-digit site ID number and 2-digits
 - Will not correspond to ID number on Patient Registry, which is usually completed later

Baseline Assessment

- To reduce demand bias:
 - Have subject answer the questions using paper-and-pencil format, when possible (give patient the choice); and
 - Re-assure subject that their responses will not be revealed to their treating staff, except for suicidal ideation

Demographics

Section A. General Information	
1. What is your age? ___ ___ ___ years old	
2. Sex: <input type="checkbox"/> Male ⁰ <input type="checkbox"/> Female ¹	
3. What is the highest grade you completed in school?	
<input type="checkbox"/> Less than high school graduate ⁰ <input type="checkbox"/> High school graduate ¹ <input type="checkbox"/> Vocational/tech training graduate ²	<input type="checkbox"/> Some college ³ <input type="checkbox"/> College graduate ⁴ <input type="checkbox"/> Any post-graduate (e.g., masters, doctorate) ⁵
4. Are you of Latino or Hispanic origin? <input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	
5. What race do you consider yourself to be? (check all that apply)	
<input type="checkbox"/> White ¹ <input type="checkbox"/> Black or African American ² <input type="checkbox"/> Asian or Pacific Islander ³	<input type="checkbox"/> American Indian, Eskimo, Aluet ⁴ <input type="checkbox"/> Other: ⁵ {many Hispanics will check other; this is okay}

Demographics (continued)

6. What type of insurance do you have? (check all that apply)	
<input type="checkbox"/> Private (e.g. BlueCross, Aetna) ¹ <input type="checkbox"/> Medicare ² <input type="checkbox"/> Medicaid ³	<input type="checkbox"/> Other public, please specify: ⁴ _____ <input type="checkbox"/> No health insurance ⁵ <input type="checkbox"/> Don't know ⁶
Write in health insurance here if you're unsure which category it fits into: _____	
7. Approximately how much money does your household make in a year?	
<input type="checkbox"/> \$0-\$20,000 ¹ <input type="checkbox"/> \$21,000-\$40,000 ² <input type="checkbox"/> \$41,000-\$60,000 ³	<input type="checkbox"/> \$61,000-\$80,000 ⁴ <input type="checkbox"/> \$80,000+ ⁵ <input type="checkbox"/> Don't know/confidential ⁶
8. How many adults currently live in your home? ___ __ {including the patient}	

Smoking History

1. How many cigarettes do you smoke per day? {If the quantity of cigarettes smoked varies from day-to-day, enter the average number of cigarettes the subject smokes daily.}					
<input type="checkbox"/> 1-10 ¹	<input type="checkbox"/> 11-20 ²	<input type="checkbox"/> 21-30 ³	<input type="checkbox"/> 31+ ⁴		
2. How many minutes after you wake up in the morning do you usually smoke your first cigarette?					
<input type="checkbox"/> 0-5 ⁴	<input type="checkbox"/> 6-30 ³	<input type="checkbox"/> 31-60 ²	<input type="checkbox"/> 61+ ¹		
3. How old were you when you began smoking regularly? ___ ___ ___ years old					
4. Do you currently live with a person who smokes regularly? <input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹					
5. About how much do you pay for a pack of cigarettes? \$___ __. __ __					
6. Since you have become a regular smoker, what is the longest you have gone without smoking because you were trying to quit?					
<input type="checkbox"/> 0 days ⁰	<input type="checkbox"/> 1-7 days ¹	<input type="checkbox"/> 8-30 days ²	<input type="checkbox"/> 1-6 months ³	<input type="checkbox"/> 6-12 months ⁴	<input type="checkbox"/> >12 months ⁵

Readiness Rulers

1. How important is quitting smoking to you?										
0	1	2	3	4	5	6	7	8	9	10
Not at all important									The most important goal of my life	
2. How ready are you to quit smoking within the next month?										
0	1	2	3	4	5	6	7	8	9	10
Not at all ready										100% ready
3. How confident are you that you will quit smoking within the next month?										
0	1	2	3	4	5	6	7	8	9	10
Not at all confident									100% confident	

Stage of Change

1. In the last year, have you gone at least 24 hours without smoking because you were trying to quit ?												
<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹												
2. Do you currently intend to quit smoking? <input type="checkbox"/> No ^{0 Go to E} <input type="checkbox"/> Yes ¹												
3. If Yes, when?												
<input type="checkbox"/> More than 12 months from now ⁰		<input type="checkbox"/> Within 6 to 12 months from now ¹		<input type="checkbox"/> Within 1 to 6 months from now ²			<input type="checkbox"/> Within the next 30 days ³		<input type="checkbox"/> Today ⁴			
4. If Yes, please rate the strength of your intention to quit in the next 30 days .												
0	1	2		3	4	5	6	7	8		9	10
No intention at all											Very strong intention	

Health

1. In the past 12 months, have you had any of the following health problems? Do not leave any blank. {The subject does not have to have a formal diagnosis of the problem to report "Yes."}			
Heart disease or heart attack	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Cancer Type of cancer→	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
High blood pressure	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Bronchitis	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
Stroke	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Wheezing, shortness of breath	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
Problems with blood circulation	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Respiratory or sinus infection	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
Peripheral vascular disease	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Cough, congestion, or cold	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
COPD/emphysema	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Pneumonia	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
Congestive heart failure	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	Asthma	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹

Health (continued)

2. Overall, my health is very good. { Might help to create a visual card for those interviewed }	1	2	3	4	5	6	7
3. My current ER visit is due to a smoking-related health problem.	1	2	3	4	5	6	7
4. My current health problem makes me afraid.	1	2	3	4	5	6	7
5. My smoking has led directly to my current health problem.	1	2	3	4	5	6	7
6. My current health problem will have a major impact on my life.	1	2	3	4	5	6	7
7. My current health problem has given me a real scare.	1	2	3	4	5	6	7
8. My current health problem is life threatening.	1	2	3	4	5	6	7
9. My ER visit is due to a serious medical condition.	1	2	3	4	5	6	7
10. If I was not a smoker, I probably would not have had to come to the ER today.	1	2	3	4	5	6	7
11. When I think of my current health problem, I get afraid about what might happen to me.	1	2	3	4	5	6	7

Mood

Over the past 2 weeks, have you (circle one for each question)	None/Little of the time	Some of the time	Most of the time	All of the time
1. Felt sad, down, or hopeless?	0	1	2	3
2. Lost interest or pleasure in things?	0	1	2	3

Alcohol

{Make sure RA's read the definition, if interviewing. If the subject consumes alcohol less than once a week, enter "0."}	
1. During the last year, have you drunk any alcohol?	No ⁰ Go to H! Yes ¹
2. On average, how many days per week do you drink alcohol?	__ __ __ days/week
3. On a typical day when you drink, how many drinks do you have? {If the subject is not sure of the number, ask the subject to estimate the range, and take the average. Ex: from "3 to 5 drinks" would be coded as 4.}	__ __ drinks
4. What is the maximum number of drinks you had on any given occasion during the last month?	__ __ __ drinks
5. During the last year, have you had a feeling of guilt or regret after drinking?	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
9. During the last year, has a friend or family member ever told you about things you said or did while you were drinking that you could not remember?	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
6. During the last year, have you failed to do what was normally expected from you because of drinking?	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹
7. Do you sometimes take a drink in the morning when you first get up?	<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹

Drug Use

Make sure RA reads intro, if interviewing

1. During the last year, have you used drugs?				<input type="checkbox"/> No ⁰ Go to 1 <input type="checkbox"/> Yes ¹ <input type="checkbox"/> Refused ² go to 1			
2. What drugs did you use? (check all that apply)							
<input type="checkbox"/> Marijuana ¹		<input type="checkbox"/> Heroin ⁴		<input type="checkbox"/> LSD ⁷		<input type="checkbox"/> Other: ¹⁰	
<input type="checkbox"/> Cocaine ²		<input type="checkbox"/> Pain killers ⁵		<input type="checkbox"/> PCP ⁸			
<input type="checkbox"/> Speed/Amphetamines ³		<input type="checkbox"/> Sedatives/Downers ⁶		<input type="checkbox"/> Ecstasy ⁹			
3. During the last year, have you had a feeling of guilt or regret after using drugs?						<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	
4. During the last year, has a friend or family member ever told you about things you said or did while you were using drugs that you could not remember?						<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	
5. During the last year, have you failed to do what was normally expected from you because of using drugs?						<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	
6. Do you sometimes use drugs in the morning when you first get up?						<input type="checkbox"/> No ⁰ <input type="checkbox"/> Yes ¹	

Opinion: Type of Intervention

{If the subject has no opinion, circle 3.}									
1. Reading a pamphlet or watching a video that describes ways to stop smoking?					1	2	3	4	5
2. Receiving a list of telephone numbers for places you can get stop-smoking counseling?					1	2	3	4	5
3. Having your name and telephone number sent confidentially to a stop-smoking counselor so he/she can call you at home to discuss treatment options?					1	2	3	4	5
4. Having an actual appointment with a stop-smoking counselor scheduled within the next four weeks? You would know the appointment date and time before you left the ER and would attend the outpatient appointment.					1	2	3	4	5
5. Stop-smoking counseling right now during your ER visit? This counseling would not delay your care or make your visit longer.					1	2	3	4	5
6. Getting a prescription for nicotine replacement therapy, like the patch, gum, lozenge, or spray. Your ER doctor would give you the prescription before you are discharged.					1	2	3	4	5
7. Getting a prescription for medication that that helps you to quit, like Zyban or Chantix? Your ER doctor would give you the prescription before you are discharged.					1	2	3	4	5
8. Being enrolled in an 8 week stop-smoking program ?					1	2	3	4	5
9. If you are even a little interested in counseling during your ER visit, how many minutes of counseling would you find okay?									
{If the subject is not interested at all in counseling during the ER visit, check 0-5 minutes.}									
<input type="checkbox"/> 0-5 minutes ⁰	<input type="checkbox"/> 6-15 minutes ¹	<input type="checkbox"/> 16-30 minutes ²	<input type="checkbox"/> 30-45 minutes ³	<input type="checkbox"/> No limit, as long as it doesn't delay my care ⁴					

Opinion: Counseling Styles

1. The counselor or doctor explains to you the health risks of smoking.	1	2	3	4	5
2. The counselor or doctor tells you that you should quit smoking immediately	1	2	3	4	5
3. The counselor or doctor asks you some questions that help you to identify your own reasons for quitting, as well as barriers that prevent you from quitting.	1	2	3	4	5
4. The counselor or doctor explains that you are addicted to nicotine.	1	2	3	4	5
5. The counselor or doctor asks you some questions that help you to identify high-risk situations and teaches you how to avoid smoking in these situations.	1	2	3	4	5
6. The counselor or doctor shows you some pictures of people's lungs after they have smoked for years to try to scare you into quitting.	1	2	3	4	5
7. The counselor or doctor tells you that you should be ashamed of yourself for smoking.	1	2	3	4	5
8. The counselor or doctor explains that it is your own choice of when and how you quit.	1	2	3	4	5
9. The counselor or doctor does an assessment and gives you feedback on how smoking has already affected your health.	1	2	3	4	5

Locator Form

- Emphasize the importance of follow-up
- Emphasize that it does not matter for the purposes of the study if they continue to smoke – we really need their data regardless
- Remind that they only get paid if they complete the follow-up
- Schedule 14-day appointment
 - Provide an appointment card to the subject
- Do not send the Locator Form to EMNet

Locator

- Emergency contact should be non-cohabiting
- If possible, at least one should be a woman

Contact Info

What name do you go by in your home?			
Social security # (optional) {But necessary to pay most subjects};			
Street Address			
City			
State Zip			
Daytime Phone #:		Nighttime Phone #:	
Cell phone #:		Email address:	
What is the best day and time to call you? ___ __: ___ __ AM PM			

Suicidal Ideation

- We do not ask about suicidal ideation
- However, if the patient spontaneously reports it, the RAs should be sure to inform the treating MD

Brochures

Provide brochures to all subjects

- Considered only those that screen + on drugs, alcohol, or depression, but decided it would be more efficient to give to all enrolled subjects
- Explain to subject that we give the information to all subjects, regardless of whether it applies to them b/c some subjects want it for their loved ones

Brochures (continued)

- AHA smoking cessation
- Drug abuse
- Alcohol abuse
- Depression

Chart Review

Triage code	Disposition
1 2 3 4 5	Admit DC AMA LWOB

Chart Review (continued)

- ICD Diagnoses
 - Write down number and text of ED diagnoses
 - From billing data

- Tobacco documentation
 - PPD = the number of packs per day the patient smokes
 - Years Smoked = the number of years the patient has smoked.
 - Counseling in ED = Circle “yes” if there is documentation that an MD, RN, Respiratory therapist, counselor, social worker, or any ED provider counseled the patient.
 - Any amount of counseling counts (“told patient to quit smoking”), but simply handing a referral does not

Chart Review (continued)

Tobacco documentation

- DC instructions = Circle “yes” if instructions to quit smoking are provided in the ED discharge instructions
- NRT = Circle “yes” if any nicotine replacement was given in the ED
 - {If a prescription was written for the patient on DC, then write this out in text: “Patient was given a prescription by ED MD.”}
- Referral = Circle “yes” if there is documentation that a referral for counseling or quit program was given in the ED

Follow-up Assessments

- Contact information

 - Copy from original form

- Keep contact log

 - On contact log, "11 day follow-up due" is a typo. Should be "___ ___ ___ follow-up due." Insert which follow-up.

Follow-up Assessments

(continued)

1. Do you now smoke cigarettes every day, some days, or not at all? (**circle one**)

1. Every day 2. Some days 3. Not at all 9. Refused

2. Since you visited the ED _____ ago, have you stopped smoking for at least one full day **because you were trying to quit smoking?**

1. Yes 2. No 7. Don't Know/Not Sure 9. Refused

3. Have you smoked any cigarettes, even a puff, in the last 7 days?

1. Yes 2. No 7. Don't Know/Not Sure 9. Refused

Follow-up Assessments

(continued)

4. When did you quit smoking? ___ ___ / ___ ___ / ___ ___
Get exact date, if possible.

If unknown, record total number of days abstinent: ___ ___

Follow-up Assessments

(continued)

5. Which of the following statements best describes your interest in quitting? (**read** choices to patient; **circle** one)

I intend to quit within the next 30 days.

I intend to quit within the next 6 months.

I do not intend to quit smoking.

Follow-up Assessments

(continued)

- Heavy Smoking Index
- Readiness Rulers

Follow-up Assessments

(continued)

11. Do you recall someone speaking to you about quitting smoking when you were in the ED on (date)?

1. Yes → Who was it (check all that apply)?

Doctor Nurse Research Assistant Other:

2. No

7. Don't Know/Not Sure

9. Refused

{Write position of counselor on form.}

12. If so, how helpful was this conversation in motivating you to quit smoking?

Follow-up Assessments

(continued)

13. Now I want to ask you about things you may have done to try to quit. We know that quitting is hard, and it takes a lot of work. Since you visited the ED _____ ago, have you used any of the following? (*check all that apply*)
- a. Nicotine patch
 - b. Other nicotine replacement product, like gum, lozenge, nasal spray
 - c. Zyban, bupropion, or wellbutrin
 - d. Chantix or varenicline
 - e. Other medications: _____

Follow-up Assessments

(continued)

14. Since you visited the ED, have you done any of the following?
(check all that apply)

- a. Called the Smokers' Quitline
- b. Gone to a smoking cessation clinic
- c. Discussed smoking with your doctor
- d. Other methods to try to stop: _____

15. What language was the interview conducted in?

English Spanish Other (specify): _____

Healthcare Provider Survey

- Made slight change to form
- May need to submit as amendment to IRB

Healthcare Provider Survey

(continued)

- Create a list of all half+ time ED providers
 - Include: MDs, Extenders, RNs
 - Exclude: agency/pool nurses, techs, paramedics, RTs
- Assign unique number
HCP + Site ID + 3 digits
- Number the surveys
- Distribute the surveys, with postage-paid envelope
 - Make sure to let Ashley know when you distributed the surveys

Healthcare Provider Survey

(continued)

- They will be mailed directly to EMNet
- EMNet will send list of “returned” subjects numbers at ~14-days after distribution
- On your master list, identify those that did not return
- Redistribute surveys to non-responders
- Repeat process again at ~30 days

Contact Information

Ashley Sullivan, Project Director

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617-724-9712

www.emnet-usa.org

Questions?

Thank You!

- We could not complete this study without your valuable contributions!
- If you have any questions, concerns, or comments – now or in the future – please email Ashley Sullivan at afsullivan@partners.org