NOTES

Form Approved OMB No. 0920-0278

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1. Label

NHAMCS-101
(7-11-2008)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

2009 PANEL

2a. Hospital contact information

Name	**RECORD ON CONTROL CARD**
Title	
Telephone number *(Area code and number)*	
FAX number	

b. ED contact information

Name	**RECORD ON CONTROL CARD**
Title	
Telephone number *(Area code and number)*	
FAX number	

c. OPD contact information

Name	**RECORD ON CONTROL CARD**
Title	
Telephone number *(Area code and number)*	
FAX number	

d. ASC contact information

Name	**RECORD ON CONTROL CARD**
Title	
Telephone number *(Area code and number)*	
FAX number	

Section I – TELEPHONE SCREENER

3. Field representative information

Telephone screener	FR Code
Hospital induction	FR Code
ED induction	FR Code
OPD induction	FR Code
ASC induction	FR Code

4. Record of telephone calls

Call	Date	Time	Results
1			
2			
3			
4			
5			
6			

5. Final outcome of hospital screening

1 ☐ Appointment

Day	Date	Time a.m. p.m.

2 ☐ Noninterview – *Complete sections VI and VII, beginning on page 21.*

During your initial call to the hospital, attempt to speak to the contact person. If the contact person is not available at this time, determine when he/she can be reached and call again at the designated time. If, after several attempts, you are still unable to talk to the contact or have determined the contact is no longer an appropriate respondent, begin the interview with a representative of the contact person or new contact, as appropriate.

Section I – TELEPHONE SCREENER – Continued

Part A. INTRODUCTION

Good (morning/afternoon) . . ., my name is *(Your name).* **I am calling for the Centers for Disease Control and Prevention concerning their study of hospital outpatient and emergency departments and hospital-based ambulatory surgery centers. You should have received a letter from Dr. Edward J. Sondik, the director of the National Center for Health Statistics, describing the study.** *(Pause)* **You've probably also received a letter from the Census Bureau, which is collecting the data for the study.**

6. Did you receive the letter(s)?
(If "No" or "DK," offer to send or deliver another copy)

1 ☐ Yes – *SKIP to STATEMENT A*
2 ☐ No
3 ☐ Don't know

7a. Let me verify that I have the correct name and address for your hospital. Is the correct name *(Read name from control card.)***?**

1 ☐ Yes
2 ☐ No – *Enter correct name*

RECORD ON CONTROL CARD

b. Is your hospital located at *(Read address from control card.)***?**

1 ☐ Yes
2 ☐ No – *Enter hospital location*

Number and street
City State ZIP Code

RECORD ON CONTROL CARD

c. Is this also the mailing address?

1 ☐ Yes
2 ☐ No – *Enter correct mailing address*

Number and street
City State ZIP Code

RECORD ON CONTROL CARD

STATEMENT A **(Although you have not received the letter), I'd like to briefly explain the study to you at this time and answer any questions about it.**

NOTES

NOTES

Section VII – NONINTERVIEW

18. Where did the nonresponse occur?

Mark (X) boxes 2, 3, and 4 if applicable.

1 ☐ Hospital – *Ask item 19*
2 ☐ Emergency service area(s)
3 ☐ Clinic(s)
4 ☐ ASC
} *SKIP to item 20*

19. What is the reason the hospital did not participate in this study?

1 ☐ Hospital closed
2 ☐ Hospital not eligible
} ***END INTERVIEW***
3 ☐ Hospital refused – *SKIP to item 20*
4 ☐ Other – *Specify*

END INTERVIEW

20a. At what point in the interview did the refusal/breakoff occur?
Mark (X) appropriate box(es)

	Hospital	ED	OPD	ASC
(1) During the telephone screening	1 ☐			
(2) During the hospital induction	2 ☐			
(3) During the ED/OPD/ASC induction	3 ☐	3 ☐	3 ☐	3 ☐
(4) After the ED/OPD/ASC induction, but prior to assigned reporting period	4 ☐	4 ☐	4 ☐	4 ☐
(5) During the assigned reporting period	5 ☐	5 ☐	5 ☐	5 ☐
b. By whom?				
(1) Hospital administrator	1 ☐	1 ☐	1 ☐	1 ☐
(2) ED/OPD/ASC director		2 ☐	2 ☐	2 ☐
(3) Approval board or official	3 ☐	3 ☐	3 ☐	3 ☐
(4) Other hospital official	4 ☐ *Specify*	4 ☐ *Specify*	4 ☐ *Specify*	4 ☐ *Specify*
(5) Was the refusal by telephone or in person?	5 ☐ Telephone 6 ☐ In person	5 ☐ Telephone 6 ☐ In person	5 ☐ Telephone 6 ☐ In person	5 ☐ Telephone 6 ☐ In person

c. What reason was given? *Please specify hospital, ED, OPD, or ASC (from item 20a) before recording responses.*

d. Was conversion attempted?

Hospital	ED	OPD	ASC
1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

Section I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

CHECK ITEM A
1 ☐ This hospital was in a previous panel – *Read INTRODUCTION STATEMENT B1*
2 ☐ This hospital is being asked to participate in the study for the FIRST time – *Read INTRODUCTION STATEMENT B2*

INTRODUCTION STATEMENT B1

The National Center for Health Statistics of the Centers for Disease Control and Prevention is continuing its annual study of hospital-based ambulatory care. We contacted your hospital previously regarding participation. Collecting data on an annual basis in hospitals, such as your own, is necessary to keep updated information on the status of ambulatory care provided in the hospital environment.

Before discussing the details, I would like to verify our basic information about *(Name of hospital)* **to be sure we have correctly included your hospital in the study. First, concerning licensing:**

INTRODUCTION STATEMENT B2

The National Center for Health Statistics of the Centers for Disease Control and Prevention is conducting an annual study of hospital-based ambulatory care. The study began data collection in 1992. They have contracted with the Census Bureau to collect the data. *(Name of hospital)* **has been selected to participate in the study. I am calling to arrange an appointment to discuss this hospital's participation. The study is authorized under the Public Health Service Act and the information will be held strictly confidential. Participation is voluntary.**

Before discussing the details, I would like to verify our basic information about *(Name of hospital)* **to be sure we have correctly included this hospital in the study. First, concerning licensing:**

8a. Is this facility a licensed hospital?

1 ☐ Yes
2 ☐ No – *SKIP to CHECK ITEM B on page 4*

b. Is this hospital voluntary non-profit, government, or proprietary?

1 ☐ Nonprofit (includes church-related, nonprofit corporation, other nonprofit ownership)
2 ☐ State or local government (includes state, county, city, city-county, hospital district or authority)
3 ☐ Proprietary (includes individually or privately owned, partnership or corporation)

c. Is this hospital owned, operated, or managed by a health care corporation that owns multiple health care facilities (eg., HCA or Health South)?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

d. Is this a teaching hospital?

1 ☐ Yes
2 ☐ No

e. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years?

1 ☐ Yes, merged
2 ☐ Yes, separated
3 ☐ No
4 ☐ Unknown
} *SKIP to item 9 on page 4*

f. Does YOUR hospital have its own medical records department that is separate from that of the OTHER hospital?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

g. What is the name and address of this OTHER hospital?

Hospital name
Number and street
City State ZIP Code

RECORD ON CONTROL CARD

Section I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

9a. Does this hospital provide emergency services that are staffed 24 HOURS each day either here at this hospital or elsewhere?
1 ☐ Yes – *SKIP to item 9c*
2 ☐ No

b. Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day?
1 ☐ Yes
2 ☐ No

c. What is the trauma level rating of this hospital?
1 ☐ Level I
2 ☐ Level II
3 ☐ Level III
4 ☐ Level IV or V
5 ☐ Other/unknown
6 ☐ None

10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?
1 ☐ Yes
2 ☐ No – *SKIP to CHECK ITEM B*

b. Does this OPD include physician services?
1 ☐ Yes
2 ☐ No

CHECK ITEM B

Mark (X) all that apply.
1 ☐ ED meets eligibility requirements (item 9a is YES) . . . .
2 ☐ OPD meets eligibility requirements (item 9a is NO and item 9b is YES, or items 10a and b are YES) . . . .
3 ☐ ASC meets eligibility requirements (item 10c is YES) . . . .
} *SKIP to CHECK ITEM B-1*
4 ☐ Hospital is ineligible because it is not licensed (item 8a is NO) – *Go to CLOSING STATEMENT B1 below.*
5 ☐ Hospital is ineligible because it has NEITHER an ED nor OPD nor ASC (items 9a, 9b, 10a, 10c, and/or 10b are NO) – *Go to CLOSING STATEMENT B2 below.*

CHECK ITEM B-1

Hospital refused
1 ☐ Yes – *SKIP to item a*
2 ☐ No – *SKIP to Part C. STUDY DESCRIPTION on page 5*

a. Determine whether hospital has an eligible ED and if so, inquire as to how many visits are expected during the reporting period.
Eligible ED?
1 ☐ Yes – ______ expected visits
2 ☐ No

b. Determine whether hospital has an eligible OPD and if so, inquire as to how many visits are expected during the reporting period.
Eligible OPD?
1 ☐ Yes – ______ expected visits
2 ☐ No

c. Determine whether hospital has an eligible ASC and if so, inquire as to how many visits are expected during the reporting period.
Eligible OPD?
1 ☐ Yes – ______ expected visits
2 ☐ No

d. If unable to determine expected visits for the assigned reporting period, obtain the number of visits to the department **last year**.
______ ED visits last year ______ OPD visits last year ______ ASC visits last year

NOTES

Go to Section VII, NONINTERVIEW on page 22.

Section VI – DISPOSITION AND SUMMARY

AMBULATORY UNIT CHECKLIST

• *COMPLETE 16a FOR **EMERGENCY** DEPARTMENT ONLY*

16a. How many emergency service areas were selected for sample?
Enter 0 if no ESAs were selected for sample.
______ Number of ESAs

Did you include a NHAMCS-101(U) for each?
1 ☐ Yes
2 ☐ No – *Explain*

• *COMPLETE 16b FOR **OUTPATIENT** DEPARTMENT ONLY*

b. How many clinics were selected for sample?
Enter 0 if no clinics were selected for sample.
______ Number of Clinics

Did you include a NHAMCS-101(U) for each?
1 ☐ Yes
2 ☐ No – *Explain*

• *COMPLETE 16c FOR **AMBULATORY SURGERY CENTER** ONLY*

c. How many ASC areas were selected for sample?
Enter 0 if no ASCs were selected for sample.
______ Number of ASCs

Did you include a NHAMCS-101(U) for each?
1 ☐ Yes
2 ☐ No – *Explain*

FORMS COMPLETED

d. Number of ED Patient Record Forms completed ______ Number of ED PRFs

e. Number of OPD Patient Record Forms completed ______ Number of OPD PRFs

f. Number of ASC Patient Record Forms completed ______ Number of ASC PRFs

17a. FINAL DISPOSITION
1 ☐ All eligible units completed Patient Record Forms } *END interview*
2 ☐ Some eligible units completed Patient Record Forms } *GO to Item 17b*
3 ☐ Hospital refused
4 ☐ Hospital closed
5 ☐ Hospital ineligible
} *Complete Section VII, NONINTERVIEW on page 22*

b. NATURE OF REFUSAL
Mark (X) all that apply.
1 ☐ Entire ED refused
2 ☐ Entire OPD refused
3 ☐ Entire ASC refused
4 ☐ Some ESAs refused
5 ☐ Some clinics refused
6 ☐ Some ASCs refused

FR NOTE – *If one or more responses are marked in 17b, complete Section VII, NONINTERVIEW on page 22 If no responses marked, END INTERVIEW.*

Section V – AMBULATORY SURGERY CENTER DESCRIPTION – Continued

Now I would like to ask you some questions about your ASC.

15c. Does your ASC use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Unknown

d. Does your ASC have a computerized system for –

	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Does this include patient problem lists?**	1 ☐	2 ☐	3 ☐	4 ☐
(2) Orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **(a) Are there warnings of drug interactions or contraindications provided?**	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are orders sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐
(4) Viewing of lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are out of range levels highlighted?**	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing of imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Can electronic images be viewed?**	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Do they include medical history and follow-up notes?**	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are notifiable diseases sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐

e. Are there any of the above features of your system that your ASC does NOT use or has turned off?

1 ☐ Yes – *Please specify*

FR NOTE – *Indicate in item 14d, last column, any component(s) turned off.*

2 ☐ No
3 ☐ Unknown

f. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section I – TELEPHONE SCREENER – Continued

CLOSING STATEMENT B1 – **Thank you . . ., but it seems that our information was incorrect. Since** *(Name of hospital)* **is not a licensed hospital it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete sections VI and VII beginning on page 21.*

CLOSING STATEMENT B2 – **Thank you . . ., but it seems that our information was incorrect. Since** *(Name of hospital)* **does not have 24-hour emergency services, outpatient clinics, or ambulatory surgery centers, it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete sections VI and VII beginning on page 21.*

Part C. STUDY DESCRIPTION

Thank you. Now I would like to provide you with further information on the study.

INSTRUCTIONS

Provide the administrator or other hospital representative with a brief description of the study.

Cover following points –

(1) The NHAMCS is the only source of national data on health care provided in hospital emergency and outpatient departments

(2) NHAMCS is endorsed by the:

- American College of Emergency Physicians
- Emergency Nurses Association
- Society for Academic Emergency Medicine
- American College of Osteopathic Emergency Physicians
- Federation of American Hospitals
- Ambulatory Surgery Center Association
- American College of Surgeons
- American Health Information Management Association
- American Academy of Ophthalmology
- Society for Ambulatory Anesthesia

(3) Nationwide sample of about 600 hospitals

(4) Four-week data collection period

(5) Brief form completed for a sample of patient visits

As one of the hospitals that has been selected for the study, your contribution will be of great value in producing reliable, national data on ambulatory care.

CHECK ITEM B-2 – *Hospital* **HAS MERGED** with or **SEPARATED** from another in the past two years? *(Item 8e is YES.)*

1 ☐ Yes – *Go to CLOSING STATEMENT C1 below.*
2 ☐ No – *Go to CLOSING STATEMENT C2 below.*

CLOSING STATEMENT C1 – **Since your hospital has merged or separated within the last 2 years, I need to get further instructions from the Centers for Disease Control and Prevention (CDC) on how to proceed. I will call you back within a week and let you know which parts of your hospital will be in the survey. Thank you for your cooperation!** *Telephone your Regional Office to report the Hospital Name and ID Number.*

CLOSING STATEMENT C2 – **I would like to arrange to meet with you so that I can better present the details of the study. Is there a convenient time within the next week or so that I could meet with you or your representative?**

Thank you . . . for your cooperation. I am looking forward to our meeting. *Record day, date and time of appointment in item 5, page 1; and terminate telephone call.*

NOTES

Section II – INDUCTION INTERVIEW

Part A. INTRODUCTION

I would like to begin with a brief review of the background for this study.

INSTRUCTIONS

Provide the administrator or other hospital representative with a brief introduction to the study and a general overview of procedures.

Cover the following points –

(1) NHAMCS is an extension of the National Ambulatory Medical Care Survey (NAMCS). The NAMCS collects data on visits to physicians in office-based practices

(2) NAMCS and NHAMCS are sponsored by the National Center for Health Statistics of the Centers for Disease Control and Prevention

(3) NAMCS and NHAMCS data are used extensively by health services planners, researchers and educators

(4) Annually, there are almost 200 million visits to hospital emergency and outpatient departments and 20 million visits to hospital-based amblulatory surgery centers

(5) Census Bureau is acting as the data collection agent for the study

(6) The study is authorized by Title 42, U.S. Code, Section 242k

(7) Participation is voluntary

(8) All information, including the name of hospital, is held in strict confidence

(9) NO patients' names or identifiers are collected

(10) The study was approved by the NCHS Research Ethics Review Board

(11) Data from the study will be used only in statistical summaries

(12) NHAMCS covers hospital facilities on and off hospital grounds

(13) NHAMCS covers care provided by or under the direct supervision of a physician

(14) NHAMCS excludes office-based physicians (these are covered under the NAMCS)

(15) NHAMCS excludes visits to clinics where only ancillary services are provided, e.g., X-ray, laboratories, and pharmacies, and where physician services are not provided, e.g., physical, speech, and occupational therapy, and dental and podiatry clinics.

(16) For the first time, we are including ambulatory surgery visits in the survey

(17) Only a 4-week data collection period

(18) On average, sample of approximately 100 ED, 150 to 200 OPD, and 100 ASC visits per hospital

SHOW PATIENT RECORD FORMS

(19) Form takes only 6 or 7 minutes to complete

(20) Forms to be completed by hospital staff at their convenience

(21) Portion containing patient's name or other identifying information is removed before collecting

Section V – AMBULATORY SURGERY CENTER DESCRIPTION

CHECK ITEM E

1 ☐ Hospital has at least one ASC.
2 ☐ Hospital does not have any ASCs – *SKIP to Section VI, DISPOSITION AND SUMMARY on page 21.*

To develop the sampling plan, I would like to (collect/verify) more specific information about this hospital's ambulatory surgery center(s).

(1) Obtain an estimate of ambulatory (outpatient) surgery cases for each ASC, covering the 4-week period. Enter the estimate in column (c) of the listing below.

(2) After obtaining the answer to item 15b, mark (X) column (b) of the listing below indicating if the ASC is included in a single electronic log/list.

FR NOTE

ASC locations:

- General or main operating room
- Dedicated ambulatory surgery room
- Satellite operating room
- Cystoscopy room
- Endoscopy room
- Cardiac catheterization lab
- Laser procedures room
- Pain block room

INSTRUCTIONS

- Only record generic ASC names in column (a) (e.g., ambulatory surgery center, cardiac cath). If the ASC has a formal/proper name, enter a generic ASC name in (a) and record the Line No. and the formal/proper name on page 2 of the control card.
- Complete columns (d) and (e) after developing the sampling plan. See page 18 of the NHAMCS-124 for instructions.

Line No.	ASC name (Generic) (a)	Log included in single log/electronic list (b)	Expected No. of ambulatory (outpatient) surgery cases from ______ to ______ (c)	Take every number (d)	Random start number (e)
1		☐			
2		☐			
3		☐			
4		☐			
5		☐			
6		☐			
7		☐			
8		☐			
	TOTAL →				

15a. Now I have some questions about generating a report for all outpatient surgery patients for sampling.

Would you or your IT staff be able to generate a single list of outpatient surgery cases for the following locations? *(Read each ASC name listed above.)*

1 ☐ Yes
2 ☐ No – ONLY 2 LOGS } *SKIP to item 15c*
3 ☐ No – More than 2 logs – *Continue with item 15b.*

b. Would you be able to generate one list of outpatient surgery cases for some of these locations?

1 ☐ Yes – **Which ones?** *(Mark (X) column (b) in the listing above next to each log/list mentioned.)*
2 ☐ No – *Continue with item 15c.*

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION

Now I would like to ask you some questions about your OPD.

14t. Does your OPD use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Unknown

u. Does your OPD have a computerized system for –

	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Does this include patient problem lists?**	1 ☐	2 ☐	3 ☐	4 ☐
(2) Orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **(a) Are there warnings of drug interactions or contraindications provided?**	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are orders sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐
(4) Viewing of lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are out of range levels highlighted?**	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing of imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Can electronic images be viewed?**	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Do they include medical history and follow-up notes?**	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are notifiable diseases sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐

v. Are there any of the above features of your system that your OPD does NOT use or has turned off?

1 ☐ Yes – *Please specify*

FR NOTE – *Indicate in item 14u, last column, any component(s) turned off.*

2 ☐ No
3 ☐ Unknown

w. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section II – INDUCTION INTERVIEW – Continued

CHECK ITEM B3

1 ☐ CHECK ITEM B = 1 (ED meets eligibility requirements)
2 ☐ CHECK ITEM B = 2, 3, or 4 (ED does NOT meet eligibility requirements) – *SKIP to Item 12 on page 8.*

Now I would like to ask you a few more questions about your hospital.

11a. How many days in a week are inpatient elective surgeries scheduled?

Number of days
1 ☐ Unknown

b. Does your hospital have a bed coordinator, sometimes referred to as a bed czar?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

c. How often are hospital bed census data available?

Read answer categories.

1 ☐ **Instantaneously**
2 ☐ **Every 4 hours**
3 ☐ **Every 8 hours**
4 ☐ **Every 12 hours**
5 ☐ **Every 24 hours**
6 ☐ **Other**
7 ☐ **Unknown**

NOTES

Part B. SURVEY IMPLEMENTATION

As I mentioned earlier, I would like to discuss the plan for conducting the study. This hospital has been assigned to a 4-week data collection period beginning on Monday, (____ / ____).
Month Day

First, I would like to discuss the steps needed to obtain approval for the study.

12. Are there any additional steps needed to obtain permission for the hospital to participate in the study?

1 ☐ Yes – *Specify the necessary steps below*
2 ☐ No

CHECK ITEM D

1 ☐ At least one OPD Clinic in-scope.
2 ☐ All OPD Clinics out-of-scope – *SKIP to Section V, AMBULATORY SURGERY CENTER DESCRIPTION on page 19.*

CHECK ITEM D1

Is the total number of expected OPD visits during the reporting period between ____ and ____ ?

1 ☐ Yes – *SKIP to 14t on page 18.*
2 ☐ No, it is **MORE THAN** the range – *GO to item a*
3 ☐ No, it is **LESS THAN** the range – *SKIP to item c*

a. Compare to previous sampling plan. Are there more clinics this year compared to last year? *(If "Yes" then verify scope and ownership of the new clinics this year, make changes if needed, and then check one of the following responses.)*

1 ☐ Yes, this is correct, some clinics have opened or should have been included last year. – *List*

2 ☐ No, the number of clinics has not increased.

b. Is the number of expected visits to any of the clinics more than twice the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have increased this year or were too low last year. – *Explain*

2 ☐ No, the number of visits has not increased dramatically.

SKIP to item 14t on page 18

c. Compare to previous sampling plan. Are there fewer clinics this year compared to last year?

1 ☐ Yes, this is correct, some clinics have closed or shouldn't have been included last year. – *List*

2 ☐ No, the number of clinics has not decreased.

d. Is the number of expected visits to any of the clinics less than half of the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have decreased this year or were too high last year. – *Explain*

2 ☐ No, the number of visits has not decreased dramatically.

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

FR NOTE

OPD Specialty Groups include:

- **GM –** General Medicine
- **SURG –** Surgery
- **PED –** Pediatrics
- **OBG –** Obstetrics/Gynecology
- **SA –** Substance Abuse
- **OTHER –** Other

INSTRUCTIONS

- Only record generic clinic names in column (a) (e.g., pediatric clinic). If the clinic has a formal/proper name, enter a generic clinic name in (a) and record the Line No. and the formal/proper name on page 2 of the control card.
- Complete columns (b) and (c) using pages 7 to 17 of the NHAMCS-124, Sampling and Information Booklet. Complete columns (e) and (f) after developing the sampling plan. See page 4 of the NHAMCS-124 for instructions.

Line No.	Outpatient department clinic name (Generic) (a)	Specialty group (b)	NHAMCS-124 Speciality Group Scope (c)	Expected No. of visits from ____ to ____ (d)	Take every number (e)	Random start number (f)
1			☐ In-Scope ☐ Out-of-Scope			
2			☐ In-Scope ☐ Out-of-Scope			
3			☐ In-Scope ☐ Out-of-Scope			
4			☐ In-Scope ☐ Out-of-Scope			
5			☐ In-Scope ☐ Out-of-Scope			
6			☐ In-Scope ☐ Out-of-Scope			
7			☐ In-Scope ☐ Out-of-Scope			
8			☐ In-Scope ☐ Out-of-Scope			
9			☐ In-Scope ☐ Out-of-Scope			
10			☐ In-Scope ☐ Out-of-Scope			
11			☐ In-Scope ☐ Out-of-Scope			
12			☐ In-Scope ☐ Out-of-Scope			
13			☐ In-Scope ☐ Out-of-Scope			
14			☐ In-Scope ☐ Out-of-Scope			
15			☐ In-Scope ☐ Out-of-Scope			
TOTAL →						

Section II – INDUCTION INTERVIEW – Continued

13. Now I would like to make arrangements to obtain the information needed for sampling. I will need to (know/verify) how your (emergency department/(and), outpatient department/(and), ambulatory surgery center) (is/are) organized and obtain an estimate of the number of patient visits expected during the 4-week reporting period. Would you prefer I (get/verify) this information from you or someone else?

1 ☐ Respondent – *Go to CHECK ITEM C below*

2 ☐ Someone else – *Specify below*

If different respondent(s), arrange to obtain data today if possible. Otherwise arrange an appointment with designated person(s). Briefly explain the study to the new respondent(s). Then proceed with Section III, Emergency Department Description, Section IV, Outpatient Department Description, or Section V, Ambulatory Surgery Center Description as appropriate. Thank current respondent for his/her time and cooperation.

Name
Title
Department
Telephone number
→ **Record on Control Card**

Name
Title
Department
Telephone number
→ **Record on Control Card**

CHECK ITEM C

1 ☐ The hospital provides emergency services that are staffed 24 hours each day. (Yes in item 9a) – *GO to Section III, EMERGENCY DEPARTMENT DESCRIPTION on page 10.*

2 ☐ The hospital DOES NOT provide emergency services that are staffed 24 hours each day. (No in item 9a) – *SKIP to Section IV, OUTPATIENT DEPARTMENT DESCRIPTION on page 15.*

NOTES

Section III – EMERGENCY DEPARTMENT DESCRIPTION

To develop the sampling plan, I would like to (collect/verify) more specific information about this hospital's emergency department.

(1) If the hospital has previously participated, simply verify that the emergency service area(s) (ESA) listed below is (are) still operating in the hospital by –

(a) crossing through any ESAs on the list that no longer exist or are no longer operational in that hospital.

(b) adding the name(s) of any new ESA(s) that have been created or have become operational in that hospital. For each new ESA added to the list, be sure to obtain the proper type to be entered in column (b).

(c) obtaining an estimate of visits **for each ESA**, covering the 4-week reporting period. Enter the estimate in column (c).

(2) If the hospital has not previously participated, obtain a complete listing of all **eligible** ESAs along with their corresponding type and expected number of visits **for each ESA** during the 4-week reporting period. Record this information in columns (a), (b), and (c) below.

INSTRUCTION:

- Only record generic ESA names in column (a) (e.g., pediatric emergency department). If the ESA has a formal/proper name, enter a generic name in (a) and record the Line No. and the formal/proper name on page 2 of the control card.

FR NOTE

ESA types include:
- General
- Adult
- PED
- Urgi-/Fast track
- PSYC
- Trauma
- Other

Line No.	Emergency service area name (Generic) (a)	ESA type (b)	Expected No. of visits from ______ to ______ (c)	Take every number (d)	Random start number (e)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
TOTAL →					

INSTRUCTIONS – *Complete columns (d) and (e) after developing the sampling plan. See page 2 of the NHAMCS-124, Sampling and Information Booklet.*

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION

To develop the sampling plan, I would like to (collect/verify) more specific information about this hospital's outpatient department.

(1) If the hospital has previously participated, simply verify that the clinic(s) listed on page 16 is (are) still operating in the hospital by –

(a) crossing through any clinics on the list which no longer exist or are no longer operational in that hospital.

(b) adding the names of any new clinics which have been created or have become operational in that hospital. For each new clinic added to the list, be sure to obtain the proper specialty code. Remember, include only ELIGIBLE clinics.

(c) obtaining an estimate of visits **for each clinic**, covering the 4-week period. Enter the estimate in column (c) of the attached listing.

(d) If this Outpatient Department has more than 5 clinics – FAX the updated list to your regional office. The regional office will choose the clinics for sample and provide you with the sampling instructions. Upon receiving the instructions, attach a copy of the completed clinic listing showing sampled clinics, the Take Every and Random Start numbers, etc., to page 15 of the NHAMCS-101, Questionnaire.

(2) If the hospital has not previously participated or a clinic list is not attached to this 101, obtain a complete listing of all **eligible** outpatient clinics along with their corresponding specialty group code, and expected number of visits **for each clinic** during the 4-week reporting period. Record this information in columns (a), (b), and (d) on the next page.

NOTES

14q. Which of the following procedures does your ED use?

Show flashcard on page 27 of the NHAMCS-124.

Mark (X) all that apply.

1 ☐ Bedside registration
2 ☐ Computer-assisted triage
3 ☐ Separate fast track unit for nonurgent care
4 ☐ Separate operating room dedicated to ED patients
5 ☐ Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources)
6 ☐ Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)
7 ☐ Zone nursing (i.e., all of a nurse's patients are located in one area)
8 ☐ "Pool" nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)
☐ Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed)
10 ☐ None of the above

r. How many levels are in your ED's nursing (R.N. and L.P.N.) triage system?

1 ☐ Three
2 ☐ Four
3 ☐ Five
4 ☐ Other – *Specify* ________
5 ☐ Do not conduct nursing triage

s. Does your ED admit to hospitalist medicine specialists, or "hospitalists?"

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

CHECK ITEM C-2

1 ☐ The hospital has an organized outpatient department that provides physician services. (Yes in items 10a and b) – *SKIP to Section IV, OUTPATIENT DEPARTMENT DESCRIPTION on page 15.*

2 ☐ The hospital does not have an organized outpatient department that provides physician services. (No in items 10a or 10b) – *SKIP to Section V, AMBULATORY SURGERY CENTER DESCRIPTION on page 19.*

NOTES

CHECK ITEM C-1

Is the total number of expected ED visits during the reporting period between ________ and ________ ?

1 ☐ Yes – *SKIP to item 14a on page 12*
2 ☐ No, it is **MORE THAN** the range – *GO to item a*
3 ☐ No, it is **LESS THAN** the range – *SKIP to item b*

a. Is the number of expected visits to any of the ESAs more than twice the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have increased this year or were too low last year. – *Explain*

2 ☐ No, the number of visits has not increased dramatically.

SKIP to item 14a on page 12

b. Is the number of expected visits to any of the ESAs less than half of the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have decreased this year or were too high last year. – *Explain*

2 ☐ No, the number of visits has not decreased dramatically.

NOTES

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

Now I would like to ask you some questions about your ED.

14a. Does your ED use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Unknown

b. Does your ED have a computerized system for –

	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Does this include patient problem lists?**	1 ☐	2 ☐	3 ☐	4 ☐
(2) Orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **(a) Are there warnings of drug interactions or contraindications provided?**	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are orders sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐
(4) Viewing of lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are out of range levels highlighted?**	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing of imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Can electronic images be viewed?**	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Do they include medical history and follow-up notes?**	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If "Yes," ask – **Are notifiable diseases sent electronically?**	1 ☐	2 ☐	3 ☐	4 ☐

c. Are there any of the above features of your system that your ED does NOT use or has turned off?

1 ☐ Yes – *Please specify*

FR NOTE – *Indicate in item 14b, last column, any component(s) turned off.*

2 ☐ No
3 ☐ Unknown

d. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14e. Does your ED have a physically separate observation or clinical decision unit?

1 ☐ Yes
2 ☐ No } *SKIP to item 14g*
3 ☐ Unknown }

f. Do ED physicians make decisions for patients in this observation or clinical decision unit?

1 ☐ Part of the ED
2 ☐ Part of the inpatient side of the hospital
3 ☐ Unknown

g. Are admitted ED patients ever "boarded" for more than 2 hours in the ED or the observation unit while waiting for an inpatient bed?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

h. If the ED is critically overloaded, are admitted ED patients ever "boarded" in inpatient hallways or in another space outside the ED?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

i. What is the total number of hours that your hospital's ED was on ambulance diversion in 2008?

☐ Total number of hours
1 ☐ Data not available
2 ☐ ED did not go on ambulance diversion in 2008 – *SKIP to item 14l*

j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

l. As of last week, how many standard treatment spaces did your ED have?

Standard treatment spaces are beds or treatment spaces specifically designed for ED patients to receive care, including asthma chairs.

☐ Total number of standard treatment spaces

m. As of last week, how many others treatment spaces did your ED have?

Other treatment spaces are other locations where patients might receive care in the ED, including chairs, stretchers in hallways that may be used during busy times.

☐ Total number of other treatment spaces

n. In the last two years, has your ED increased the number of standard treatment spaces?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

o. In the last two years, has your ED's physical space been expanded?

1 ☐ Yes – *SKIP to item 14q*
2 ☐ No
3 ☐ Unknown

p. Do you have plans to expand your ED's physical space within the next two years?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown