





**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 ASCs 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 } Complete Section VII,  
4  Hospital closed } NONINTERVIEW on page 23  
5  Hospital ineligible }

**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 23. If no responses marked, END INTERVIEW.

**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 U.S. 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 nonprofit, 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 (e.g., 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 9a 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 V – AMBULATORY SURGERY CENTER DESCRIPTION – Continued**

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

**15c. 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 15e  
 3  No – More than 2 logs – Continue with item 15d.

**d. Would you or your IT staff be able to generate one list of outpatient surgery cases for some of these locations?**

1  Yes – Make sure that the "Single log/list" box is marked on the NHAMCS-101(U) in item 11 for each AU.  
 2  No – Continue with item 15e.

Give a copy of the "Single Sampling List Instructions" to the IT contact.

IT Contact name

Telephone number  
(Area code and number)

**RECORD ON CONTROL CARD**

**e. Does your ASC use ELECTRONIC MEDICAL OR HEALTH RECORDS (EMR/EHR) (not including billing records)?**

Mark (X) only one box.

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

**f. Does your ASC have a computerized system for –**

	Yes	No	Unknown	Turned off
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**(1) Patient demographic information?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **Does this include patient problem lists?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(2) Orders for prescriptions?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **(a) Are warnings of drug interactions or contraindications provided?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(b) Are prescriptions sent electronically to the pharmacy?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(3) Orders for tests?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **Are orders sent electronically?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(4) Viewing of lab results?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **Are out of range levels highlighted?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(5) Viewing of electronic imaging results in the ASC?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(6) Clinical notes?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **Do they include medical history and follow-up notes?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(7) Reminders for guideline-based interventions and/or screening tests?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

**(8) Public health reporting?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

If "Yes," ask – **Are notifiable diseases sent electronically?**

	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
--	----------------------------	----------------------------	----------------------------	----------------------------

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

1  Yes – Please specify

Show flashcard on page 29 of the NHAMCS-124.

**FR NOTE** – Indicate in item 15f, last column, any component(s) turned off.

2  No      1  Unknown  
 3  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 and ambulatory surgery centers
- (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
  - American College of Surgeons
  - American Health Information Management Association
  - American Academy of Ophthalmology
  - Society for Ambulatory Anesthesia
  - Surgeon General's office
- (3)** Nationwide sample of about 600 hospitals and 200 free-standing ambulatory surgery centers
- (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 a sister survey of the National Ambulatory Medical Care Survey (NAMCS). 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 care organizations, 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 ambulatory surgery centers
- (5) The U.S. 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) Any identifiable information will be held confidential and will be used only by NCHS staff, contractors or agents, only when necessary and with strict controls, and will not be disclosed to anyone else without the consent of your facility. By law, every employee as well as every agent has taken an oath and is subject to a jail term of up to five years, a fine of up to \$250,000, or both if he or she willfully discloses ANY identifiable information about you, your hospital and its patients
- (9) NO patients' names or identifiers are collected
- (10) The study was approved by the NCHS Research Ethics Review Board or IRB
- (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 are 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 (Yes in item 10c).
- 2  Hospital does not have any ASCs – SKIP to Section VI, DISPOSITION AND SUMMARY on page 22.

**15a. Does this facility have any satellite facilities which perform ambulatory (outpatient) surgery?**

- 1  Yes – Continue with item 15b.
- 2  No – SKIP to developing sampling plan

**b. What are the names, addresses, and telephone numbers of the satellite facilities?**

Name \_\_\_\_\_  
 Address \_\_\_\_\_  
 Telephone number (Area code and number) \_\_\_\_\_

**RECORD UP TO 3 ON CONTROL CARD**

**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 reporting period. Enter the estimate in column (d) of the listing below.
- (2) After asking 15c and 15d to determine if the ASC log/list is included in a single or multiple log/list, assign each ASC an AU number and enter it in column (c).

**FR NOTE**

In-scope 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

Out-of-scope locations:

- Dentistry
- Family planning
- Lump and bump procedure rooms
- Podiatry
- Abortion
- Birth center

ASC specialty groups include:

- GEN – General
- MULTI – Multi-specialty
- GI – Gastroenterology
- OPH – Ophthalmology
- ORTHO – Orthopedics
- PAIN – Pain Block
- PLASTIC – Plastic Surgery
- OTHER – Other specialty

**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 (e) and (f) after developing the sampling plan. See page 18 of the NHAMCS-124 for instructions.

Line No.	ASC name (Generic) (a)	Specialty group (b)	AU number (c)	Expected No. of ambulatory (outpatient) surgery cases		Take every number (e)	Random start number (f)
				from	to		
1							
2							
3							
4							
5							
6							
7							
8							
<b>TOTAL</b>							

**CHECK ITEM F**

- 1  Hospital has only 1 ASC location – SKIP to Item 15e.
- 2  Hospital has more than 1 ASC location – Continue with item 15c. Make sure that the "Single log/list" or "Multiple log/list" box is marked on the NHAMCS-101(U) in item 11.





**Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued**

**FR NOTE**

OPD Specialty Groups include:

- **GM** – General Medicine      • **PED** – Pediatrics      • **SA** – Substance Abuse
- **SURG** – Surgery              • **OBG** – Obstetrics/Gynecology      • **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 10 to 20 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 Specialty Group Scope (c)	Expected No. of visits from _____ to _____ (d)	Take every number (e)	Random start number (f)
1			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
2			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
3			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
4			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
5			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
6			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
7			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
8			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
9			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
10			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
11			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
12			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
13			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
14			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
15			<input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope			
<b>TOTAL</b> →						

**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**

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 – Continued**

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

**14a. Does your ED use ELECTRONIC MEDICAL OR HEALTH RECORDS (EMR/EHR) (not including billing records)?**

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

Mark (X) only one box.

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

**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

Show flashcard on page 29 of the NHAMCS-124.

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

2  No  
3  Unknown

**CHECK ITEM C-2**

1  The ED uses ELECTRONIC MEDICAL/HEALTH RECORDS (Yes (all) or Yes (part) in item 14a) – Continue with item 14d.  
 2  The ED either does not use ELECTRONIC MEDICAL/HEALTH RECORDS or it is unknown (No or Unknown in item 14a) – SKIP to item 14f.

**d. What year did your ED buy or last upgrade your EMR/EHR system?**

Year      1  Unknown

**e. Is your ED's EMR/EHR system certified by the "Commission for Healthcare Information Technology" (CCHIT)?**

1  Yes  
2  No  
3  Unknown

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

1  Yes      3  Maybe  
2  No      4  Unknown

**Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued**

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

1  Yes  
2  No  
3  Unknown } SKIP to item 14i

**h. What type of physicians make decisions for patients in this observation or clinical decision unit?**

1  ED physicians  
2  Hospitalists  
3  Other physicians  
4  Unknown

**i. 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

**j. 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

**k. What is the total number of hours that your hospital's ED was on ambulance diversion in 2009?**

Total number of hours  
1  Data not available  
2  ED did not go on ambulance diversion in 2009 – SKIP to item 14n

**l. 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

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

1  Yes  
2  No  
3  Unknown

**n. 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  
1  Data not available

**o. As of last week, how many other 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  
1  Data not available

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

1  Yes  
2  No  
3  Unknown

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

1  Yes  
2  No  
3  Unknown

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

1  Yes  
2  No  
3  Unknown