NOTES

Form Approved: OMB No. 0920-0278; Expiration date 08/31/2012

1. Label

NHAMCS-101
(12-10-2009)

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

2010 PANEL

2a. Hospital contact information		**b.** ED contact information	
Name Title Telephone number *(Area code and number)* FAX number	**RECORD ON CONTROL CARD**	Name Title Telephone number *(Area code and number)* FAX number	**RECORD ON CONTROL CARD**
c. OPD contact information		**d.** ASC contact information	
Name Title Telephone number *(Area code and number)* FAX number	**RECORD ON CONTROL CARD**	Name Title Telephone number *(Area code and number)* FAX number	**RECORD ON CONTROL CARD**

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 22.*

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 U.S. Census Bureau, which is collecting the data for the study.**

6. Did you receive the letter(s)?
(If "No" or "Don't know," 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

Section VII – NONINTERVIEW

19a. 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 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 ambulatory surgery locations were selected for sample?

Enter 0 if no ambulatory surgery locations were selected for sample.

_____ Number of ambulatory surgery locations

Did you include a NHAMCS-101(U) for each log/list?

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

17. FINAL DISPOSITION

1 ☐ All eligible units completed Patient Record Forms } *END interview*
2 ☐ Some eligible units completed Patient Record Forms } *GO to Item 18*
3 ☐ Hospital refused
4 ☐ Hospital closed } *END interview*
5 ☐ Hospital ineligible

18. 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 ambulatory surgery locations refused

FR NOTE – *If one or more responses are marked in 18, 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. 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 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 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
} *SKIP to item 10a*

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
See page 29 of the NHAMCS-124 for definitions

10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?

1 ☐ Yes
2 ☐ No – *SKIP to item 10c*

b. Does this OPD include physician services?

1 ☐ Yes
2 ☐ No

c. Does this hospital have locations that perform ambulatory surgery?

Read the following statement.
ASC locations include a general or main operating room, dedicated ambulatory surgery room, satellite operating room, cystoscopy room, endoscopy room, cardiac catheterization lab, laser procedures room, or a pain block room.

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

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 on page 5.*
5 ☐ Hospital is ineligible because it has NEITHER an ED nor OPD nor ASC (items 9a, 9b, 10a, 10b, and/or 10c are NO) – *Go to CLOSING STATEMENT B2 on page 5.*

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 ASC?
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

Go to Section VII, NONINTERVIEW on page 23.

Section V – AMBULATORY SURGERY CENTER DESCRIPTION – Continued

	1	2	3	4
(3) Orders for prescriptions?	☐	☐ *Skip to 15h4*	☐ *Skip to 15h4*	☐ *Skip to 15h4*
If Yes, ask – **(a)** Are warnings of drug interactions or contraindications provided?	☐	☐	☐	☐
(b) Are prescriptions sent electronically to the pharmacy?	☐	☐	☐	☐
(4) Orders for lab tests?	☐	☐ *Skip to 15h5*	☐ *Skip to 15h5*	☐ *Skip to 15h5*
If Yes, ask – **(a)** Are orders sent electronically to the lab?	☐	☐	☐	☐
(5) Viewing lab results?	☐	☐ *Skip to 15h6*	☐ *Skip to 15h6*	☐ *Skip to 15h6*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	☐	☐	☐	☐
(b) Are out of range levels highlighted?	☐	☐	☐	☐
(6) Viewing imaging results?	☐	☐	☐	☐
(7) Reminders for guideline-based interventions or screening tests?	☐	☐	☐	☐
(8) Electronic reporting to immunization registries?	☐	☐	☐	☐

i. At your ASC, if orders for prescriptions or lab tests are submitted electronically, who submits them?

1 ☐ Prescribing practitioner
2 ☐ Other clinician (including RN)
3 ☐ Lab technician
4 ☐ Administrative personnel
5 ☐ Other
6 ☐ Prescriptions and lab test orders not submitted electronically
7 ☐ Unknown

NOTES

Section V – AMBULATORY SURGERY CENTER DESCRIPTION – Continued

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 ambulatory surgery location name listed on the previous page.)

1 ☐ Yes
2 ☐ No – ONLY 2 LISTS } *SKIP to item 15e*
3 ☐ No – More than 2 lists – *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 item 11 is marked on the NHAMCS-101(U), Section B, for each AU.
2 ☐ No – *Continue with item 15e.*

Record the name and telephone number of the IT contact on the Control Card.

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

FR NOTE *If multiple logs were combined into one list, then assign the same AU number to each location and record in column (c) on page 19.*

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

e. Does your ASC submit CLAIMS electronically (electronic billing)?

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

f. Does your ASC use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system. Do not include billing record systems.

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic } *Go to item 15f1*
3 ☐ No
4 ☐ Unknown } *SKIP to item 15g*

(1) Which year did your ASC install the EMR/EHR system?

☐☐☐☐ Year

(2) What is the name of your current EMR/EHR system?

Mark (X) only one box.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ eClinicalWorks
4 ☐ Eclipsys
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE Centricity
8 ☐ Greenway Medical
9 ☐ HealthPort
10 ☐ McKesson
11 ☐ NextGen
12 ☐ Praxis
13 ☐ Practice One
14 ☐ Sage Intergy
15 ☐ Other
16 ☐ Unknown

g. Does your ASC have plans for installing a new EMR/EHR system within the next 18 months?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

h. Indicate whether your ASC has each of the following computerized capabilities. Does your ASC have a computerized system for: *Mark (X) only one box per row.*

	Yes	Yes, but turned off or not used	No	Unknown
(1) Patient history and demographic information? .	1 ☐	2 ☐ *Skip to 15h2*	3 ☐ *Skip to 15h2*	4 ☐ *Skip to 15h2*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Clinical notes?	1 ☐	2 ☐ *Skip to 15h3*	3 ☐ *Skip to 15h3*	4 ☐ *Skip to 15h3*
If Yes, ask – **(a)** Do they include a list of medications that the patient is taking?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Do they include a comprehensive list of the patient's allergies (including allergies to medication)?	1 ☐	2 ☐	3 ☐	4 ☐

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 Section VI on page 22.*

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 Section VI on page 22.*

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
- 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 and 246 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 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) Only a 4-week data collection period

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

SHOW PATIENT RECORD FORMS

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

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

(20) 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 ambulatory surgery location *(Yes in item 10c).*
2 ☐ Hospital does not have any ambulatory surgery locations – *SKIP to Section VI, DISPOSITION AND SUMMARY on page 22.*

15a. Does this hospital 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 locations.

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

FR NOTE

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

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

INSTRUCTIONS

- Only record generic ambulatory surgery location names in column (a) (e.g., ambulatory surgery center, cardiac cath). If the ambulatory surgery location 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.
- Record the specialty group acronym in column (b).
- Complete columns (e) and (f) after developing the sampling plan. See page 18 of the NHAMCS-124 for instructions.

Line No.	Name of ambulatory surgery location (Generic) (a)	Specialty group (b)	AU number (c)	Expected No. of ambulatory (outpatient) surgery cases from ____ to ____ (d)	Take every number (e)	Random start number (f)
1						
2						
3						
4						
5						
6						
7						
8						
	TOTAL →					

CHECK ITEM F

1 ☐ Hospital has only 1 ambulatory surgery location – *SKIP to Item 15e.*
2 ☐ Hospital has more than 1 ambulatory surgery location – *Continue with item 15c. Make sure that item 11 is marked on the NHAMCS-101(U), Section B.*

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

14v. Does your OPD have plans for installing a new EMR/EHR system within the next 18 months?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

w. Please indicate whether your OPD has each of the computerized capabilities listed below. Does your OPD have a computerized system for: *Mark (X) only one box per row.*

	Yes	Yes, but turned off or not used	No	Unknown
(1) Patient history and demographic information?	1 ☐	2 ☐ *Skip to 14w2*	3 ☐ *Skip to 14w2*	4 ☐ *Skip to 14w2*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Clinical notes?	1 ☐	2 ☐ *Skip to 14w3*	3 ☐ *Skip to 14w3*	4 ☐ *Skip to 14w3*
If Yes, ask – **(a)** Do they include a list of medications that the patient is taking?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Do they include a comprehensive list of the patient's allergies (including allergies to medication)?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for prescriptions?	1 ☐	2 ☐ *Skip to 14w4*	3 ☐ *Skip to 14w4*	4 ☐ *Skip to 14w4*
If Yes, ask – **(a)** Are warnings of drug interactions or contraindications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Orders for lab tests?	1 ☐	2 ☐ *Skip to 14w5*	3 ☐ *Skip to 14w5*	4 ☐ *Skip to 14w5*
If Yes, ask – **(a)** Are orders sent electronically to the lab?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing lab results?	1 ☐	2 ☐ *Skip to 14w6*	3 ☐ *Skip to 14w6*	4 ☐ *Skip to 14w6*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are out of range levels highlighted?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐

x. At your OPD, if orders for prescriptions or lab tests are submitted electronically, who submits them?

1 ☐ Prescribing practitioner
2 ☐ Other clinician (including RN)
3 ☐ Lab technician
4 ☐ Administrative personnel
5 ☐ Other
6 ☐ Prescriptions and lab test orders not submitted electronically
7 ☐ Unknown

NOTES

Section II – INDUCTION INTERVIEW – Continued

CHECK ITEM B-3

1 ☐ CHECK ITEM B = 1 (ED meets eligibility requirements)
2 ☐ CHECK ITEM B = 2 or 3 (ED does NOT meet eligibility requirements) – *SKIP to Part B. Survey Implementation 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**

d. Does your hospital have hospitalists on staff?

A hospitalist is a physician whose primary professional focus is the general care of hospitalized patients. He/she may oversee ED patients being admitted to the hospital.

1 ☐ Yes
2 ☐ No
3 ☐ Unknown } *SKIP to Part B. Survey Implementation on page 8*

e. Do the hospitalists on staff at your hospital admit patients from your ED?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

f. Beginning in 2011, Medicare and Medicaid will offer incentives to facilities that have "meaningful use of Health IT". Does your hospital have plans to apply for Medicare or Medicaid incentive payments for meaningful use of Health IT?

1 ☐ Yes, we intend to apply – *Go to item 11f1*
2 ☐ Uncertain whether we will apply } *SKIP to Part B*
3 ☐ No, we will not apply

(1) What year does your hospital expect to apply for the meaningful use payments?

1 ☐ 2011
2 ☐ 2012
3 ☐ After 2012
4 ☐ Unknown

(2) What incentive payment does your hospital plan to apply for?

1 ☐ Medicare
2 ☐ Medicaid
3 ☐ 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 D-1

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.

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

14t. Does your OPD submit CLAIMS electronically (electronic billing)?

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

u. Does your OPD use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system. Do not include billing record systems.

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic } *Go to item 14u(1)*
3 ☐ No
4 ☐ Unknown } *SKIP to item 14v*

(1) Which year did your OPD install the EMR/EHR system?

____ Year

(2) What is the name of your current EMR/EHR system?

Mark (X) only one box.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ eClinicalWorks
4 ☐ Eclipsys
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE Centricity
8 ☐ Greenway Medical
9 ☐ HealthPort
10 ☐ McKesson
11 ☐ NextGen
12 ☐ Praxis
13 ☐ Practice One
14 ☐ Sage Intergy
15 ☐ Other
16 ☐ Unknown

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 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 Specialty 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**
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 has/have been created or has/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
- Pediatric
- Urgent care/Fast track
- Psychiatric
- 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 name(s) of any new clinic(s) which has/have been created or 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 reporting period. Enter the estimate in column (d).

(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 the NHAMCS-101(C) Control Card.

(2) If the hospital has not previously participated or a clinic list is not attached to NHAMCS-101(C) Control Card, 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

14s. Does your ED use —

Show flashcard on page 31 of the NHAMCS-124.

Mark (X) only one box.

	Yes	No	Unknown
(1) Bedside registration	1 ☐	2 ☐	3 ☐
(2) Computer-assisted triage	1 ☐	2 ☐	3 ☐
(3) Separate fast track unit for nonurgent care	1 ☐	2 ☐	3 ☐
(4) Separate operating room dedicated to ED patients	1 ☐	2 ☐	3 ☐
(5) Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources)	1 ☐	2 ☐	3 ☐
(6) Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)	1 ☐	2 ☐	3 ☐
(7) Zone nursing (i.e., all of a nurse's patients are located in one area)	1 ☐	2 ☐	3 ☐
(8) Pool nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)	1 ☐	2 ☐	3 ☐
(9) Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed)	1 ☐	2 ☐	3 ☐

CHECK ITEM C-3

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.

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

14a. Does your ED submit CLAIMS electronically (electronic billing)?

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

b. Does your ED use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system. Do not include billing record systems.

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
} *Go to item 14b(1)*
3 ☐ No
4 ☐ Unknown
} *SKIP to item 14c*

(1) Which year did your ED install the EMR/EHR system?

____ Year

(2) What is the name of your current EMR/EHR system?

Mark (X) only one box.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ eClinicalWorks
4 ☐ Eclipsys
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE Centricity
8 ☐ Greenway Medical
9 ☐ HealthPort
10 ☐ McKesson
11 ☐ NextGen
12 ☐ Praxis
13 ☐ Practice One
14 ☐ Sage Intergy
15 ☐ Other
16 ☐ Unknown

c. Does your ED have plans for installing a new EMR/EHR system within the next 18 months?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14d. Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for: *Mark (X) only one box per row.*

	Yes	Yes, but turned off or not used	No	Unknown
(1) Patient history and demographic information?	1 ☐	2 ☐ *Skip to 14d2*	3 ☐ *Skip to 14d2*	4 ☐ *Skip to 14d2*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Clinical notes?	1 ☐	2 ☐ *Skip to 14d3*	3 ☐ *Skip to 14d3*	4 ☐ *Skip to 14d3*
If Yes, ask – **(a)** Do they include a list of medications that the patient is taking?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Do they include a comprehensive list of the patient's allergies (including allergies to medication)?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Orders for prescriptions?	1 ☐	2 ☐ *Skip to 14d4*	3 ☐ *Skip to 14d4*	4 ☐ *Skip to 14d4*
If Yes, ask – **(a)** Are warnings of drug interactions or contraindications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Orders for lab tests?	1 ☐	2 ☐ *Skip to 14d5*	3 ☐ *Skip to 14d5*	4 ☐ *Skip to 14d5*
If Yes, ask – **(a)** Are orders sent electronically to the lab?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Viewing lab results?	1 ☐	2 ☐ *Skip to 14d6*	3 ☐ *Skip to 14d6*	4 ☐ *Skip to 14d6*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are out of range levels highlighted?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐

e. At your ED, if orders for prescriptions or lab tests are submitted electronically, who submits them?

1 ☐ Prescribing practitioner
2 ☐ Other clinician (including RN)
3 ☐ Lab technician
4 ☐ Administrative personnel
5 ☐ Other
6 ☐ Prescriptions and lab test orders not submitted electronically
7 ☐ Unknown

g. 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 ☐ Hospital lists
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

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14j. 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. Did your ED go on ambulance diversion in 2009?

1 ☐ Yes – *GO to item (1)*
2 ☐ No
3 ☐ Unknown } *SKIP to item 14n*

(1) 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

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

NOTES