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

NOTICE – Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Information Collection Review Office; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential; will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls; and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

1. Label

NHAMCS-101
(11-2-2010)

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

2011 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. Ambulatory surgery 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
Ambulatory surgery 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 23.*

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 locations. 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

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:**

Question	Response
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 } *SKIP to item 9a on page 4* 4 ☐ Unknown }
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
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

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.
Ambulatory surgery 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 ☐ Ambulatory surgery location 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 ambulatory surgery location (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 ambulatory surgery location and if so, inquire as to how many visits are expected during the reporting period.

Eligible Ambulatory surgery location?
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   ______ Ambulatory surgery visits last year

Go to Section VII, NONINTERVIEW on page 24.

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 23.*

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 23.*

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 locations

(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 **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 locations

(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) NHAMCS excludes the following types of ambulatory surgery locations: dentistry, podiatry, abortion, birth center, family planning, and small procedures

(17) Only a 4-week data collection period

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

SHOW PATIENT RECORD FORMS

(19) Form takes only 6 to 9 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

CHECK ITEM B-3

1 ☐ CHECK ITEM B = 1 (ED meets eligibility requirements)
2 ☐ ED does NOT meet eligibility requirements (no in item 9a) – *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 } *SKIP to item 11f*
3 ☐ Unknown } *SKIP to item 11f*

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 demonstrate "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 11f(1)*
2 ☐ Uncertain whether we will apply } *SKIP to Part B on page 8*
3 ☐ No, we will not apply } *SKIP to Part B on page 8*

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

1 ☐ 2011
2 ☐ 2012
3 ☐ After 2012
4 ☐ 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

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 locations) (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 Location Description as appropriate. Thank current respondent for his/her time and cooperation.

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

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

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

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 Check Item C-3 on page 14.*

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.*

CHECK ITEM C-1

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

1 ☐ Yes – *SKIP to item 14a*
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

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 any CLAIMS electronically (electronic billing)?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

b. Does your ED verify an individual patient's insurance eligibility electronically, with results returned immediately?

1 ☐ Yes, with a stand-alone practice management system
2 ☐ Yes, with an EMR/EHR system
3 ☐ Yes, using another electronic system
4 ☐ No
5 ☐ Unknown

c. 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 14c(1)*
3 ☐ No
4 ☐ Unknown } *SKIP to item 14d*

(1) In 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.

If "Other" is marked, specify the name.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ CHARTCARE
4 ☐ eClinicalWorks
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE/Centricity
8 ☐ Greenway Medical
9 ☐ MED3000
10 ☐ NextGen
11 ☐ Sage
12 ☐ SOAPware
13 ☐ Practice Fusion
14 ☐ Other ________
15 ☐ Unknown

d. 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

14e. 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) Recording patient history and demographic information?	1 ☐ *Go to 14e(1)(a)*	2 ☐ *Skip to 14e(2)*	3 ☐ *Skip to 14e(2)*	4 ☐ *Skip to 14e(2)*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Recording clinical notes?	1 ☐ *Go to 14e(2)(a)*	2 ☐ *Skip to 14e(3)*	3 ☐ *Skip to 14e(3)*	4 ☐ *Skip to 14e(3)*
If Yes, ask – **(a)** Do they include a comprehensive list of the patient's medications and allergies?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Ordering prescriptions?	1 ☐ *Go to 14e(3)(a)*	2 ☐ *Skip to 14e(4)*	3 ☐ *Skip to 14e(4)*	4 ☐ *Skip to 14e(4)*
If Yes, ask – **(a)** Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are warnings of drug interactions or containdications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Providing reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Ordering lab tests?	1 ☐ *Go to 14e(5)(a)*	2 ☐ *Skip to 14e(6)*	3 ☐ *Skip to 14e(6)*	4 ☐ *Skip to 14e(6)*
If Yes, ask – **(a)** Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Providing standard order sets related to a particular condition or procedure?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Viewing lab results?	1 ☐ *Go to 14e(7)(a)*	2 ☐ *Skip to 14e(8)*	3 ☐ *Skip to 14e(8)*	4 ☐ *Skip to 14e(8)*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(9) Viewing data on quality of care measures?	1 ☐	2 ☐	3 ☐	4 ☐
(10) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐
(11) Public health reporting?	1 ☐ *Go to 14e(11)(a)*	2 ☐ *Skip to 14e(12)*	3 ☐ *Skip to 14e(12)*	4 ☐ *Skip to 14e(12)*
If Yes, ask – **(a)** Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(12) Providing patients with clinical summaries for each visit?	1 ☐	2 ☐	3 ☐	4 ☐
(13) Exchanging secure messages with patients?	1 ☐	2 ☐	3 ☐	4 ☐

(14) At your ED, if orders for prescriptions or lab tests are submitted electronically, who submits them?

Mark (X) all that apply.

1 ☐ Prescribing practitioner
2 ☐ Other
3 ☐ Prescriptions and lab test orders not submitted electronically
4 ☐ Unknown

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14f. Does your ED exchange patient clinical summaries electronically with any other providers?

- 1 ☐ Yes, send summaries only
- 2 ☐ Yes, receive summareis only
- 3 ☐ Yes, send and receive summaries
  } *Go to 14f(1)*
- 4 ☐ No
- 5 ☐ Unknown
  } *SKIP to item 14g*

(1) How does your ED electronically send or receive patient clinical summaries?

Mark (X) all that apply.

- 1 ☐ Through EMR/EHR vendor
- 2 ☐ Through hospital-based system
- 3 ☐ Through Health Information Organization or state exchange
- 4 ☐ Through secure email attachment
- 5 ☐ Other
- 6 ☐ 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?

Mark (X) all that apply.

- 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. Did your ED go on ambulance diversion in 2010?

- 1 ☐ Yes – *GO to item 14k(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 2010?

______ 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

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14q. 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

s. 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 LOCATION DESCRIPTION on page 20.*

NOTES

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

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 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 IV – OUTPUT DEPARTMENT DESCRIPTION – Continued

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 20.*

CHECK ITEM D-1

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

1 ☐ Yes – *SKIP to item 14t*
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***

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 any CLAIMS electronically (electronic billing)?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

u. Does your OPD verify an individual patient's insurance eligibiltiy electronically, with results returned immediately?

1 ☐ Yes, with a stand-alone practice management system
2 ☐ Yes, with an EMR/EHR system
3 ☐ Yes, using another electronic system
4 ☐ No
5 ☐ Unknown

v. 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 14v(1)*
3 ☐ No
4 ☐ Unknown } *SKIP to item 14w*

(1) In 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.

If "Other " is marked, specifiy the name.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ CHARTCARE
4 ☐ eClinicalWorks
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE/Centricity
8 ☐ Greenway Medical
9 ☐ MED3000
10 ☐ NextGen
11 ☐ Sage
12 ☐ SOAPware
13 ☐ Practice Fusion
14 ☐ Other *(specify)*
15 ☐ Unknown

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

14w. 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

x. Indicate whether your OPD has each of the following computerized capabilities. 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) Recording patient history and demographic information?	1 ☐ *Go to 14x(1)(a)*	2 ☐ *Skip to 14x(2)*	3 ☐ *Skip to 14x(2)*	4 ☐ *Skip to 14x(2)*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Recording clinical notes?	1 ☐ *Go to 14x(2)(a)*	2 ☐ *Skip to 14x(3)*	3 ☐ *Skip to 14x(3)*	4 ☐ *Skip to 14x(3)*
If Yes, ask – **(a)** Do they include a comprehensive list of the patient's medications and allergies?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Ordering prescriptions?	1 ☐ *Go to 14x(3)(a)*	2 ☐ *Skip to 14x(4)*	3 ☐ *Skip to 14x(4)*	4 ☐ *Skip to 14x(4)*
If Yes, ask – **(a)** Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are warnings of drug interactions or containdications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Providing reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Ordering lab tests?	1 ☐ *Go to 14x(5)(a)*	2 ☐ *Skip to 14x(6)*	3 ☐ *Skip to 14x(6)*	4 ☐ *Skip to 14x(6)*
If Yes, ask – **(a)** Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Providing standard order sets related to a particular condition or procedure?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Viewing lab results?	1 ☐ *Go to 14x(7)(a)*	2 ☐ *Skip to 14x(8)*	3 ☐ *Skip to 14x(8)*	4 ☐ *Skip to 14x(8)*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(9) Viewing data on quality of care measures? . . .	1 ☐	2 ☐	3 ☐	4 ☐
(10) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐
(11) Public health reporting?	1 ☐ *Go to 14x(11)(a)*	2 ☐ *Skip to 14x(12)*	3 ☐ *Skip to 14x(12)*	4 ☐ *Skip to 14x(12)*
If Yes, ask – **(a)** Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(12) Providing patients with clinical summaries for each visit?	1 ☐	2 ☐	3 ☐	4 ☐
(13) Exchanging secure messages with patients? .	1 ☐	2 ☐	3 ☐	4 ☐

(14) At your OPD, if orders for prescriptions or lab tests are submitted electronically, who submits them?

Mark (X) all that apply.

1 ☐ Prescribing practitioner
2 ☐ Other
3 ☐ Prescriptions and lab test orders not submitted electronically
4 ☐ Unknown

y. Does your OPD exchange patient clinical summaries electronically with any other providers?

1 ☐ Yes, send summaries only
2 ☐ Yes, receive summaries only
3 ☐ Yes, send and receive summaries
} *Go to 14y(1)*

4 ☐ No
5 ☐ Unknown
} *SKIP to Check item E*

(1) How does your OPD electronically send or receive patient clinical summaries?

Mark (X) all that aplly.

1 ☐ Through EMR/EHR vendor
2 ☐ Through hospital-based system
3 ☐ Through Health Information Organization or state exchange
4 ☐ Through secure email attachment
5 ☐ Other
6 ☐ Unknown

NOTES

Section V – AMBULATORY SURGERY LOCATION 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 23.*

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
- Family planning
- Small procedures
- Podiatry
- Abortion
- Birth center

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 ambulatory surgery location names in column (a) (e.g., pain block room, cardiac cath lab). 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.*

Section V – AMBULATORY SURGERY LOCATION 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 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
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 20.*

Now I would like to ask you some questions about your Ambulatory Surgery Location.

e. Does your ambulatory surgery location submit any CLAIMS electronically (electronic billing)?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

f. Does your ambulatory surgery location verify an individual patient's insurance eligibility electronically, with results returned immediately?

1 ☐ Yes, with a stand-alone practice management system
2 ☐ Yes, with an EMR/EHR system
3 ☐ Yes, using another electronic system
4 ☐ No
5 ☐ Unknown

g. Does your ambulatory surgery location 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 15g(1)*
3 ☐ No
4 ☐ Unknown } *SKIP to item 15h*

(1) In which year did your ambulatory surgery location install the EMR/EHR system?

☐☐☐☐ Year

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

Mark (X) only one box.

If "Other" is marked, specify the name.

1 ☐ Allscripts
2 ☐ Cerner
3 ☐ CHARTCARE
4 ☐ eClinicalWorks
5 ☐ Epic
6 ☐ eMDs
7 ☐ GE/Centricity
8 ☐ Greenway Medical
9 ☐ MED3000
10 ☐ NextGen
11 ☐ Sage
12 ☐ SOAPware
13 ☐ Practice Fusion
14 ☐ Other ________
15 ☐ Unknown

h. Does your ambulatory surgery location have plans for installing a new EMR/EHR system within the next 18 months?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

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

	Yes	Yes, but turned off or not used	No	Unknown
(1) Recording patient history and demographic information?	1 ☐ *Go to 15i(1)(a)*	2 ☐ *Skip to 15i(2)*	3 ☐ *Skip to 15i(2)*	4 ☐ *Skip to 15i(2)*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Recording clinical notes?	1 ☐ *Go to 15i(2)(a)*	2 ☐ *Skip to 15i(3)*	3 ☐ *Skip to 15i(3)*	4 ☐ *Skip to 15i(3)*
If Yes, ask – **(a)** Do they include a comprehensive list of the patient's medications and allergies?	1 ☐	2 ☐	3 ☐	4 ☐

Section V – AMBULATORY SURGERY LOCATION DESCRIPTION – Continued

	Yes	Yes, but turned off or not used	No	Unknown
(3) Ordering prescriptions?	1 ☐ *Go to 15i(3)(a)*	2 ☐ *Skip to 15i(4)*	3 ☐ *Skip to 15i(4)*	4 ☐ *Skip to 15i(4)*
If Yes, ask – **(a)** Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are warnings of drug interactions or containdications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Providing reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Ordering lab tests?	1 ☐ *Go to 15i(5)(a)*	2 ☐ *Skip to 15i(6)*	3 ☐ *Skip to 15i(6)*	4 ☐ *Skip to 15i(6)*
If Yes, ask – **(a)** Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Providing standard order sets related to a particular condition or procedure?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Viewing lab results?	1 ☐ *Go to 15i(7)(a)*	2 ☐ *Skip to 15i(8)*	3 ☐ *Skip to 15i(8)*	4 ☐ *Skip to 15i(8)*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(9) Viewing data on quality of care measures?	1 ☐	2 ☐	3 ☐	4 ☐
(10) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐
(11) Public health reporting?	1 ☐ *Go to 15i(11)(a)*	2 ☐ *Skip to 15i(12)*	3 ☐ *Skip to 15i(12)*	4 ☐ *Skip to 15i(12)*
If Yes, ask – **(a)** Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(12) Providing patients with clinical summaries for each visit?	1 ☐	2 ☐	3 ☐	4 ☐
(13) Exchanging secure messages with patients?	1 ☐	2 ☐	3 ☐	4 ☐

(14) At your ambulatory surgery location, if orders for prescriptions or lab tests are submitted electronically, who submits them?

Mark (X) all that apply.

1 ☐ Prescribing practitioner
2 ☐ Other
3 ☐ Prescriptions and lab test orders not submitted electronically
4 ☐ Unknown

15j. Does your ambulatory surgery location exchange patient clinical summaries electronically with any other providers?

1 ☐ Yes, send summaries only
2 ☐ Yes, receive summaries only
3 ☐ Yes, send and receive summaries } *Go to 15j(1)*
4 ☐ No
5 ☐ Unknown } *Skip to 16a*

(1) How does your ambulatory surgery location electronically send or receive patient clinical summaries?

Mark (X) all that apply.

1 ☐ Through EMR/EHR vendor
2 ☐ Through hospital-based system
3 ☐ Through Health Information Organization or state exchange
4 ☐ Through secure email attachment
5 ☐ Other
6 ☐ Unknown

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 LOCATIONS*** *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 ambulatory surgery Patient Record Forms completed — ______ Number of ambulatory surgery PRFs

17. FINAL DISPOSITION

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

18. NATURE OF REFUSAL

Mark (X) all that apply.

1 ☐ Entire ED refused
2 ☐ Entire OPD refused
3 ☐ All ambulatory surgery locations 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 24. If no responses marked, END INTERVIEW.*

Section VII – NONINTERVIEW

19a. At what point in the interview did the refusal/breakoff occur?
Mark (X) appropriate box(es)

	Hospital	ED	OPD	Ambulatory Surgery
(1) During the telephone screening	1 ☐			
(2) During the hospital induction	2 ☐			
(3) During the ED/OPD/ Ambulatory Surgery induction	3 ☐	3 ☐	3 ☐	3 ☐
(4) After the ED/OPD/ Ambulatory Surgery 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/Ambulatory Surgery 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 if hospital, ED, OPD, or Ambulatory Surgery (from item 19a) before recording responses.*

d. Was conversion attempted?

Hospital	ED	OPD	Ambulatory Surgery
1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

NOTES

NOTES