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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 | | b. ED contact information | |
|--|-------------------------------|--|-------------------------------|
| Name | RECORD ON CONTROL CARD | Name | RECORD ON CONTROL CARD |
| Title | | Title | |
| Telephone number (Area code and number) | | Telephone number (Area code and number) | |
| FAX number | | FAX number | |
| c. OPD contact information | | d. Ambulatory surgery contact information | |
| Name | RECORD ON CONTROL CARD | Name | RECORD ON CONTROL CARD |
| Title | | Title | |
| Telephone number (Area code and number) | | Telephone number (Area code and number) | |
| FAX number | | FAX number | |

Section I – TELEPHONE SCREENER

| 3. Field representative information | | 4. Record of telephone calls | | | |
|-------------------------------------|---------|------------------------------|------|------|---------|
| | | Call | Date | Time | Results |
| Telephone screener | FR Code | 1 | | | |
| Hospital induction | FR Code | 2 | | | |
| ED induction | FR Code | 3 | | | |
| OPD induction | FR Code | 4 | | | |
| | | 5 | | | |
| Ambulatory surgery induction | FR Code | 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 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to CHECK ITEM B on page 4</i> |
| b. Is this hospital nonprofit, government, or proprietary? | 1 <input type="checkbox"/> Nonprofit (includes church-related, nonprofit corporation, other nonprofit ownership) 2 <input type="checkbox"/> State or local government (includes state, county, city, city-county, hospital district or authority) 3 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown |
| d. Is this a teaching hospital? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| e. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years? | 1 <input type="checkbox"/> Yes, merged 2 <input type="checkbox"/> Yes, separated 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown } <i>SKIP to item 9a on page 4</i> |
| f. Does YOUR hospital have its own medical records department that is separate from that of the OTHER hospital? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| b. Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| c. What is the trauma level rating of this hospital? | 1 <input type="checkbox"/> Level I 3 <input type="checkbox"/> Level III 5 <input type="checkbox"/> Other/unknown 2 <input type="checkbox"/> Level II 4 <input type="checkbox"/> Level IV or V 6 <input type="checkbox"/> None <i>See page 29 of the NHAMCS-124 for definitions</i> |

| | |
|---|---|
| 10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to item 10c</i> |
| b. Does this OPD include physician services? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| c. Does this hospital have locations that perform ambulatory surgery? <i>Read the following statement.</i> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> 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)
 - 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.*
- } *SKIP to CHECK ITEM B-1*

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.

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 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

Section II – INDUCTION INTERVIEW – Continued

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.

11 a. 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 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

(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

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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

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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
- Pediatric
- Psychiatric
- Adult
- Urgent care/Fast track
- Other

| Line No. | Emergency service area name (Generic) (a) | ESA type (b) | Expected No. of visits from <input style="width: 40px;" type="text"/> to <input style="width: 40px;" type="text"/> (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 III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

**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 <input type="checkbox"/> Allscripts | 7 <input type="checkbox"/> GE/Centricity | 12 <input type="checkbox"/> SOAPware |
| 2 <input type="checkbox"/> Cerner | 8 <input type="checkbox"/> Greenway Medical | 13 <input type="checkbox"/> Practice Fusion |
| 3 <input type="checkbox"/> CHARTCARE | 9 <input type="checkbox"/> MED3000 | 14 <input type="checkbox"/> Other ↘ |
| 4 <input type="checkbox"/> eClinicalWorks | 10 <input type="checkbox"/> NextGen | <input style="width: 100px; height: 20px;" type="text"/> |
| 5 <input type="checkbox"/> Epic | 11 <input type="checkbox"/> Sage | 15 <input type="checkbox"/> Unknown |
| 6 <input type="checkbox"/> eMDs | | |

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: <i>Mark (X) only one box per row.</i> | Yes | Yes, but turned off or not used | No | Unknown |
|---|--|--|--|--|
| (1) Recording patient history and demographic information? | 1 <input type="checkbox"/> <i>Go to 14e(1)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(2)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(2)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(2)</i> |
| <i>If Yes, ask – (a) Does this include a patient problem list?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (2) Recording clinical notes? | 1 <input type="checkbox"/> <i>Go to 14e(2)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(3)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(3)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(3)</i> |
| <i>If Yes, ask – (a) Do they include a comprehensive list of the patient’s medications and allergies?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (3) Ordering prescriptions? | 1 <input type="checkbox"/> <i>Go to 14e(3)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(4)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(4)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(4)</i> |
| <i>If Yes, ask – (a) Are prescriptions sent electronically to the pharmacy?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (b) Are warnings of drug interactions or contraindications provided? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (4) Providing reminders for guideline-based interventions or screening tests? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (5) Ordering lab tests? | 1 <input type="checkbox"/> <i>Go to 14e(5)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(6)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(6)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(6)</i> |
| <i>If Yes, ask – (a) Are orders sent electronically?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (6) Providing standard order sets related to a particular condition or procedure? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (7) Viewing lab results? | 1 <input type="checkbox"/> <i>Go to 14e(7)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(8)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(8)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(8)</i> |
| <i>If Yes, ask – (a) Are results incorporated in EMR/EHR?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (8) Viewing imaging results? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (9) Viewing data on quality of care measures? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (10) Electronic reporting to immunization registries? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (11) Public health reporting? | 1 <input type="checkbox"/> <i>Go to 14e(11)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 14e(12)</i> | 3 <input type="checkbox"/> <i>Skip to 14e(12)</i> | 4 <input type="checkbox"/> <i>Skip to 14e(12)</i> |
| <i>If Yes, ask – (a) Are notifiable diseases sent electronically?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (12) Providing patients with clinical summaries for each visit? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (13) Exchanging secure messages with patients? .. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (14) At your ED, if orders for prescriptions or lab tests are submitted electronically, who submits them? <i>Mark (X) all that apply.</i> | 1 <input type="checkbox"/> Prescribing practitioner 2 <input type="checkbox"/> Other 3 <input type="checkbox"/> Prescriptions and lab test orders not submitted electronically 4 <input type="checkbox"/> Unknown | | | |

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

| | |
|---|--|
| <p>14f. Does your ED exchange patient clinical summaries electronically with any other providers?</p> | <p>1 <input type="checkbox"/> Yes, send summaries only 2 <input type="checkbox"/> Yes, receive summaries only 3 <input type="checkbox"/> Yes, send and receive summaries 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown } <i>Go to 14f(1)</i> } <i>SKIP to item 14g</i></p> |
| <p>(1) How does your ED electronically send or receive patient clinical summaries?</p> <p><i>Mark (X) all that apply.</i></p> | <p>1 <input type="checkbox"/> Through EMR/EHR vendor 2 <input type="checkbox"/> Through hospital-based system 3 <input type="checkbox"/> Through Health Information Organization or state exchange 4 <input type="checkbox"/> Through secure email attachment 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> Unknown</p> |
| <p>g. Does your ED have a physically separate observation or clinical decision unit?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown } <i>SKIP to item 14i</i></p> |
| <p>h. What type of physicians make decisions for patients in this observation or clinical decision unit?</p> <p><i>Mark (X) all that apply.</i></p> | <p>1 <input type="checkbox"/> ED physicians 2 <input type="checkbox"/> Hospitalists 3 <input type="checkbox"/> Other physicians 4 <input type="checkbox"/> Unknown</p> |
| <p>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?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>j. If the ED is critically overloaded, are admitted ED patients ever "boarded" in inpatient hallways or in another space outside the ED?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>k. Did your ED go on ambulance diversion in 2010?</p> <p>(1) What is the total number of hours that your hospital's ED was on ambulance diversion in 2010?</p> | <p>1 <input type="checkbox"/> Yes – <i>GO to item 14k(1)</i> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown } <i>SKIP to item 14n</i></p> <p><input type="text"/> Total number of hours</p> <p>1 <input type="checkbox"/> Data not available</p> |
| <p>l. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>m. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>n. As of last week, how many standard treatment spaces did your ED have?</p> <p>Standard treatment spaces are beds or treatment spaces specifically designed for ED patients to receive care, including asthma chairs.</p> | <p><input type="text"/> Total number of standard treatment spaces</p> <p>1 <input type="checkbox"/> Data not available</p> |
| <p>o. As of last week, how many other treatment spaces did your ED have?</p> <p>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.</p> | <p><input type="text"/> Total number of other treatment spaces</p> <p>1 <input type="checkbox"/> Data not available</p> |
| <p>p. In the last two years, has your ED increased the number of standard treatment spaces?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |

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 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (2) Computer-assisted triage | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (3) Separate fast track unit for nonurgent care | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (4) Separate operating room dedicated to ED patients | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (5) Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (6) Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (7) Zone nursing (i.e., all of a nurse's patients are located in one area) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (8) Pool nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (9) Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed) | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> |

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

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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 | | Take every number (e) | Random start number (f) |
|-----------|---|------------------------|--|--|--|--------------------------|----------------------------|
| | | | | from <input style="width: 50px; height: 20px;" type="text"/> | to <input style="width: 50px; height: 20px;" type="text"/> | | |
| 1 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 2 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 3 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 4 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 5 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 6 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 7 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 8 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 9 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 10 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 11 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 12 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 13 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 14 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |
| 15 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | | |

TOTAL →

| | | |
|--|--|--|
| | | |
|--|--|--|

Section IV – OUTPATIENT 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 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

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 } *SKIP to item 14w*
- 4 Unknown

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

_____|_____|_____|_____| Year

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

- 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

Mark (X) only one box.

If "Other" is marked, specify the name.

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

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 lab

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 | Take every number (e) | Random start number (f) |
|----------|--|------------------------|------------------|--|--------------------------|----------------------------|
| | | | | from <input type="text"/> to <input type="text"/> (d) | | |
| 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.

(1) Recording patient history and demographic information?

If Yes, ask – (a) Does this include a patient problem list?

(2) Recording clinical notes?

If Yes, ask – (a) Do they include a comprehensive list of the patient's medications and allergies?

| | Yes | Yes, but turned off or not used | No | Unknown |
|----------------------------|----------------------------|---------------------------------|----------------------------|---------|
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | |
| <i>Go to 15i(1)(a)</i> | <i>Skip to 15i(2)</i> | <i>Skip to 15i(2)</i> | <i>Skip to 15i(2)</i> | |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | |
| <i>Go to 15i(2)(a)</i> | <i>Skip to 15i(3)</i> | <i>Skip to 15i(3)</i> | <i>Skip to 15i(3)</i> | |
| 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> | |

Section V – AMBULATORY SURGERY LOCATION DESCRIPTION – Continued

| | Yes | Yes, but turned off or not used | No | Unknown |
|--|---|--|--|--|
| (3) Ordering prescriptions? | 1 <input type="checkbox"/> <i>Go to 15i(3)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 15i(4)</i> | 3 <input type="checkbox"/> <i>Skip to 15i(4)</i> | 4 <input type="checkbox"/> <i>Skip to 15i(4)</i> |
| <i>If Yes, ask – (a) Are prescriptions sent electronically to the pharmacy?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (b) Are warnings of drug interactions or contraindications provided? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (4) Providing reminders for guideline-based interventions or screening tests? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (5) Ordering lab tests? | 1 <input type="checkbox"/> <i>Go to 15i(5)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 15i(6)</i> | 3 <input type="checkbox"/> <i>Skip to 15i(6)</i> | 4 <input type="checkbox"/> <i>Skip to 15i(6)</i> |
| <i>If Yes, ask – (a) Are orders sent electronically?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (6) Providing standard order sets related to a particular condition or procedure? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (7) Viewing lab results? | 1 <input type="checkbox"/> <i>Go to 15i(7)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 15i(8)</i> | 3 <input type="checkbox"/> <i>Skip to 15i(8)</i> | 4 <input type="checkbox"/> <i>Skip to 15i(8)</i> |
| <i>If Yes, ask – (a) Are results incorporated in EMR/EHR?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (8) Viewing imaging results? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (9) Viewing data on quality of care measures? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (10) Electronic reporting to immunization registries? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (11) Public health reporting? | 1 <input type="checkbox"/> <i>Go to 15i(11)(a)</i> | 2 <input type="checkbox"/> <i>Skip to 15i(12)</i> | 3 <input type="checkbox"/> <i>Skip to 15i(12)</i> | 4 <input type="checkbox"/> <i>Skip to 15i(12)</i> |
| <i>If Yes, ask – (a) Are notifiable diseases sent electronically?</i> | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (12) Providing patients with clinical summaries for each visit? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (13) Exchanging secure messages with patients? .. | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (14) At your ambulatory surgery location, if orders for prescriptions or lab tests are submitted electronically, who submits them? <i>Mark (X) all that apply.</i> | 1 <input type="checkbox"/> Prescribing practitioner 2 <input type="checkbox"/> Other 3 <input type="checkbox"/> Prescriptions and lab test orders not submitted electronically 4 <input type="checkbox"/> Unknown | | | |
| 15j. Does your ambulatory surgery location exchange patient clinical summaries electronically with any other providers? | 1 <input type="checkbox"/> Yes, send summaries only 2 <input type="checkbox"/> Yes, receive summaries only 3 <input type="checkbox"/> Yes, send and receive summaries 4 <input type="checkbox"/> No 5 <input type="checkbox"/> Unknown } <i>Go to 15j(1)</i> } <i>Skip to 16a</i> | | | |
| (1) How does your ambulatory surgery location electronically send or receive patient clinical summaries? <i>Mark (X) all that apply.</i> | 1 <input type="checkbox"/> Through EMR/EHR vendor 2 <input type="checkbox"/> Through hospital-based system 3 <input type="checkbox"/> Through Health Information Organization or state exchange 4 <input type="checkbox"/> Through secure email attachment 5 <input type="checkbox"/> Other 6 <input type="checkbox"/> 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.

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

Number of ESAs

- 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.

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

Number of Clinics

- 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.

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

Number of ambulatory surgery locations

- 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 } *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 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? <i>Mark (X) appropriate box(es)</i> | Hospital | ED | OPD | Ambulatory Surgery |
|--|--|--|--|--|
| (1) During the telephone screening | 1 <input type="checkbox"/> | | | |
| (2) During the hospital induction | 2 <input type="checkbox"/> | | | |
| (3) During the ED/OPD/ Ambulatory Surgery induction | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (4) After the ED/OPD/ Ambulatory Surgery induction, but prior to assigned reporting period | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (5) During the assigned reporting period | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |
| b. By whom? | | | | |
| (1) Hospital administrator | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| (2) ED/OPD/Ambulatory Surgery Director | | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| (3) Approval board or official | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| (4) Other hospital official | 4 <input type="checkbox"/> <i>Specify ↘</i> <input type="text"/> <input type="text"/> | 4 <input type="checkbox"/> <i>Specify ↘</i> <input type="text"/> <input type="text"/> | 4 <input type="checkbox"/> <i>Specify ↘</i> <input type="text"/> <input type="text"/> | 4 <input type="checkbox"/> <i>Specify ↘</i> <input type="text"/> <input type="text"/> |
| (5) Was the refusal by telephone or in person? | 5 <input type="checkbox"/> Telephone 6 <input type="checkbox"/> In person | 5 <input type="checkbox"/> Telephone 6 <input type="checkbox"/> In person | 5 <input type="checkbox"/> Telephone 6 <input type="checkbox"/> In person | 5 <input type="checkbox"/> Telephone 6 <input type="checkbox"/> In person |

c. What reason was given? *Please specify if hospital, ED, OPD, or Ambulatory Surgery (from item 19a) before recording responses.*

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| d. Was conversion attempted? | Hospital | ED | OPD | Ambulatory Surgery |
|-------------------------------------|---|---|---|---|
| | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |

