

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> ↘	4 <input type="checkbox"/> <i>Specify</i> ↘	4 <input type="checkbox"/> <i>Specify</i> ↘	4 <input type="checkbox"/> <i>Specify</i> ↘
(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? <i>Please specify if hospital, ED, OPD, or Ambulatory Surgery (from item 19a) before recording responses.</i>				
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

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).

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1. Label	NHAMCS-101 <small>(11-30-2010)</small> 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 <i>(Area code and number)</i>		Telephone number <i>(Area code and number)</i>	
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 <i>(Area code and number)</i>		Telephone number <i>(Area code and number)</i>	
FAX number		FAX number	

Section I – TELEPHONE SCREENER

3. Field representative information	FR Code	4. Record of telephone calls			
		Call	Date	Time	Results
Telephone screener		1			
Hospital induction		2			
ED induction		3			
OPD induction		4			
Ambulatory surgery induction		5			
		6			

5. Final outcome of hospital screening	<i>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.</i>
1 <input type="checkbox"/> Appointment	
Day	Date
Time	a.m. p.m.
2 <input type="checkbox"/> Noninterview – Complete Sections VI and VII, beginning on page 23.	

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)? <i>(If "No" or "Don't know," offer to send or deliver another copy.)</i>	1 <input type="checkbox"/> Yes – SKIP to STATEMENT A 2 <input type="checkbox"/> No 3 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Enter correct name ↘ <div style="text-align: center;">RECORD ON CONTROL CARD</div>
b. Is your hospital located at (Read address from Control Card)?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Enter hospital location ↘ Number and street City State ZIP Code <div style="text-align: center;">RECORD ON CONTROL CARD</div>
c. Is this also the mailing address?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Enter correct mailing address ↘ Number and street City State ZIP Code <div style="text-align: center;">RECORD ON CONTROL CARD</div>

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

NOTES

Section VI – DISPOSITION AND SUMMARY

AMBULATORY UNIT CHECKLIST

<ul style="list-style-type: none"> COMPLETE 16a FOR EMERGENCY DEPARTMENT ONLY <p>16a. How many emergency service areas were selected for sample? <i>Enter 0 if no ESAs were selected for sample.</i></p> <p>Did you include a NHAMCS-101(U) for each?</p>	<input type="text"/> Number of ESAs 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Explain ↘ <input type="text"/>
<ul style="list-style-type: none"> COMPLETE 16b FOR OUTPATIENT DEPARTMENT ONLY <p>b. How many clinics were selected for sample? <i>Enter 0 if no clinics were selected for sample.</i></p> <p>Did you include a NHAMCS-101(U) for each?</p>	<input type="text"/> Number of Clinics 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Explain ↘ <input type="text"/>
<ul style="list-style-type: none"> COMPLETE 16c FOR AMBULATORY SURGERY LOCATIONS ONLY <p>c. How many ambulatory surgery locations were selected for sample? <i>Enter 0 if no ambulatory surgery locations were selected for sample.</i></p> <p>Did you include a NHAMCS-101(U) for each log/list?</p>	<input type="text"/> Number of ambulatory surgery locations 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – Explain ↘ <input type="text"/>
FORMS COMPLETED	<input type="text"/>
d. Number of ED Patient Record Forms completed	<input type="text"/> Number of ED PRFs
e. Number of OPD Patient Record Forms completed	<input type="text"/> Number of OPD PRFs
f. Number of ambulatory surgery Patient Record Forms completed	<input type="text"/> Number of ambulatory surgery PRFs
17. FINAL DISPOSITION	1 <input type="checkbox"/> All eligible units completed Patient Record Forms } <i>END interview</i> 2 <input type="checkbox"/> Some eligible units completed Patient Record Forms } <i>GO to Item 18</i> 3 <input type="checkbox"/> Hospital refused 4 <input type="checkbox"/> Hospital closed 5 <input type="checkbox"/> Hospital ineligible } <i>END interview</i>
18. NATURE OF REFUSAL <i>Mark (X) all that apply.</i>	1 <input type="checkbox"/> Entire ED refused 2 <input type="checkbox"/> Entire OPD refused 3 <input type="checkbox"/> All ambulatory surgery locations refused 4 <input type="checkbox"/> Some ESAs refused 5 <input type="checkbox"/> Some clinics refused 6 <input type="checkbox"/> 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 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 I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

CHECK ITEM A

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

INTRODUCTION STATEMENT B1 ▶ **The National Center for Health Statistics of the Centers for Disease Control and Prevention is continuing its annual study of hospital-based ambulatory care. We contacted your hospital previously regarding participation. Collecting data on an annual basis in hospitals, such as your own, is necessary to keep updated information on the status of ambulatory care provided in the hospital environment.**

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

INTRODUCTION STATEMENT B2 ▶ **The National Center for Health Statistics of the Centers for Disease Control and Prevention is conducting an annual study of hospital-based ambulatory care. The study began data collection in 1992. They have contracted with the U.S. Census Bureau to collect the data. (Name of hospital) has been selected to participate in the study. The study is authorized under the Public Health Service Act and the information will be held strictly confidential. Participation is voluntary.**

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

8a. Is this facility a licensed hospital?

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

b. Is this hospital nonprofit, government, or proprietary?

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

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

1 Yes
 2 No
 3 Unknown

d. Is this a teaching hospital?

1 Yes
 2 No

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

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

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

1 Yes
 2 No
 3 Unknown

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

Hospital name
 Number and street
 City State ZIP Code

RECORD ON CONTROL CARD

Section I - TELEPHONE SCREENER - Continued

Part B. VERIFICATION OF ELIGIBILITY

9a. Does this hospital provide emergency services that are staffed 24 HOURS each day either here at this hospital or elsewhere? 1 Yes 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 3 Level III 5 Other/unknown
2 Level II 4 Level IV or V 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? 1 Yes 2 No 3 Unknown
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.

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 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 4 No 2 Yes, with an EMR/EHR system 5 Unknown 3 Yes, using another electronic system

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

Mark (X) only one box.
If "Other" is marked, specify the name.

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 <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>	<i>Skip to 15i(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"/>	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>	<i>Skip to 15i(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"/>

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)	Specialty group	AU number	Expected No. of ambulatory (outpatient) surgery cases		Take every number	Random start number
				from	to		
	(a)	(b)	(c)	(d)		(e)	(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 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 IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

(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
 - 4 No
 - 5 Unknown
- } *Go to 14y(1)*
} *SKIP to Check item E*

(1) How does your OPD 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

NOTES

Blank lined area for notes.

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 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.

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?

1 Yes
 2 No
 3 Unknown } *SKIP to item 11f*

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.

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

Blank area for notes.

Section II – INDUCTION INTERVIEW – Continued

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 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 should not 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown
u. Does your OPD verify an individual patient's insurance eligibilitiy electronically, with results returned immediately?	1 <input type="checkbox"/> Yes, with a stand-alone practice management system 4 <input type="checkbox"/> No 2 <input type="checkbox"/> Yes, with an EMR/EHR system 5 <input type="checkbox"/> Unknown 3 <input type="checkbox"/> Yes, using another electronic system
v. Does your OPD use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system? Do not include billing record systems.	1 <input type="checkbox"/> Yes, all electronic 2 <input type="checkbox"/> Yes, part paper and part electronic } Go to item 14v(1) 3 <input type="checkbox"/> No } SKIP to item 14w 4 <input type="checkbox"/> 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 <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 5 <input type="checkbox"/> Epic 11 <input type="checkbox"/> Sage 15 <input type="checkbox"/> Unknown 6 <input type="checkbox"/> eMDs

Mark (X) only one box.
If "Other" is marked, specify the name.

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

FR NOTE

OPD Specialty Groups include:

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

INSTRUCTIONS

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

Line No.	Outpatient department clinic name (Generic) (a)	Specialty group (b)	NHAMCS-124 Specialty Group Scope (c)	Expected No. of visits		Take every number (e)	Random start number (f)
				from	to		
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 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
Title
Department
Telephone number
Name
Title
Department
Telephone number
Name
Title
Department
Telephone number

Record on Control Card

Record on Control Card

Record on Control Card

- CHECK ITEM C**
- 1 The hospital provides emergency services that are staffed 24 hours each day. (Yes in item 9a) – GO to Section III, EMERGENCY DEPARTMENT DESCRIPTION on page 10.
 - 2 The hospital DOES NOT provide emergency services that are staffed 24 hours each day. (No in item 9a) – SKIP to 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
- Pediatric
- Psychiatric
- Adult
- Urgent care/Fast track
- Other

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

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

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION

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

- (1)** If the hospital has previously participated, simply verify that the clinic(s) listed on page 16 is (are) still operating in the hospital by –
- (a)** crossing through any clinics on the list which no longer exist or are no longer operational in that hospital.
 - (b)** adding the name(s) of any new clinic(s) which has/have been created or become operational in that hospital. For each new clinic added to the list, be sure to obtain the proper specialty code. Remember, include only ELIGIBLE clinics.
 - (c)** obtaining an estimate of visits **for each clinic**, covering the 4-week reporting period. Enter the estimate in column (d).
 - (d) If this Outpatient Department has more than 5 clinics** – FAX the updated list to your regional office. The regional office will choose the clinics for sample and provide you with the sampling instructions. Upon receiving the instructions, attach a copy of the completed clinic listing showing sampled clinics, the Take Every and Random Start numbers, etc., to the NHAMCS-101(C) Control Card.
- (2)** If the hospital has not previously participated or a clinic list is not attached to NHAMCS-101(C) Control Card, obtain a complete listing of all **eligible** outpatient clinics along with their corresponding specialty group code, and expected number of visits **for each clinic** during the 4-week reporting period. Record this information in columns (a), (b), and (d) on the next page.

NOTES

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

Blank space for notes.

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* ↘

Blank space for explanation.

- 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* ↘

Blank space for explanation.

- 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 <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?	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			
<i>Mark (X) all that apply.</i>				

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14f. Does your ED 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 14f(1)</i>	
			} <i>SKIP to item 14g</i>
(1) How does your ED 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		
g. Does your ED have a physically separate observation or clinical decision unit?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		} <i>SKIP to item 14i</i>
h. What type of physicians make decisions for patients in this observation or clinical decision unit?	1 <input type="checkbox"/> ED physicians 2 <input type="checkbox"/> Hospitalists 3 <input type="checkbox"/> Other physicians 4 <input type="checkbox"/> Unknown		
<i>Mark (X) all that apply.</i>			
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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> 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 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		
k. Did your ED go on ambulance diversion in 2010?	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>
(1) What is the total number of hours that your hospital's ED was on ambulance diversion in 2010?	_____ Total number of hours 1 <input type="checkbox"/> Data not available		
l. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		
m. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		
n. As of last week, how many standard treatment spaces did your ED have?	_____ Total number of standard treatment spaces Standard treatment spaces are beds or treatment spaces specifically designed for ED patients to receive care, including asthma chairs. 1 <input type="checkbox"/> Data not available		
o. As of last week, how many other treatment spaces did your ED have?	_____ Total number of other treatment spaces 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. 1 <input type="checkbox"/> Data not available		
p. In the last two years, has your ED increased the number of standard treatment spaces?	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown		