NOTES

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

1. Label

NHAMCS-101(FS)
(11-9-2010)

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
FREESTANDING AMBULATORY SURGERY CENTERS
2011 PANEL

2a. ASC administrator contact information		**b.** ASC 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

	FR Code
Telephone screener	
ASC induction	

4. Record of telephone calls

Call	Date	Time	Results
1			
2			
3			

5. Final outcome of ASC screening

1 ☐ Appointment

Day	Date	Time a.m. p.m.

2 ☐ Noninterview – *Complete Sections V and VI on page 19.*

During your initial call to the ASC, 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.

NOTES

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 ambulatory surgery in freestanding ambulatory surgery centers and in hospitals. You should have received a letter from Dr. Edward J. Sondik, the director of the National Center for Health Statistics, describing the study.** *(Pause)* **You've probably also received a letter from the U.S. Census Bureau, which is collecting the data for the study.**

6. Did you receive the letter(s)?
(If "No" or "DK," offer to send or deliver another copy.)

1 ☐ Yes – *SKIP to STATEMENT A*
2 ☐ No
3 ☐ Don't know

7a. Let me verify that I have the correct name and address for your ASC. Is the correct name *(Read name from Control Card)***?**

1 ☐ Yes
2 ☐ No – *Enter correct name* ↙

RECORD ON CONTROL CARD

b. Is your ASC located at *(Read address from Control Card)***?**

1 ☐ Yes
2 ☐ No – *Enter ASC location* ↙

Number and street
City State ZIP Code

RECORD ON CONTROL CARD

c. Is this also the mailing address?

1 ☐ Yes
2 ☐ No – *Enter correct mailing address* ↙

Number and street
City State ZIP Code

RECORD ON CONTROL CARD

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

Part B. VERIFICATION OF ELIGIBILITY

INTRODUCTION STATEMENT B1 **The National Center for Health Statistics of the Centers for Disease Control and Prevention is conducting an annual study of ambulatory care. The study began data collection in 1992. CDC has contracted with the U.S. Census Bureau to collect the data.** *(Name of ASC)* **has been selected to participate in the study. I am calling to arrange an appointment to discuss your participation. The study is authorized under the Public Health Service Act and the information will be held strictly confidential. Participation is voluntary.**

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

8a. Is ambulatory (outpatient) surgery or are ambulatory diagnostic or therapeutic procedures currently performed in this facility?

NOTE: *Do not ask item 8b if facility is an eye surgery center.*

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

b. In this study we are excluding facilities that are exclusively family planning clinics, birthing centers, abortion clinics, podiatry centers or dentistry centers.

Is *(Name of facility)* **exclusively one of these?**

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

9. Is this facility currently licensed by the state?

1 ☐ Yes
2 ☐ No

Section V – DISPOSITION AND SUMMARY

AMBULATORY UNIT CHECKLIST

16a. How many ambulatory surgery locations were selected for sample?
Enter 0 if no ambulatory surgery locations were selected for sample.

_____ Number of ambulatory surgery locations

Did you complete an Ambulatory Unit Record for each log/list?

1 ☐ Yes
2 ☐ No – *Explain* ↙

b. Number of ASC Patient Record Forms completed

_____ Number of ASC PRFs

17. FINAL DISPOSITION

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

Section VI – NONINTERVIEW

18a. At what point in the interview did the refusal/breakoff occur?
Mark (X) appropriate box.

1 ☐ During the telephone screening
2 ☐ During the ASC induction
3 ☐ After the ASC induction, but prior to assigned reporting period
4 ☐ During the assigned reporting period

b. By whom?

1 ☐ ASC administrator
2 ☐ ASC Director
3 ☐ Approval board or official
4 ☐ Other ASC official

c. Was the refusal by telephone or in person?

1 ☐ Telephone
2 ☐ In person

d. What reason was given?

e. Was conversion attempted?

1 ☐ Yes
2 ☐ No

Section IV – AMBULATORY UNIT RECORD – Continued

Section H – FINAL DISPOSITION

1. FINAL DISPOSITION

Ambulatory unit

1 ☐ Participated
- a ☐ Patients seen, *Continue to Item 2*
- b ☐ No patients seen

2 ☐ Refused

3 ☐ Closed
- a ☐ Temporary
- b ☐ Permanent

4 ☐ Ineligible
- a ☐ AU not under auspices of ASC
- b ☐ Only ancillary services provided
- c ☐ AU classified as out-of-scope
- d ☐ Other – *Specify*

END

2. Who completed the patient record forms?
Mark (X) all that apply

1 ☐ ASC staff
2 ☐ FR – abstraction DURING reporting period
3 ☐ FR – abstraction AFTER reporting period
4 ☐ Other – *Specify*

NOTES

Section I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

10. It is important for us to determine whether or not your facility operates under the license or Provider of Services (POS) number of a parent facility.

a. Does your ASC operate under the license of a parent facility?
1 ☐ Yes
2 ☐ No

b. Does your ASC operate under the Provider of Services (POS) number of a parent facility?
1 ☐ Yes
2 ☐ No

CHECK ITEM A
Refer to items 10a and 10b.
Is "Yes" marked in ANY of these items?

1 ☐ Yes – **What is the name and address of your parent facility?**

Parent facility name	**RECORD ON CONTROL CARD**
Number and street	
City State ZIP Code	

Thank you for your time and assistance. We may contact you again in a few days regarding participation in this study. *Terminate telephone call.*

FR NOTE If after contacting your RO you find that the ASC is eligible, continue with item 11.
If the ASC is not eligible, go to CHECK ITEM B on page 4 and mark checkbox 4.

2 ☐ No – *GO to item 11.*

11. Is this facility owned, operated, or managed by –
1 ☐ A hospital
2 ☐ One or more physicians
3 ☐ Health maintenance organization
4 ☐ Another health care provider
5 ☐ A health care corporation that owns multiple health care facilities (e.g., HCA or Health South)
6 ☐ Other

12. Is the ambulatory (outpatient) surgery performed here primarily one specialty?
1 ☐ Yes – **What is the specialty?**

SKIP to CHECK ITEM B on page 4.

2 ☐ No

13. Is the ambulatory (outpatient) surgery performed here multi-specialty?
1 ☐ Yes
2 ☐ No

NOTES

Section I – TELEPHONE SCREENER – Continued

CHECK ITEM B

1 ☐ ASC meets eligibility requirements (item 8a is YES) – *SKIP to Check Item B-1*
2 ☐ ASC is ineligible because it does not perform ambulatory surgery (item 8a is NO) – *Go to CLOSING STATEMENT B1 below.*
3 ☐ ASC is ineligible because specialty is out-of-scope (item 8b is YES) – *Go to CLOSING STATEMENT B2 below.*
4 ☐ ASC is ineligible because it operates under a parent facility that is on the sampling frame *(Item 10a is YES) – Complete Section V on page 19.*

CHECK ITEM B-1

ASC refused ↙

1 ☐ Yes – *SKIP to item a*
2 ☐ No – *SKIP to Part C. STUDY DESCRIPTION on page 5*

a. Determine whether facility has an eligible ASC and if so, inquire as to how many visits are expected during the reporting period.

Eligible ASC?

1 ☐ Yes – _____ expected visits
2 ☐ No

b. If unable to determine expected visits for the assigned reporting period, obtain the number of visits to the facility **last year**.

_____ ASC visits last year

Complete Sections V and VI on page 19.

CLOSING STATEMENT B1

Thank you . . ., but it seems that our information was incorrect. Since *(Name of ASC)* **does not perform ambulatory surgery, it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete Section V on page 19.*

CLOSING STATEMENT B2

Thank you. . ., but it seems that our information was incorrect. Since *(Name of ASC)***'s specialty is out-of-scope for our study, it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete Section V on page 19.*

NOTES

Section IV – AMBULATORY UNIT RECORD – Continued

Section D – VERIFICATION OF ESTIMATED VISITS

Verify with ASC director BEFORE data collection begins (and records have been pulled).

1. According to our information, about (number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

2. About how many visits do you expect during the reporting period, _____ to _____?

Revised estimate

Determine if new Take Every and Random Start numbers must be calculated for this ASC.

3a. Divide the revised estimate by the original estimate from B-3.

$$\frac{\text{Revised estimate}}{\text{Original estimate}} = \frac{\square}{\square} = \square \text{ (Result)}$$

b. Is the result of (a) between 0.7 and 1.3?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

Section E – CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS UNIT

1. Calculate new Take Every, using the appropriate table (page 19) of the NHAMCS-124. *(Use the revised estimate of visits from D-2 and the original total visits from B-4).*

New Take Every ☐☐☐

2. Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101(FS).

New Random Start ☐☐☐

Section G – PATIENT RECORD FORM INFORMATION

1. *Enter the range of Patient Record Forms that were* ***ACTUALLY*** *used by the unit.*

FIRST FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐
SECOND FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐
THIRD FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐

NOTES

Section IV – AMBULATORY UNIT RECORD

COMPLETE FOR EACH AMBULATORY UNIT SELECTED

Section A – AMBULATORY UNIT INFORMATION

a. *Mark (X) specialty —*

1☐ GEN 2☐ MULTI 3☐ GI 4☐ OPH 5☐ ORTHO 6☐ PLASTIC 7☐ PAIN 8☐ OTHER

b. AU No. **3** of _____
Total AU's sampled within the ASC

Section B – SAMPLE INFORMATION

1. Take every number

2. Random start number

3. Estimated number of visits in this AU during reporting period

4. Total estimated number of visits during reporting period for **ALL** operating rooms within the ASCs

5. REPORTING PERIOD *(Month/Day/Year)*
From: / /
To: / /

Item 6 is the AU No. from Section A, Item b.
Items 7 and 8 are each 1.

6. SU number	**7.** Numerator	**8.** Denominator
3	**1**	**1.00**

9. What was the total number of patient visits to this AU from *(dates specified in B5)*?(Refer to patient logs, etc. Ask if necessary.DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)

NUMBER OF VISITS				
Week 1	Week 2	Week 3	Week 4	TOTAL
/ – /	/ – /	/ – /	/ – /	

10. How many patient record forms were filled out for this AU?

NUMBER OF FORMS				
Week 1	Week 2	Week 3	Week 4	TOTAL

11. Was this Ambulatory Unit Record completed for multiple ambulatory surgery locations that were combined in a single list?

1☐ Yes
2☐ No

Section C – ASC HOURS OF OPERATION

1. What are the ASC hours of operation?

Day(s) (a)	Time (b)	*Mark (X) ONLY one (if applicable)* Open 24 hours (c)	Not open (d)	Hours vary (e)
Monday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Tuesday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Wednesday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Thursday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Friday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Saturday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐
Sunday	FROM a.m. p.m. TO a.m. p.m.	1☐	2☐	3☐

Section I – TELEPHONE SCREENER – Continued

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 facility representative with a brief description of the study.

Cover following points –

(1) The NHAMCS is the only source of national data on health care provided in hospital emergency and outpatient departments and ambulatory surgery centers.

(2) NHAMCS is endorsed by the:
- Ambulatory Surgery Center Association
- American College of Surgeons
- American Health Information Management Association
- American Academy of Ophthalmology
- Society for Ambulatory Anesthesia
- American College of Emergency Physicians
- Emergency Nurses Association
- Society for Academic Emergency Medicine
- American College of Osteopathic Emergency Physicians

(3) Nationwide sample of about 600 hospitals and 246 freestanding ambulatory surgery centers.

(4) Four-week data collection period

(5) Brief form completed for a sample of patient visits

As one of the ASC's that has been selected for the study, your contribution will be of great value in producing reliable, national data on ambulatory surgery.

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? 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 phone 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 facility 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 35 million visits to ambulatory surgery centers, including 15 million visits to freestanding ambulatory surgery centers

(5) The U.S. Census Bureau is the data collection agent for the study

(6) The study is authorized by Title 42, U.S. Code, Section 242k

(7) Participation is voluntary

(8) Any identifiable information will be held confidential and will be used only by NCHS staff, contractors or agents, only when necessary and with strict controls, and will not be disclosed to anyone else without the consent of your facility. By law, every employee as well as every agent has taken an oath and is subject to a jail term of up to five years, a fine of up to $250,000, or both if he or she willfully discloses ANY identifiable information about your facility 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 excludes office-based physicians (these are covered under the NAMCS)

(13) NHAMCS excludes the following types of ASCs: dentistry, podiatry, abortion, small procedures, birth center, and family planning.

(14) Only a 4-week data collection period

(15) On average, sample of approximately 100 ASC visits per hospital and 100 freestanding ASC visits.

SHOW PATIENT RECORD FORM

(16) Form takes only 6 minutes to complete

(17) Forms are to be completed by ASC staff at their convenience

(18) Portion containing patient's name or other identifying information is removed before collecting

Section IV – AMBULATORY UNIT RECORD – Continued

Section H – FINAL DISPOSITION

1. FINAL DISPOSITION

Ambulatory unit

1 ☐ Participated
- a ☐ Patients seen, *Continue to Item 2*
- b ☐ No patients seen

2 ☐ Refused

3 ☐ Closed
- a ☐ Temporary
- b ☐ Permanent

4 ☐ Ineligible ↙
- a ☐ AU not under auspices of ASC
- b ☐ Only ancillary services provided
- c ☐ AU classified as out-of-scope
- d ☐ Other – *Specify* ↙

} *END*

2. Who completed the patient record forms?

Mark (X) all that apply

1 ☐ ASC staff
2 ☐ FR – abstraction DURING reporting period
3 ☐ FR – abstraction AFTER reporting period
4 ☐ Other – *Specify* ↙

NOTES

Section IV – AMBULATORY UNIT RECORD – Continued

Section D – VERIFICATION OF ESTIMATED VISITS

Verify with ASC director BEFORE data collection begins (and records have been pulled).

1. According to our information, about (number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

2. About how many visits do you expect during the reporting period, _____ to _____?

Revised estimate

Determine if new Take Every and Random Start numbers must be calculated for this ASC.

3a. Divide the revised estimate by the original estimate from B-3.

Revised estimate / Original estimate = ☐☐☐ = ☐☐☐ (Result)

b. Is the result of (a) between 0.7 and 1.3?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

Section E – CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS UNIT

1. Calculate new Take Every, using the appropriate table (page 19) of the NHAMCS-124. *(Use the revised estimate of visits from D-2 and the original total visits from B-4).*

New Take Every ☐☐☐

2. Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101(FS).

New Random Start ☐☐☐

Section G – PATIENT RECORD FORM INFORMATION

1. *Enter the range of Patient Record Forms that were **ACTUALLY** used by the unit.*

FIRST FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

SECOND FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

THIRD FOLIO FROM: ☐☐☐☐☐☐☐ TO: ☐☐☐☐☐☐☐

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 ASC 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.

14a. Are there any additional steps needed to obtain permission for the ASC to participate in the study?

1 ☐ Yes – *Specify the necessary steps below*

2 ☐ No

14b. Now I would like to make arrangements to obtain the information needed for sampling. I will need to (know/verify) how your ambulatory surgery center is 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
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, Ambulatory Surgery Center Description as appropriate. Thank current respondent for his/her time and cooperation.

Name
Title
Department
Telephone number

Record on Control Card

Name
Title
Department
Telephone number

Record on Control Card

Section III – AMBULATORY SURGERY CENTER DESCRIPTION

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

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

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

Name
Address
Telephone number (Area code and number)

RECORD UP TO 3 ON CONTROL CARD

To develop the sampling plan, I would like to (collect/verify) more specific information about this facility'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., ambulatory surgery center, endoscopy). If the ambulatory surgery location has a formal/proper name, enter a generic name in (a) and record the Line No. and the formal/proper name on page 2 of the Control Card.
- Record the specialty group acronym in column (b).
- Complete columns (e) and (f) after developing the sampling plan. See page 18 of the NHAMCS-124 for instructions.

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

CHECK ITEM F

1 ☐ Facility has only 1 ambulatory surgery location – *SKIP to Item 15e.*
2 ☐ Facility has more than 1 ambulatory surgery location – *Continue with item 15c.*

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 above.)*

1 ☐ Yes
2 ☐ No – ONLY 2 lists } *SKIP to item 15e*
3 ☐ No – More than 2 lists – *Continue with item 15d.*

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

1 ☐ Yes
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).

Section IV – AMBULATORY UNIT RECORD

COMPLETE FOR EACH AMBULATORY UNIT SELECTED

Section A – AMBULATORY UNIT INFORMATION

a. *Mark (X) specialty —*

1 ☐ GEN 2 ☐ MULTI 3 ☐ GI 4 ☐ OPH 5 ☐ ORTHO 6 ☐ PLASTIC 7 ☐ PAIN 8 ☐ OTHER

b. AU No. **2** of ____
Total AU's sampled within the ASC

Section B – SAMPLE INFORMATION

1. Take every number
2. Random start number
3. Estimated number of visits in this AU during reporting period
4. Total estimated number of visits during reporting period for **ALL** operating rooms within the ASC
5. REPORTING PERIOD *(Month/Day/Year)* From: / / To: / /

Item 6 is the AU No. from Section A, Item b. Items 7 and 8 are each 1.

6. SU number	**7.** Numerator	**8.** Denominator
2	**1**	**1.00**

9. What was the total number of patient visits to this AU from *(dates specified in B5)*?(Refer to patient logs, etc. Ask if necessary.DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)

NUMBER OF VISITS				
Week 1	Week 2	Week 3	Week 4	TOTAL
/ – /	/ – /	/ – /	/ – /	

10. How many patient record forms were filled out for this AU?

NUMBER OF FORMS				
Week 1	Week 2	Week 3	Week 4	TOTAL

11. Was this Ambulatory Unit Record completed for multiple ambulatory surgery locations that were combined in a single list?

1 ☐ Yes
2 ☐ No

Section C – ASC HOURS OF OPERATION

1. What are the ASC hours of operation?

Day(s) (a)	Time (b)	Mark (X) ONLY one (if applicable) Open 24 hours (c)	Not open (d)	Hours vary (e)
Monday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Tuesday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Wednesday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Thursday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Friday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Saturday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Sunday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐

Section IV – AMBULATORY UNIT RECORD – Continued

Section D – VERIFICATION OF ESTIMATED VISITS

Verify with ASC director BEFORE data collection begins (and records have been pulled).

1. According to our information, about (number from B-3) patient visits are expected during the reporting period. Do you agree with this estimate?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

2. About how many visits do you expect during the reporting period, _____ to _____?

Revised estimate

Determine if new Take Every and Random Start numbers must be calculated for this ASC.

3a. Divide the revised estimate by the original estimate from B-3.

Revised estimate / Original estimate = ☐ = ☐ (Result)

b. Is the result of (a) between 0.7 and 1.3?

1 ☐ Yes – *SKIP to section G*
2 ☐ No

Section E – CALCULATE NEW TAKE EVERY AND RANDOM START NUMBERS FOR THIS UNIT

1. Calculate new Take Every, using the appropriate table (page 19) of the NHAMCS-124. *(Use the revised estimate of visits from D-2 and the original total visits from B-4).*

New Take Every ☐☐☐

2. Calculate new Random Start, using the next available row on the label affixed to the back of the NHAMCS-101(FS).

New Random Start ☐☐☐

Section G – PATIENT RECORD FORM INFORMATION

1. *Enter the range of Patient Record Forms that were **ACTUALLY** used by the unit.*

FIRST FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐
SECOND FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐
THIRD FOLIO	FROM:	☐☐☐☐☐☐☐	TO:	☐☐☐☐☐☐☐

Section H – FINAL DISPOSITION

1. FINAL DISPOSITION

Ambulatory unit

1 ☐ Participated
  a ☐ Patients seen, *Continue to Item 2*
  b ☐ No patients seen
2 ☐ Refused
3 ☐ Closed
  a ☐ Temporary
  b ☐ Permanent
} *END*

4 ☐ Ineligible
  a ☐ AU not under auspices of ASC
  b ☐ Only ancillary services provided
  c ☐ AU classified as out-of-scope
  d ☐ Other – *Specify*
} *END*

2. Who completed the patient record forms?

Mark (X) all that apply

1 ☐ ASC staff
2 ☐ FR – abstraction DURING reporting period
3 ☐ FR – abstraction AFTER reporting period
4 ☐ Other – *Specify*

Section III – AMBULATORY SURGERY CENTER DESCRIPTION – Continued

15e. Does your ASC submit any CLAIMS electronically (electronic billing)?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

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

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

(1) In which year did your ASC install your 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 ASC 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 ASC has each of the following computerized capabilities. Does your ASC have a computerized system for: *Mark (X) only one box per row.*

	Yes	Yes, but turned off or not used	No	Unknown
(1) Recording patient history and demographic information?	1 ☐ *Go to 15i(1)(a)*	2 ☐ *Skip to 15i(2)*	3 ☐ *Skip to 15i(2)*	4 ☐ *Skip to 15i(2)*
If Yes, ask – **(a)** Does this include a patient problem list?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Recording clinical notes?	1 ☐ *Go to 15i(2)(a)*	2 ☐ *Skip to 15i(3)*	3 ☐ *Skip to 15i(3)*	4 ☐ *Skip to 15i(3)*
If Yes, ask – **(a)** Do they include a comprehensive list of the patient's medication and allergies?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Ordering prescriptions?	1 ☐ *Go to 15i(3)(a)*	2 ☐ *Skip to 15i(4)*	3 ☐ *Skip to 15i(4)*	4 ☐ *Skip to 15i(4)*
If Yes, ask – **(a)** Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are warnings of drug interactions or contraindications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Providing reminders for guideline-based interventions or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Ordering lab tests?	1 ☐ *Go to 15i(5)(a)*	2 ☐ *Skip to 15i(6)*	3 ☐ *Skip to 15i(6)*	4 ☐ *Skip to 15i(6)*
If Yes, ask – **(a)** Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Providing standard order sets related to a particular condition or procedure?	1 ☐	2 ☐	3 ☐	4 ☐

Section III – AMBULATORY SURGERY CENTER DESCRIPTION – Continued

15i. Continued	Yes	Yes, but turned off or not used	No	Unknown
(7) Viewing lab results?	1 ☐ *Go to 15i(7)(a)*	2 ☐ *Skip to 15i(8)*	3 ☐ *Skip to 15i(8)*	4 ☐ *Skip to 15i(8)*
If Yes, ask – **(a)** Are results incorporated in EMR/EHR?	1 ☐	2 ☐	3 ☐	4 ☐
(8) Viewing imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
(9) Viewing data on quality of care measures?	1 ☐	2 ☐	3 ☐	4 ☐
(10) Electronic reporting to immunization registries?	1 ☐	2 ☐	3 ☐	4 ☐
(11) Public health reporting?	1 ☐ *Go to 15i(11)(a)*	2 ☐ *Skip to 15i(12)*	3 ☐ *Skip to 15i(12)*	4 ☐ *Skip to 15i(12)*
If yes, ask – **(a)** Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(12) Providing patients with clinical summaries for each visit?	1 ☐	2 ☐	3 ☐	4 ☐
(13) Exchanging secure messages with patients?	1 ☐	2 ☐	3 ☐	4 ☐

(14) At your ASC, 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

j. Does your ASC exchange patient clinical summaries <u>electronically</u> with any other providers?

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

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

Mark 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

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

1 ☐ Yes, we intend to apply – *Go to 15k(1)*
2 ☐ Uncertain whether we will apply } *SKIP to Section IV*
3 ☐ No, we will not apply

(1) In which year do you expect to apply for the meaningful use payments?

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

Notes

Section IV – AMBULATORY UNIT RECORD

COMPLETE FOR EACH AMBULATORY UNIT SELECTED

Section A – AMBULATORY UNIT INFORMATION

a. *Mark (X) specialty —*
1 ☐ GEN 2 ☐ MULTI 3 ☐ GI 4 ☐ OPH 5 ☐ ORTHO 6 ☐ PLASTIC 7 ☐ PAIN 8 ☐ OTHER

b. AU No. **1** of ____
Total AU's sampled within the ASC

Section B – SAMPLE INFORMATION

1. Take every number
2. Random start number
3. Estimated number of visits in this AU during reporting period
4. Total estimated number of visits during reporting period for **ALL** operating rooms within the ASC
5. REPORTING PERIOD *(Month/Day/Year)* From: / / To: / /

Item 6 is the AU No. from Section A, Item b. Items 7 and 8 are each 1.

6. SU number	**7.** Numerator	**8.** Denominator
1	**1**	**1.00**

9. What was the total number of patient visits to this AU from *(dates specified in B5)*?(Refer to patient logs, etc. Ask if necessary.DO NOT LEAVE TOTAL BLANK. BE AS COMPLETE AND ACCURATE AS POSSIBLE.)

NUMBER OF VISITS				
Week 1	Week 2	Week 3	Week 4	TOTAL
/ – /	/ – /	/ – /	/ – /	

10. How many patient record forms were filled out for this AU?

NUMBER OF FORMS				
Week 1	Week 2	Week 3	Week 4	TOTAL

11. Was this Ambulatory Unit Record completed for multiple ambulatory surgery locations that were combined in a single list?
1 ☐ Yes
2 ☐ No

Section C – ASC HOURS OF OPERATION

1. What are the ASC hours of operation?

Day(s) (a)	Time (b)	*Mark (X) ONLY one (if applicable)* Open 24 hours (c)	Not open (d)	Hours vary (e)
Monday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Tuesday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Wednesday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Thursday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Friday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Saturday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐
Sunday	FROM a.m. p.m. TO a.m. p.m.	1 ☐	2 ☐	3 ☐

Notes