

# ATTACHMENT I: NHAMCS Hospital Induction Form

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## INTRO\_APPT

Text: Hello,  
**This is ... from the U.S. Census Bureau.  
I'm (calling/visiting) to let you know that this hospital will be included in our study.  
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?**  
◆ [Enter 999 to start the induction interview](#)

## NAMECHECK

Text: **Let me verify that I have the correct name and address for your hospital. Is the correct name (facility name)?**

1. Yes
2. No

## HSP\_NAME

Text: **What is your hospital's name?**  
◆ [Enter 1 to update the hospitals name](#)

1. Enter 1 to update information
2. Continue

## ADDCHEK

Text: **Is your hospital located at (Facility Address)**

1. Yes

2. No

#### HSP\_ADDRESS

Text: **What is the correct address?**

- ◆ Enter 1 to update the hospitals address

#### MAILADD

Text: **Is this also the mailing address?**  
(Facility Address)

1. Yes
2. No

#### MHSP\_STRET

Text: **What is the correct mailing address?**

- ◆ Enter the number and street or press enter if same

#### INTRO\_AB

Text: **(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. The National Center for Health Statistics of the Centers for Disease Control and Prevention is (conducting an/continue its) annual study of hospital-based ambulatory care. (Intro for the survey) Before discussing the details, I would like to verify our basic information about (facility name) to be sure we have correctly included this hospital in the study. First, concerning licensing:**

#### LICHOSP

Text: **Is this facility a licensed hospital?**

1. Yes
2. No

#### OWN101

Text: **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)

#### **OWNHCC**

Text: **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

#### **TEACHOSP**

Universe: LICHOSP = 1

Text: **Is this a teaching hospital?**

1. Yes
2. No

#### **MERGER**

Text: **Did this hospital either merge or separate from any OTHER hospital in the past 2 years?**

1. Merged or separated
2. No
3. Unknown

#### **MERSEP**

Text: **Was this a merger or a separation?**

**MERGMEDR**

Text: **Does YOUR hospital have its own medical records department that is separate from that of the OTHER hospital?**

1. Yes
2. No
3. Unknown

**OTHNAME**

Text: **What is the name and address of this OTHER hospital?**

**ESA24**

Text: **Does this hospital provide emergency services that are staffed 24 HOURS each day either here at this hospital or elsewhere?**

1. Yes
2. No

**ESANOT24**

Text: **Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day?**

1. Yes
2. No

**TRAUMA**

Text: **What is the trauma level rating of this hospital?**

1. Level I
2. Level II
3. Level III

4. Level IV
5. Level V
6. Other/unknown
7. None

**OOOPD**

Text: **Does this hospital operate an organized outpatient department either at this hospital or elsewhere?**

1. Yes
2. No

**PHYSSERV**

Text: **Does this OPD include physician services?**

1. Yes
2. No

**AMBSURG**

Text: **Does this hospital have locations that perform ambulatory surgery? Ambulatory surgery locations include a general or main operating room, dedicated ambulatory surgery room, satellite operating room, cystoscopy room, endoscopy room, cardiac catheterization lab, laser procedures room, or a pain block room.**

1. Yes
2. No
3. Unknown

**ELIGREQ**

Text: **\*\* Not displayed \*\***

## STUDY\_DESC

Text: **Thank you.**

◆ Explain the following **ONLY** if this is a new hospital. Provide the administrator or other hospital representative with a brief description of the study. Cover the following points

Now I would like to provide you with further information on the study.

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

(2) NHAMCS is endorsed by the:

American College of Emergency Physicians

Emergency Nurses Association

Society for Academic Emergency Medicine

American College of Osteopathic Emergency Physicians

Federation of American Hospitals

Ambulatory Surgery Center Association

American College of Surgeons

American Health Information Management Association

American Academy of Ophthalmology

Society for Ambulatory Anesthesia

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

## INDUCTION\_APPT

Text: **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?**

◆ Record day, date and time of appointment

◆ Enter 999 if the respondent wants to continue with the induction now

## SCREENER\_THK

Text: **Thank you for your cooperation. I am looking forward to our meeting.**

## THANK\_MERGSEP

Text: **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.**

## CALLRO\_MERGSEP

Text: ♦ Call your RO and inform them of the situation.  
Await resolution from the RO before continuing with this case.

## THANK\_B1

Text: **Thank you, but it seems that our information is incorrect.**  
**Since (facility name) is not a licensed hospital, it should not have been chosen for our study. Thank you very much for your cooperation.**

## THANK\_B2

Text: **Thank you, but it seems that our information is incorrect.**  
**Since (facility name) 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.**

## REVIEW

Text: ? [F1]

**I would like to begin with a brief review of the background for this study.**  
♦ Provide the administrator or other hospital representative with a brief introduction to the study and a general overview of procedures. Press F1 for points to be covered

## SURGDAY

Text: **Now I would like to ask you a few more questions about your hospital.**  
**How many days in a week are inpatient elective surgeries scheduled?**  
♦ Enter CTRL-D if unknown

## BEDCZAR

Text: **Does your hospital have a bed coordinator, sometimes referred to as a bed czar?**

1. Yes
2. No

3. Unknown

## **BEDDATA**

Text: **How often are hospital bed census data available?**

1. Instantaneously
2. Every 4 hours
3. Every 8 hours
4. Every 12 hours
5. Every 24 hours
6. Other
7. Unknown

## **HLIST**

Text: **Does your hospital have hospitalists on staff?**

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

1. Yes
2. No
3. Unknown

## **HLISTED**

Text: **Do the hospitalists on staff at your hospital admit patients from your ED?**

1. Yes
2. No
3. Unknown



**PAYHITH**

- Text: **Medicare and Medicaid offer incentives to practices that demonstrate “meaningful use of health IT”. Does your hospital have plans to apply for these incentive payments?**
1. Yes, we already applied
  2. Yes, we intend to apply
  3. Uncertain if we will apply
  4. No, we will not apply

**PAYDR**

- Text: **In which year did you first apply for meaningful use payments?**
1. 2011
  2. 2012

**PAYYR**

- Text: **In which year do you expect to apply for the meaningful use payments?**
1. 2012
  2. 2013 or later
  3. Unknown

**PERMPART**

- Text: **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, (Reporting period begin date). First, I would like to discuss the steps needed to obtain approval for the study. Are there any additional steps needed to obtain permission for the hospital to participate in the study?**
1. Yes
  2. No

**PERMPARTSPEC**

Text: ♦ Specify the necessary steps needed to obtain permission for the hospital to participate in the study  
Include the name, address, phone and title of the person(s) who can grant approval

#### PERM\_THANK

Text: **Thank you for your help.**

#### RO\_PERMISSION

Text: ♦ Call the Regional Office to inform them of the additional steps needed to obtain permission

#### VSREPPER

Text: **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/or outpatient department and/or ambulatory surgery location) (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
2. Someone else

#### CWHO

Text: **What is the name of the person I should talk to?**  
[Alternate Contacts](#)

1. Existing Contact
2. New Contact
3. Continue interview

#### CINFO

Text: **What is the name of the person I should talk to?**  
♦ Enter 1 to enter/update contact person information

1. New contact
2. Continue interview

## THANK\_RESP

Text: ♦ Thank current respondent for his/her time and cooperation

## CONTACT\_DEPT

Text: ♦ (All eligible departments are complete.  
Enter 9 to wrap up the case./All eligible departments are complete or refusals.  
Press F10 if you plan to follow up.  
Department Status  
ED (Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpltd / Inelig)  
OPD (Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpltd / Inelig)  
ASL (Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpltd / Inelig)

1. ED
2. OPD
3. ASL
4. Department refusal
5. Department callback
9. Wrap up case

## WHICH\_DEPT

Text: ♦ Which department (is refusing/are you setting a callback for)?

1. ED
2. OPD
3. ASC

## INTRO\_ED

Text: ♦ If necessary, introduce yourself and explain the survey  
♦ Explain that in order to develop a sampling plan, you would like to collect more specific information about this hospital's emergency department

**ESA\_NUM**

Text: **\*\* Show only \*\***

**DEL\_ESA**

Text: **(Does (ESA name) still exist and is it still operational?)**

(Enter 97 to delete this ESA / If No, Enter 97 to delete If Yes, Press ENTER to move to the next row)

**ESA\_NAME**

Text: **(What is the name of the (first/next) emergency service area? /Are there any other emergency service areas?)**

◆ Enter 999 for no more

**ESA\_TYPE**

Text: ? [F1]

◆ What type of ESA is (ESA name)

1. General
2. Adult
3. Pediatric
4. Urgent care/Fast track
5. Psychiatric
6. Other

**ESA\_EVISITS**

Text: **What is the expected number of visits from (Reporting period begin date) to (Reporting period end date) for (ESA name)?**

## TWICELY

Text: ♦ Is the number of expected visits to any of the ESAs more than twice the number shown on the previous sampling plan?

$$\frac{\text{ESA\_Name Visits}}{\text{ESA\_Name Visits Previous}}$$
  
ESA\_NAME    ESA\_VISITS    I\_ESA\_VISITS

1. Yes
2. No

## TWICELY\_SPEC

Text: ♦ Specify why visits have increased this year or were too low the last time the ED participated

## HALFLY

Text: ♦ Is the number of expected visits to any of the ESAs less than half of the number of visits shown on the previous sampling plan?

$$\frac{\text{ESA\_Name Visits}}{\text{ESA\_Name Visits Previous}}$$
  
ESA\_NAME    ESA\_VISITS    I\_ESA\_VISITS

1. Yes
2. No

## HALFLYSPEC

Text: ♦ Specify why visits have decreased this year or were too high the last time the ED participated

## EBILLRECE

Text: **Now I would like to ask you some questions about your ED.  
Does your ED submit any CLAIMS electronically (electronic billing)?**

1. Yes
2. No
3. Unknown

## EINSELIGE

Text: **Does your ED verify an individual patient's insurance eligibility electronically, with results returned immediately?**

[Read answer categories out loud](#)

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

## EMEDRECE

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

[Read answer categories out loud](#)

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

## EHRINSYRE

Text: **In which year did your ED install the EMR/EHR system?**

## EHRNAME

Text: **What is the name of your current EMR/EHR system?**

1. Allscripts
2. Cerner
3. eClinicalWorks
4. Epic
5. GE/Centricity

6. Greenway Medical
7. McKesson/Practice Partner
8. NextGen
9. Sage
10. Other - Specify
11. Unknown

**EHRNAME\_SP**


Text:  Enter name of EMR/EHR system

**EHRINSE**

Text: **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

**EDEMOGE**

Text:  6

**Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:**

**Recording patient history and demographic information?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EPROLSTE

Text: **Does this include a patient problem list?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EPNOTESE

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Recording clinical notes?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EMEDALGE

Text: **Do they include a comprehensive list of the patient's medications and allergies?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## ECPOEE

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Ordering prescriptions?**

1. Yes, used routinely
2. Yes, but not used routinely



3. No
4. Unknown

#### ESCRIBE

Text: **Are prescriptions sent electronically to the pharmacy?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### EWARNE

Text: **Are warnings of drug interactions or contraindications provided?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### EREMINDE

Text: Indicate whether your ED has each of the following computerized capabilities.  
Does your ED have a computerized system for:  
**Providing reminders for guideline-based interventions or screening tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### ECTOEE

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Ordering lab tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**EORDERE**

Text: **Are orders sent electronically?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**ESETSE**

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Providing standard order sets related to a particular condition or procedure?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**ERESULTE**

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Viewing lab results?**

1. Yes, used routinely

2. Yes, but not used routinely
3. No
4. Unknown

#### **EIMGRESE**

Text: Indicate whether your ED has each of the following computerized capabilities.  
Does your ED have a computerized system for:

**Viewing imaging results?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **EQOCE**

Text: Indicate whether your ED has each of the following computerized capabilities.  
Does your ED have a computerized system for:

**Viewing data on quality of care measures?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **EIMMREGE**

Text: Indicate whether your ED has each of the following computerized capabilities.  
Does your ED have a computerized system for:

**Electronic reporting to immunization registries?**

1. Yes, used routinely
2. Yes, but not used routinely

3. No
4. Unknown

## ESUME

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Providing patients with clinical summaries for each visit?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EMSGE

Text: Indicate whether your ED has each of the following computerized capabilities. Does your ED have a computerized system for:

**Exchanging secure messages with patients?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EHRWHO

Text: **At your ED, if orders for prescriptions or lab tests are submitted electronically, who submits them?**

◆ Read answer categories out loud  
Enter all that apply, separate with commas

1. Prescribing practitioner
2. Other
3. Prescriptions and lab test orders not submitted electronically

4. Unknown

## EXCHSUME

Text: **Do you share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?**

◆ Read answer categories out loud

1. Yes
2. No

## EXCHSUM1E

Text: **How do you electronically share patient health information?**

◆ Read answer categories out loud

◆ Enter all that apply, separate with commas

1. EHR/EMR
2. Web portal (separate from EHR/EMR)
3. Other electronic method: \_\_\_\_\_

## OBSUNITS

Text: **Does your ED have a physically separate observation or clinical decision unit?**

1. Yes
2. No
3. Unknown

## OBSDECMD

Text: **What type of physicians make decisions for patients in this observation or clinical decision unit?**

Read answer categories out loud

Enter all that apply, separate with commas

1. ED physicians
2. Hospitalists

3. Other physicians
4. Unknown

## BOARD

Text: **Are admitted ED patients ever "boarded" for more than 2 hours in the ED or the observation unit while waiting for an inpatient bed?**

1. Yes
2. No
3. Unknown

## BOARDHOS

Text: **If the ED is critically overloaded, are admitted ED patients ever "boarded" in inpatient hallways or in another space outside the ED?**

1. Yes
2. No
3. Unknown

## AMBDIV

Text: **Did your ED go on ambulance diversion in TOTHRDIV\_FILL?**

1. Yes
2. No
3. Unknown

## TOTHRDIV

Text: **What is the total number of hours that your hospital's ED was on ambulance diversion in TOTHRDIV\_FILL?**

◆ Enter CTRL-D if data not available

## REGDIV

Text: **Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?**

1. Yes
2. No
3. Unknown

## ADMDIV

Text: **Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?**

1. Yes
2. No
3. Unknown

## NUMSTATX

Text: **As of last week, how many standard treatment spaces did your ED have?**  
Standard treatment spaces are beds or treatment spaces specifically designed for ED patients to receive care, including asthma chairs.  
◆ Enter CTRL-D if data not available

## NUMOTHTX

Text: **As of last week, how many other treatment spaces did your ED have?**  
Other treatment spaces are other locations where patients might receive care in the ED, including chairs, stretchers in hallways that may be used during busy times.  
Enter CTRL-D if data not available

## EDSPACES

Text: **In the last two years, did your ED increase the number of standard treatment spaces?**

1. Yes
2. No

3. Unknown

## PHYSSPACE

Text: **In the last two years, did your ED's physical space expand?**

1. Yes
2. No
3. Unknown

## EXPAND

Text: **Do you have plans to expand your ED's physical space within the next two years?**

1. Yes
2. No
3. Unknown

## BEDREG

Text:  7  
**Does your ED use - Bedside registration?**

1. Yes
2. No
3. Unknown


## CATRIAGE

Text:  7  
**Does your ED use - Computer-assisted triage?**

1. Yes
2. No
3. Unknown




## FASTTRAK

Text:  7

Does your ED use - **Separate fast track unit for nonurgent care?**

1. Yes
2. No
3. Unknown


## EDPTOR

Text:  7

Does your ED use - **Separate operating room dedicated to ED patients?**

1. Yes
2. No
3. Unknown


## DASHBOARD

Text:  7

Does your ED use - **Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources)?**

1. Yes
2. No
3. Unknown


## RFID

Text:  7

Does your ED use - **Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)?**

1. Yes
2. No
3. Unknown


## ZONENURS

Text:  7

Does your ED use - **Zone nursing (i.e., all of a nurse's patients are located in one area)?**

1. Yes
2. No
3. Unknown


## POOLNURS

Text:  7

Does your ED use - **Pool nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)?**

1. Yes
2. No
3. Unknown

## FULLCAP

Text:  7

Does your ED use - **Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed)?**

1. Yes
2. No
3. Unknown

## FREDIND

Text: **\*\* Not Displayed \*\***

## ESA\_NUM

Text: **\*\* SHOW ONLY \*\***

**ESA\_NAME**

Text: **\*\*\* SHOW ONLY \*\***

**ESA\_TYPE**

Text: **\*\* SHOW ONLY \*\***

1. General
2. Adult
3. Pediatric
4. Urgent care/Fast track
5. Psychiatric
6. Other

**ESA\_EVISITS**

Text: **\*\* SHOW ONLY \*\***

**ESA\_ONSITE**

Text: ♦ [Is \(ESA name\) on-site?](#)

1. Yes
2. No

**ESA\_STRET**

Text: **What is (ESA name)'s address?**

**ESA\_PHONE**

Text: **What is (ESA name)'s telephone number?**

**ESA\_CONTACT**

Text: ♦ Enter ESA contact person's name

**TE**

Text: **\*\* NOT DISPLAYED \*\***

**RS**

Text: **\*\* NOT DISPLAYED \*\***

**AU\_TYPE**

Text: **\*\* NON\_DISPLAYED \*\***

**INTRO\_OPD**

Text: ♦ If necessary, introduce yourself and explain the survey  
♦ Explain that in order to develop a sampling plan, you would like to collect more specific information about this hospital's outpatient department

**CLIN\_NUM**

Text: **\*\* NOT DISPLAYED \*\***

**DEL\_CLIN**

Text: **(Does (clinic name) still exist and is it still operational?)**  
♦ (Enter 97 to delete this clinic / If No, Enter 97 to delete If Yes, Press ENTER to move to the next row)

**CLIN\_NAME**

Text: 🗨️ NHAMCS-124, 7 - 12  
**(What is the name of the (first/next) clinic? /Are there any other clinics?)**  
♦ Enter 999 for no more. Enter XXX if clinic is not listed

**CLIN\_GROUP**

Text: **What is (Clinic Name)'s specialty group?**

1. General Medicine
2. Surgery
3. Pediatrics
4. Obstetrics/Gynecology
5. Substance Abuse
6. Other
7. Out of scope

**CLIN\_EVISITS**

Text: **What is the expected number of visits from (Reporting period begin date) to (Reporting period end date) for (Clinic Name)?**

**I\_CLIN**

Text: **\*\* Not Displayed \*\***

**CLIN\_EVISITS\_TOTAL**

Text: **\*\* Not Displayed \*\***

**TOTALCLIN**

Text: **\*\* Not Displayed \*\***

**TOTVSOP**

Text: **\*\* Not Displayed \*\***

## MORECLINSPEC

Text: List clinics that have opened or should have been included previously

## TWICECLINSPEC

Text: ♦ Explain why visits have increased this year or were too low previously

## LESSCLINSPEC

Text: ♦ There are fewer clinics this year than in previous panel  
Specify which clinics have closed or should not have been included previously

## HALFCLINSPEC

Text: ♦ Specify why visits have decreased this year or were too high last year

## EBILLRECO

Text: **Does your OPD submit any CLAIMS electronically (electronic billing)?**

1. Yes
2. No
3. Don't know

## EINSELIGO

Text: **Does your OPD verify an individual patient's insurance eligibility electronically, with results returned immediately?**

- ♦ Read answer categories out loud
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

## EMEDRECO

Text: **Does your OPD use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system? Do not include billing record systems.**  
◆ [Read answer categories out loud](#)

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

## EHRINSYRO

Text: **In which year did your OPD install your EMR/EHR system?**

## EHRNAMO

Text: **What is the name of your current EMR/EHR system?**

1. Allscripts
2. Cerner
3. eClinicalWorks
4. Epic
5. GE/Centricity
6. Greenway Medical
7. McKesson/Practice Partner
8. NextGen
9. Sage
10. Other - Specify

11. Unknown

#### **EHRNAMO\_SP**

Text: **What is the name of your current EMR/EHR system?**

#### **EHRINSO**

Text: **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

#### **EDEMOGO**

Text: **Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:  
**Recording patient history and demographic information?****

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **EPROLSTO**

Text: **Does this include a patient problem list?**

1. Yes, used routinely
2. Yes, but not used routinely



3. No
4. Unknown

#### EPNOTESO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Recording clinical notes?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### EMEDALGO

Text: **Do they include a comprehensive list of the patient's medications and allergies?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### ECPOEO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Ordering Prescriptions?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## ESCRIPO

Text: **Are prescriptions sent electronically to the pharmacy?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EWARNO

Text: **Are warnings of drug interactions or contraindications provided?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EREMINDO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Providing reminders for guideline-based interventions or screening tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## ECTOEO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Ordering lab tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **EORDERO**

Text: **Are orders sent electronically?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **ESETSO**

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Providing standard order sets related to a particular condition or procedure?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### **ERESULTO**

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Viewing lab results?**

1. Yes, used routinely
2. Yes, but not used routinely

3. No
4. Unknown

## EIMGRESO

Text: Indicate whether your OPD has each of the following computerized capabilities.  
Does your OPD have a computerized system for:  
**Viewing imaging results?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EQOCO

Text: Indicate whether your OPD has each of the following computerized capabilities.  
Does your OPD have a computerized system for:

**Viewing data on quality of care measures?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EIMMREGO

Text: Indicate whether your OPD has each of the following computerized capabilities.  
Does your OPD have a computerized system for:

**Electronic reporting to immunization registries?**

1. Yes, used routinely

2. Yes, but not used routinely
3. No
4. Unknown

## ESUMO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Providing patients with clinical summaries for each visit?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EMSGO

Text: Indicate whether your OPD has each of the following computerized capabilities. Does your OPD have a computerized system for:

**Exchanging secure messages with patients?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EHRWHOO

Text: **At your OPD, if orders for prescriptions or lab tests are submitted electronically, who submits them?**

[Read answer categories out loud](#)

[Enter all that apply, separate with commas](#)

1. Prescribing practitioner

2. Other
3. Prescriptions and lab test orders are not submitted electronically
4. Unknown

**EXCHSUMO**

Text: **Does your OPD exchange patient clinical summaries electronically with any other providers?**

1. Yes
2. No

**EXCHSUM10**

Text: **How does your OPD electronically send or receive patient clinical summaries?**

[Read answer categories out loud](#)  
[Enter all that apply, separate with commas](#)

1. EHR/EMR
2. Web portal (separate from EHR/EMR)
3. Other electronic method: \_\_\_\_\_

**CLIN\_NUM**

Text: **\*\* NOT DISPLAYED \*\***

**SAMPLED**

Text: **\*\* Not Displayed \*\***

**CLIN\_NUM**

Text: **\*\* SHOW ONLY \*\***

**CLIN\_NAME**

Text: **\*\*\* SHOW ONLY \*\***

**CLIN\_GROUP**

Text: **\*\* SHOW ONLY \*\***

1. General Medicine
2. Surgery
3. Pediatrics
4. Obstetrics/Gynecology
5. Substance Abuse
6. Other
7. Out of scope

**CLIN\_EVISITS**

Text: **\*\* SHOW ONLY \*\***

**CLIN\_STRET**

Text: **What is (Clinic Name)'s address?**  
◆ Enter number and street.

**CLIN\_STRET2**

Text: What is (Clinic Name)'s address?  
◆ Enter the second line of address or press enter if same/none

**CLIN\_CITY**

Text: What is (Clinic Name)'s address?  
◆ Enter city

**CLIN\_STATE**

Text: What is (Clinic Name)'s address?  
◆ Enter state

**CLIN\_ZIP**

Text: What is (Clinic Name)'s address?  
◆ Enter zip code

**CLIN\_PHONE**

Text: **What is (Clinic Name)'s telephone number?**

**CLIN\_PHTYP**

Text: ◆ Enter phone type

1. Home
2. Work
3. Mobile
4. Pager, Beeper, Answering Service
5. Public Pay Phone
6. Toll Free
7. Other
8. Fax
9. Unknown



**CLIN\_CONTACT**

Text: [◆ Enter clinic director/contact person's name](#)

**TE**

Text: **\*\* NOT DISPLAYED \*\***

**RS**

Text: **\*\* NOT DISPLAYED \*\***

**AU\_TYPE**

Text: **\*\* NON\_DISPLAYED \*\***

**I\_OPDMIN**

Text: **\*\* Not displayed \*\***

**I\_OPDMAV**

Text: **\*\* Not displayed \*\***

**I\_TOTCLIN**

Text: **\*\* Not displayed \*\***

**TOT\_GOODCLIN**

Text: **\*\* NOT Displayed \*\***

## ASL\_INTRO

- Text: **To develop the sampling plan, I would like to (collect/verify) more specific information about this facility's ambulatory surgery (centers/locations). We are only interested in the following types of (centers/locations):**
- |   |                                     |
|---|-------------------------------------|
| <b>General or main operating rooms</b>    | <b>Endoscopy rooms</b>              |
| <b>Dedicated ambulatory surgery rooms</b> | <b>Cardiac catheterization labs</b> |
| <b>Satellite operating rooms</b>          | <b>Laser procedures rooms</b>       |
| <b>Cystoscopy rooms</b>                   | <b>Pain block rooms</b>             |
1. Continue
  2. No in-scope locations

## ASL\_NUM

Text: **\*\* SHOW ONLY \*\***

## DEL\_ASL

Text: **(Does (ASL name) still exist and is it still operational?)**  
◆ (Enter 97 to delete this ASL/ASL entered by mistake/ If Yes, Press ENTER to move to the next row If No, Enter 97 to delete )

## ASL\_NAME

Text: [?] F1

**( What is the name of the (first/next) ambulatory surgery location? /Are there any other ambulatory surgery locations?)**  
◆ Enter only IN\_SCOPE (ASCs/ASLs) (Press F1 for in-scope (centers/locations))  
Include any (ASCs/ASLs) that are located in satellite facilities  
Enter 999 for no more

## ASL\_SPEC\_GRP

- Text: **What is ASL Name's specialty group?**
1. General
  2. Multi-specialty
  3. Gastroenterology

4. Ophthalmology
5. Orthopedics
6. Pain Block
7. Plastic Surgery
8. Ear, Nose and Throat
9. Obstetrics - Gynecology
10. Urology
11. Other specialty

#### ASL\_EVISITS

Text: **What is the expected number of ambulatory (outpatient) surgery cases for ASL Name from (Reporting period begin date) to (Reporting period end date)?**

#### I\_ASL

Text: **\*\* Not Displayed \*\***

#### TOT\_GOODASL

Text: **\*\* NOT Displayed \*\***

#### ANYMORE\_ASLS

Text: ♦ The max of 15 (ASCs/ASLs) were entered.  
Are there any more (ASCs/ASLs)?

1. Yes
2. No

#### EXTRA\_ASLS

Text: ♦ How many other (ASCs/ASLs) are there?

#### TOT\_GOODASL2

Text: **\*\* NOT Displayed \*\***

#### CHECK\_EVISITS

Text: **You have indicated that none of your ambulatory surgery (centers/locations) will be seeing patients from (Reporting period begin date) to (Reporting period end date).  
Is that correct?**

1. Yes
2. No

#### THANK\_INELIG

Text: **Since there are no in-scope ambulatory surgery (centers/locations) for (facility name), it should not have been chosen for our survey. Thank you very much for your cooperation.**

#### ASCLISTA

Text: **Now I have some questions about generating a report for all ambulatory surgery patients for sampling. Would you or your IT staff be able to generate a single list of ambulatory surgery cases for any of the following (centers/locations)?  
(Name of all ASLs)**

1. Yes
2. No - ONLY 2 LOGS
3. No - More than 2 logs

#### ASCLISTB

Text: **For which of these (centers/locations) can lists be combined?**  
♦ Enter all that apply, separate with commas

1. ASL\_NAME [1]

2. ASL\_NAME [2]
3. ASL\_NAME [3]
4. ASL\_NAME [4]
5. ASL\_NAME [5]
6. ASL\_NAME [6]
7. ASL\_NAME [7]
8. ASL\_NAME [8]
9. ASL\_NAME [9]
10. ASL\_NAME [10]
11. ASL\_NAME [11]
12. ASL\_NAME [12]
13. ASL\_NAME [13]
14. ASL\_NAME [14]
15. ASL\_NAME [15]

**IT\_CNAME**

Text: **What is the name of the IT contact?**

**IT\_CTITLE**

Text: **What is (IT contact name)'s title?**

**IT\_CSTRET**

Text: **What is (IT contact name)'s address?**  
◆ Enter number and street or press enter if same

**IT\_CSTRET2**

Text: What is (IT contact name)'s address?  
◆ Enter second line of address or press enter for none/same

#### IT\_CCITY

Text: What is (IT contact name)'s address?  
◆ Enter city or press enter if same

#### IT\_CSTATE

Text: What is (IT contact name)'s address?  
◆ Enter state or press enter if same

#### IT\_CZIP

Text: What is (IT contact name)'s address?  
◆ Enter zip code or press enter if same

#### IT\_CPHONE

Text: **What is (IT contact name)'s phone number?**

#### IT\_CPHTYP

Text: ◆ Enter phone typ

1. Home
2. Work
3. Mobile
4. Pager, Beeper, Answering Service
5. Public Pay Phone
6. Toll Free
7. Other

8. Fax
9. Unknown

#### UPDATE\_BCONTACTS

Text: **\*\* Not Displayed \*\***

#### ASL\_NUM

Text: **\*\* SHOW ONLY \*\***

#### ASL\_NAME

Text: **\*\* SHOW ONLY \*\***

#### AU\_NUMBER

Text: [◆ Assign AU number](#)  
Assign the same AU number to each (center/location) where the ambulatory surgery cases can be combined into the one listing.

#### EBILLRECA

Text: **Does your (ASC/ambulatory surgery location) submit any CLAIMS electronically (electronic billing)?**

1. Yes
2. No
3. Don't know

#### EINSELIGA

Text: **Does your (ASC/ambulatory surgery location) verify an individual patient's insurance eligibility electronically, with results returned immediately?**

- [◆ Read answer categories](#)
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

## EMEDRECA

Text: **Does your (ASC/ambulatory surgery location) use an electronic MEDICAL record (EMR) or electronic HEALTH record (EHR) system? Do not include billing record systems.**

◆ [Read answer categories out loud](#)

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

## EHRINSYRA

Text: **In which year did your (ASC/ambulatory surgery location) install your EMR/EHR system?**

## EHRNAMA

Text: **What is the name of your current EMR/EHR system?**

1. Allscripts
2. Cerner
3. eClinicalWorks
4. Epic
5. GE/Centricity
6. Greenway Medical



7. McKesson/Practice Partner
8. NextGen
9. Sage
10. Other - Specify
11. Unknown

**EHRNAMA\_SP**

Text: **What is the name of your current EMR/EHR system?**

**EHRINSA**

Text: **Does your (ASC/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

**EDEMOGA**

Text: **Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.  
Does your (ASC/ambulatory surgery location) have a computerized system for:**

- Recording patient history and demographic information?**
1. **Yes, used routinely**
  2. **Yes, but not used routinely**
  3. No
  4. Unknown

## EPROLSTA

Text: **Does this include a patient problem list?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EPNOTESA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

### **Recording clinical notes?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EALLERGA

Text: **Do they include a comprehensive list of the patient's medications and allergies?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## ECPOEA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Ordering Prescriptions?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**ESCRIPA**

Text: **Are prescriptions sent electronically to the pharmacy?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**EWARNA**

Text: **Are warnings of drug interactions or contraindications provided?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

**EREMINDA**

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Providing reminders for guideline-based interventions or screening tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### ECTOEA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Ordering lab tests?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### EORDERA

Text: **Are orders sent electronically?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### ESETSA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Providing standard order sets related to a particular condition or procedure?**

1. Yes, used routinely

2. Yes, but not used routinely
3. No
4. Unknown

## ERESULTA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

### Viewing lab results?

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EIMGRESA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

### Viewing imaging results?

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

## EQOCA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

### Viewing data on quality of care measures?

1. Yes, used routinely

2. Yes, but not used routinely
3. No
4. Unknown

#### EIMMREGA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Electronic reporting to immunization registries?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### ESUMA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Providing patients with clinical summaries for each visit?**

1. Yes, used routinely
2. Yes, but not used routinely
3. No
4. Unknown

#### EMSGA

Text: Indicate whether your (ASC/ambulatory surgery location) has each of the following computerized capabilities.

Does your (ASC/ambulatory surgery location) have a computerized system for:

**Exchanging secure messages with patients?**

1. Yes, used routinely
2. Yes, but not used routinely

3. No
4. Unknown

#### EHRWHO

Text: **At your (ASC/ambulatory surgery location), if orders for prescriptions or lab tests are submitted electronically, who submits them?**

◆ Read answer categories out loud. Enter all that apply, separate with commas

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

#### EXCHSUMA

Text: **Do you share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?**

1. Yes
2. No

#### EXCHSUMMCA

Text: **How do you electronically share patient health information?**

- ◆ Read answer categories out loud
- ◆ Enter all that apply, separate with commas

1. EHR/EMR
2. Web portal (separate from EHR/EMR)
3. Other electronic method: \_\_\_\_\_

#### PAYHITA

Text: **Medicare and Medicaid offer incentives to practices that demonstrate “meaningful use of health IT”. Does your hospital have plans to apply for these incentive payments?**

1. Yes, we already applied
2. Yes, we intend to apply
3. Uncertain if we will apply
4. No, we will not apply

**PAYDRA**

Text: **In which year did you first apply for meaningful use payments?**

1. 2011
2. 2012

**PAYYRA**

Text: **In which year do you expect to apply for the meaningful use payments?**

1. 2012
2. 2013 or later
3. Unknown

**ASL\_EVISITS**

Text: **\*\* SHOW ONLY \*\***

**ASL\_ONSITE**

Text: **◆ Is ASL Name on-site?**

1. Yes
2. No

**ASL\_STRET**



Text: **What is ASL Name's address or the address where the abstractions will be done?**  
◆ Enter number and street.

#### ASL\_STRET2

Text: What is ASL Name's address or the address where the abstractions will be done?  
◆ Enter the second line of address or press enter if same/none

#### ASL\_CITY

Text: What is ASL Name's address or the address where the abstractions will be done?  
◆ Enter city.

#### ASL\_STATE

Text: What is ASL Name's address or the address where the abstractions will be done?  
◆ Enter state.

#### ASL\_ZIP

Text: What is ASL Name's address or the address where the abstractions will be done?  
◆ Enter zip code.

#### ASL\_PHONE

Text: **What is ASL Name's telephone number or the telephone number where the abstractions will be done?**

#### ASL\_CONTACT

Text: ◆ Enter ambulatory surgery (center/location) contact person's name

#### EXIT\_REFUSAL

Text: ◆ Are you exiting this case because of a refusal?

1. Yes
2. No

#### CALLBACKNOTES

Text: **I'd like to schedule a DATE to (conduct/complete) the interview. What DATE AND TIME would be best to visit again?**  
◆ Today is: ^IntDate

#### THANKCB

Text: **Thank you. I will call/come back at the time suggested**  
◆ Revisit (Callback information)

#### FOLLOW\_UP

Text: ◆ The following departments have refused. Do you plan to follow-up on these department(s)?

1. Yes, will follow-up on department(s)
2. No , wrap case up

#### CALLBACKNOTES

Text: **I'd like to schedule a DATE to (conduct/complete) the interview. What DATE AND TIME would be best to visit again?** ◆ Today is: ^IntDate

#### THANKCB

Text: **Thank you. I will call/come back at the time suggested** ◆ Revisit (Callback information)

#### THANKYOU

Text: **This concludes the interview. Thank you for your patience, and for taking the time to answer our questions.**

#### SET\_REINT

Text: **\*\* Non Displayed \*\***

#### HOSPREF

Text: **\*\* Not displayed \*\***

#### ELIGED

Text: ♦ Does this hospital have an eligible ED?

1. Yes
2. No

#### VSED101

Text: ♦ Enter number of expected visits for the ED

#### VSEDLY

Text: ♦ Enter the number of visits to the department last year

#### ELIGOPD

Text: ♦ Does this hospital have an eligible OPD?

1. Yes
2. No

#### VSOPD101

Text: ♦ Enter number of expected visits for this OPD.

#### VSOPDLY

Text: ♦ Enter number of OPD visits last year

#### ELIGASC

Text: ♦ Does this hospital have an eligible ambulatory surgery center?

1. Yes

2. No

#### **VSASC101**

Text: ◆ Enter number of expected visits

#### **VSASCLY**

Text: ◆ Enter number of ambulatory surgery visits last year

#### **WHOMHOSP**

Text: **By whom?**

1. Hospital administrator
2. Approval board or official
3. Other hospital official

#### **WHOMED**

Text: **By whom?**

1. Hospital administrator
2. ED/OPD/Ambulatory Surgery Director
3. Approval board or official
4. Other hospital official-Specify

#### **WHOMOP**

Text: **By whom?**

1. Hospital administrator
2. ED/OPD/Ambulatory Surgery Director

3. Approval board or official
4. Other hospital official-Specify

#### **WHOMAS**

Text: **By whom?**

1. Hospital administrator
2. ED/OPD/Ambulatory Surgery Director
3. Approval board or official
4. Other hospital official-Specify

#### **WHOMHOSPSPEC**

Text: ♦ Specify the name of the other hospital official who refused for the hospital

#### **WHOMEDSPEC**

Text: ♦ Specify the name of the other hospital official who refused for the ED

#### **WHOMOPSPEC**

Text: ♦ Specify the name of the other hospital official who refused for the OPD

#### **WHOMASSPEC**

Text: ♦ Specify the name of the other hospital official who refused for the ASL

#### **TELPERHO**

Text: **Was the refusal by telephone or in person for the hospital?**

1. Telephone
2. In person

#### **TELPERED**

Text: **Was the refusal by telephone or in person for the ED?**

1. Telephone
2. In person

#### **TELPEROP**

Text: **Was the refusal by telephone or in person for the OPD?**

1. Telephone
2. In person

#### **TELPERAS**

Text: **Was the refusal by telephone or in person for the ASL?**

1. Telephone
2. In person

#### **REASON**

Text: [◆ Specify what reason was given for the refusal/breakoff](#)  
[◆ Specify if hospital, ED, OPD. or Ambulatory Surgery Location](#)

#### **CONVHOSP**

Text: [◆ Was conversion attempted?](#)

1. Yes
2. No

### CONVED

Text: ♦ Was conversion attempted?

1. Yes
2. No

### CONVOP

Text: ♦ Was conversion attempted?

1. Yes
2. No

### CONVAS

Text: ♦ Was conversion attempted?

1. Yes
2. No