

# ATTACHMENT J:

## NHAMCS Hospital Induction Form for New Sample

OMB No. 0920-0278; Exp. Date: \_\_\_\_\_

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### INTRO\_APPT

Text: ? [F1]

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](#)

### NAMECHEK

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?**

**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  
(conduct 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: ? [F1]

**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: ? [F1]  5

**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

**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?**

◆ 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

## **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](#)  
(Alternate contact person(s))

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 compete. Enter 9 to wrap up the case./All eligible departments are compete or refusals. Press F10 if you plan to follo

	<u>Department</u>	<u>Status</u>
Inelig)	ED	(Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpl /
Inelig)	OPD	(Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpl /
Inelig)	ASL	(Elig /Partial /Elig (refusal) / Partial (refusal) / Cmpl /

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?

<u>ESA</u>	<u>Visits</u>	<u>Visits Previous</u>
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?

<u>ESA</u>	<u>Visits</u>	<u>Visits Previous</u>
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: ? [F1]

**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: ? [F1]

**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 \*\***

## 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](#)

## 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

## 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

## 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

## REASON

Text: ♦ Specify what reason was given for the refusal/breakoff  
♦ Specify if hospital or ED

## CONVHOSP

Text: ♦ Was conversion attempted?

1. Yes
2. No

## CONVED

Text: ♦ Was conversion attempted?

1. Yes

2. No