**Attachment H**

**Freestanding Ambulatory Surgery Center Induction Form**

**Ambulatory Care Pretest, National Hospital Care Survey**

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|  **OMB No. 0920-xxxx; Exp. Date: Assurance of confidentiality –** All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).**Notice –** Public reporting burden for this collection of information is estimated to average 30 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a current valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-xxxx). |
| **INTRO\_SCR** |  |
|  | Hello (Respondent's name),**This is ... .  I'm calling on behalf of the National Center for Health Statistics, part of 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 National Hospital Care Survey.  Did you receive our letter?** If "No" or "DK", offer to send or deliver another copy. |
| 1. | Yes |
| 2. | No |
| 3. | Unknown |
|  |  |
| **INTRO\_SCR\_PT** |  |
| Text: | Hello, this is ...... **calling on behalf of the National Center for Health Statistics, part of the Centers for Disease Control and Prevention.** If necessary, introduce survey **We completed part of the interview for the National Hospital Care Survey - Freestanding Ambulatory Surgery Centers and would like to finish it now.** |
| **INTRO\_IND** |  |
| Text: | o  Identify yourself - show I.D.o  Ask to speak to:  (Respondent's name)    (Press ALT-F9 to update Administrator/Alternate contact information)o  Introduce survey, as necessary |
| 1. | Continue |
| 2. | Reluctant Respondent |
| 3. | Inconvenient time |
| 4. | Other Outcome |
| 5. | Conduct/continue induction by phone |
|  |  |
| **HELLO** |  |
| Text: | **Hello.  This is . . . . from calling on behalf of the National Center for Health Statistics, part of the Centers for Disease Control and Prevention. May I speak to (Respondent's name)?** |
| 1. | Correct person, Correct person called to the phone, or call is transferred to correct person |
| 2. | Unknown/no longer there  |
| 3. | Reached on a different number |
| 4. | Not available now, not at desk, etc. |
| 5. | On vacation or otherwise temporarily away from work |
| 6. | Other outcome or problem interviewing respondent |
| **TRY\_BACK** |  |
| Text: | Do you want to callback later to try and speak to (Respondent's name)    or do you want to continue with a new/different respondent? REPORTING  PERIOD:  (Reporting period begin date) - (Reporting period end date) |
| 1. | Callback later |
| 2. | Continue with new/different respondent |
|  |  |
| **KNOWL\_RESP** |  |
| Text: | **Perhaps you can help me.  I am calling on behalf of the National Center for Health Statistics, part of the Centers for Disease Control and Prevention.  May I speak to someone who can answer questions about ambulatory surgery?** |
| 1. | Person you are speaking with can help |
| 2. | Someone else can help |
|  |  |
| **TRANSFER** |  |
| Text: | **Can you transfer me?** |
| 1. | Yes |
| 2. | No |
|  |  |
| **INTROB** |  |
| Text: | ((Hello, this is . . . calling on behalf of the National Center for Health Statistics, part of the Centers for Disease Control and Prevention./ ) Is respondent ready to complete the interview?) |
| 1. | Continue |
| 2. | Reluctant Respondent |
| 3. | Inconvenient time |
| 4. | Other Outcome |
|  |  |
| **NAMECHEK** |  |
| Text: | **Let me verify that I have the correct name and address for your ASC.Is the correct name (facility name)?** |
| 1. | Yes |
| 2. | No |
|  |  |
| **ASC\_NAME** |  |
| Text: | **What is your ASC's name?** |
| 1. | Enter 1 to update information |
| 2. | Continue |
|  |  |
| **ADDCHEK** |  |
| Text: | **Is your ASC located at (Facility Address)** |
| 1. | Yes |
| 2. | No |
|  |  |
| **ASC\_ADDRESS** |  |
| Text: | **What is the correct address?** |
| 1. | Enter 1 to update information |
| 2. | Continue |
|  |  |
| **MAILADD** |  |
| Text: | **Is this the mailing address?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **MASC\_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 conducting an annual study of ambulatory care.  The study began data collection in 1992. CDC has contracted with Westat to collect the data.  (facility name) has been selected to participate in the study. I am calling to arrange an appointment to discuss your participation. The meeting will take about 30 minutes of your time. 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 (facility name) to be sure we have correctly included this ASC in the study.** |
|  |  |
| **PRFMSURG** |  |
| Text: |   Do not ask item if facility is an eye surgery center.**Is ambulatory (outpatient) surgery or ambulatory diagnostic or therapeutic procedures currently performed in this facility?**  |
| 1. | Yes |
| 2. | No |
| 3. | Eye surgery center |
|  |  |
| **THANK\_B1** |  |
| Text: | **Thank you (Respondent's name) but it seems that our information is incorrect. Since (facility name) does not perform ambulatory surgery, it should not have been chosen for our study. Thank you very much for your cooperation.**  |
|  |  |
| **INELSPEC** |  |
| Text: | **In this study we are excluding facilities that are exclusively dedicated to family planning, birthing, abortion, podiatry or dentistry. Is (facility name) exclusively one of these?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **THANK\_B2** |  |
| Text: | **Thank you (Respondent's name), but it seems that our information is incorrect. Since (facility name)'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.**  |
|  |  |
| **LICASC** |  |
| Text: | **Is this facility currently licensed by the state?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **PRNTLIC** |  |
| Text: | **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.Does your ASC operate under the license of a parent facility?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **PRNTPOS** |  |
| Text: | It is important for us to determine whether or not your facility operates under the license of Provider of Services (POS) number of a parent facility. **Does your ASC operate under the Provider of Services (POS) number of a parent facility?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **PARFAC\_NAME** |  |
| Text: | **What is the name of the parent facility?** |
|  |  |
| **PARFAC\_STRET** |  |
| Text: | **What is the address of (Parent Facility Name)?** |
| **PFNC\_THANK** |  |
| Text: | **Thank you for your time and assistance. We may contact you again in a few days regarding participation in this study.**  |
|  |  |
| **CALLRO\_PFNC** |  |
| Text: |   Call your RO and inform them of the situation.     Await resolution from the RO before continuing with this case.    Situation:  (Operates under a parent facility/Name change/Address change) |
|  |  |
| **OWNASC** |  |
| Text: | **Is this facility owned, operated, or managed by -**   Read answer categories |
| 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 |
|  |  |
| **ONESPEC** |  |
| Text: | **Is the ambulatory (outpatient) surgery performed here primarily one specialty?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **SPECNAME** |  |
| Text: | **What is the specialty?**  |
| 1. | General Surgery |
| 2. | Gastroenterology |
| 3. | Ophthalmology |
| 4. | Orthopedics |
| 5. | Plastic Surgery |
| 6. | Pain Block |
| 7. | Urology |
| 8. | Other  |
|  |  |
| **SPECNAME\_SP** |  |
| Text: | **What is the specialty?** |
|  |  |
| **MULTSPEC** |  |
| Text: | **Is the ambulatory (outpatient) surgery performed here multi-specialty?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **STUDY\_DESC** |  |
| Text: | **Thank you.  Now I would like to provide you with further information on the study.**Provide the administrator or other facility representative with a brief description of the study. **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.**  |
|  |  |
| **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?**  Record day, date and time of appointment ( Enter 999 to start the induction now) |
| **SCREENER\_THK** |  |
| Text: | **Thank you (Respondent's name) for your cooperation.  I am looking forward to our meeting.**  |
| **ELIGREQ** |  |
| Text: | **\*\* NOT DISPLAYED \*\*** |
|  |  |
| **REVIEW** |  |
| Text: | **I would like to begin with a brief review of the background for this study.**  Provide the administrator or other facility representative with a brief introduction to the study and a general overview of procedures |
|  |  |
|  |  |
| **PERMPART** |  |
| Text: | **As I mentioned earlier, I would like to discuss the plan for conducting the study.  This ASC has been assigned to a (1-month, 2-month, 3-month) data collection period beginning on Monday, (Reporting period begin date). First, I would like to discuss the steps needed to obtain approval for this study. Are there any additional steps needed to obtain permission for the ASC to participate in the study?**  |
| 1. | Yes |
| 2. | No |
|  |  |
| **PERMPART\_SP** |  |
| Text: | **Please specify the necessary steps.**  Be sure to ask for the name, title, address and phone of the person(s) able to grant permission |
|  |  |
|  |  |
| **PERM\_THANK** |  |
| Text: | **Thank you for your time** |
|  |  |
| **RO\_PERMISSION**  |  |
| Text: |   Call your regional office and inform them of the situation.     Await guidance before continuing with the case. |
|  |  |
| **VSREPPER** |  |
| Text: | **Now I would like to make arrangements to obtain the information needed for sampling.  I will need to (verify/know) how your ambulatory surgery center is organized and obtain an estimate of the number of patient visits expected during the (1-month, 2-month, 3-month) reporting period.  Would you prefer I (verify/get) this information from you or someone else?**  |
| 1. | Respondent |
| 2. | Someone Else |
|  |  |
| **CINFO** |  |
| Text: | **What is the name of the person I should talk to?**Enter 1 to enter/update contact person information or change respondent        |
| 1. | New contact  |
| 2. | Continue interview |
|  |  |
| **THANK\_RESP** |  |
| Text: | **Thank you for your time and cooperation.**  |
|  |  |
| **REACH\_CPERSON** |  |
| Text: |   Are the new contacts available to answer the questions at this time?      If unavailable, press F10 to set an appointment  |
| 1. | Yes |
|  |  |
| **NEWC\_INTRO** |  |
| Text: |  Read if necessary**Now I would like to obtain the information needed for sampling.  I will need to (verify/know) how your ambulatory surgery center is organized and obtain an estimate of the number of patient visits expected during the (1-month, 2-month, 3-month) reporting period.**  |
|  |  |
| **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):General or main operating rooms                Endoscopy roomsDedicated ambulatory surgery rooms        Cardiac catheterization labsSatellite operating rooms                              Laser procedures roomsCystoscopy rooms                                         Pain block rooms** |
| 1. | Continue |
| 2. | No in-scope ^centerslocations |
|  |  |
| **ASL\_NUM** |  |
| Text: | **\*\* SHOW ONLY \*\*** |
|  |  |
| **DEL\_ASL** |  |
| Text: | **(Does (ASL name) still exist and is it still operational?)**  (Enter 97 to delete this (ASC/ASL)/(ASC/ASL) entered by mistake/ If Yes, Press ENTER to move to the next row If No, Enter 97 to delete) |
|  |  |
| **ASL\_NAME** |  |
| Text: | **(What is the name of the (first/next) ambulatory surgery (center/location)? /Are there any other ambulatory surgery (center/locations)?)**  Enter only IN\_SCOPE (ASC/ASL)'s   (Press F1 for in-scope locations) |
| **ASL\_SPEC\_GRP** |  |
| Text: | **What is (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 (name) from (Reporting period begin date) to (Reporting period end date)?**  |
|  |  |
| **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 - All |
| 2. | Yes - Some Locations |
| 3. | No |
|  |  |
| **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\_CPHONE** |  |
| Text: | **What is (IT contact name)'s phone number?** |
|  |  |
| **AU\_NUMBER** |  |
| Text: |   Assign AU number    If you can do abstractions for multiple offices in one (center/location), then assign the same AU number to each of those (centers/locations).  |
|  |  |
| **EBILLRECA** |  |
| Text: | **Does your ASC submit any CLAIMS electronically (electronic billing)?**  |
| 1. | Yes |
| 2. | No |
| 3. | Unknown |
|  |  |
| **EINSELIGA** |  |
| Text: | **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 |
|  |  |
| **EMEDRECA** |  |
| Text: | **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 |
| 3. | No |
| 4. | Unknown |
|  |  |
| **EHRINSYRA** |  |
| Text: | **In which year did your ASC 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 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 has each of the following computerized capabilities.  Does your ASC have a computerized system for:   Recording patient history and demographic information?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EPROLSTA** |  |
| Text: | **Does this include a patient problem list?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EVITALA** |  |
| Text: | **Recording and charting vital signs?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ESMOKEA** |  |
| Text: | **Recording patient smoking status?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EPNOTESA** |  |
| Text: | **Recording clinical notes?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EMEDALGA** |  |
| 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. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
| **ECPOEA** |  |
| Text: | **Ordering prescriptions?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ESCRIPA** |  |
| Text: | **Are prescriptions sent electronically to the pharmacy?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ERXWHOA/ EHRWHOA** |  |
| Text: | **At your ASC, when orders for prescriptions are submitted electronically, are they submitted by the prescribing practitioner, or by someone else?**Enter all that apply, separate with commas |
| 1. | Prescribing practitioner |
| 2. | Someone else |
| 3. | Unknown |
|  |  |
| **EWARNA** |  |
| Text: | **Are warnings of drug interactions or contraindications provided?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EREMINDA** |  |
| Text: | Indicate whether your ASC has each of the following computerized capabilities.  Does your ASC 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. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ESETSA** |  |
| Text: | **Providing standard order sets related to a particular condition or procedure?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ECTOEA** |  |
| Text: | **Ordering lab tests?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EORDERA** |  |
| Text: | **Are orders sent electronically?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ELABWHOA** |  |
| Text: | **At your ASC, when orders for lab tests are submitted electronically, are they submitted by the prescribing practitioner, or by someone else?**Enter all that apply, separate with commas |
| 1. | Prescribing practitioner |
| 2. | Someone else |
| 3. | Unknown |
|  |  |
| **ERESULTA** |  |
| Text: | Indicate whether your ASC has each of the following computerized capabilities.  Does your ASC have a computerized system for:**Viewing lab results?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EGRAPHA** |  |
| Text: | **Can the EHR/EMR automatically graph a specific patient's lab results over time?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EIMGRESA** |  |
| Text: | Indicate whether your ASC has each of the following computerized capabilities.  Does your ASC have a computerized system for:**Viewing imaging results?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EQOCA** |  |
| Text: | **Viewing data on quality of care measures?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ECQMA** |  |
| Text: | **Reporting clinical quality measures to federal or state agencies (such as CMS or Medicaid)?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EGENLISTA** |  |
| Text: | **Generating lists of patients with particular health conditions?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EIMMREGA** |  |
| Text: | **Electronic reporting to immunization registries?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
|  |  |
| **EMUREPA** |  |
| Text: | **Is the electronic reporting to immunization registries reported in standards specified by Meaningful Use criteria?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **ESUMA** |  |
| Text: | Indicate whether your ASC has each of the following computerized capabilities.  Does your ASC have a computerized system for:**Providing patients with clinical summaries for each visit?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EMSGA** |  |
| Text: | **Exchanging secure messages with patients?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EHLTHINFOA** |  |
| Text: | **Providing patients with an electronic copy of their health information?** |
| 1. | Yes, used routinely |
| 2. | Yes, but not used routinely |
| 3. | Yes, but turned off or not used |
| 4. | No |
| 5. | Unknown |
|  |  |
| **EXCHSUMA/ESHAREA** |  |
| Text: | **Does your ASC share any patient health information electronically (not fax) with other providers, including hospitals, ambulatory providers, or labs?** |
| 1. | Yes |
| 2. | No |
|  |  |
| **EXCHSUM1A/ESHAREHOWA** |  |
| Text: | **How does your ASC electronically share patient health information?**     Enter all that apply, separate with commas |
| 1. | EHR/EMR |
| 2. | Web portal (separate from EHR/EMR) |
| 3. | Other electronic method: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  |
|  |  |
| **LABRESA** |  |
| Text: | **Please indicate whether your ASC electronically (not fax) shares each of the following types of health data and with which types of health care providers. Lab results?**Enter all that apply, separate with commas |
| 1. | Hospitals with which your ASC is affiliated |
| 2. | Ambulatory providers inside your ASC |
| 3. | Hospitals with which your ASC is not affiliated |
| 4. | Ambulatory providers outside your ASC |
|  |  |
| **IMAGREPA** |  |
| Text: | **Imaging reports?**Enter all that apply, separate with commas |
| 1. | Hospitals with which your ASC is affiliated |
| 2. | Ambulatory providers inside your ASC |
| 3. | Hospitals with which your ASC is not affiliated |
| 4. | Ambulatory providers outside your ASC |
|  |  |
| **PTPROBA** |  |
| Text: | **Patient problem lists?**Enter all that apply, separate with commas |
| 1. | Hospitals with which your ASC is affiliated |
| 2. | Ambulatory providers inside your ASC |
| 3. | Hospitals with which your ASC is not affiliated |
| 4. | Ambulatory providers outside your ASC |
|  |  |
| **MEDLISTA** |  |
| Text: | **Medication lists?**Enter all that apply, separate with commas |
| 1. | Hospitals with which your ASC is affiliated |
| 2. | Ambulatory providers inside your ASC |
| 3. | Hospitals with which your ASC is not affiliated |
| 4. | Ambulatory providers outside your ASC |
|  |  |
| **ALGLISTA** |  |
| Text: | **Medication allergy lists?**Enter all that apply, separate with commas |
| 1. | Hospitals with which your ASC is affiliated |
| 2. | Ambulatory providers inside your ASC |
| 3. | Hospitals with which your ASC is not affiliated |
| 4. | Ambulatory providers outside your ASC |
|  |  |
| **PAYHITA** |  |
| Text: | **Medicare and Medicaid offer incentives to practices that demonstrate “meaningful use of health IT”. Does your ASC have plans to apply for these incentive payments?** |
| 1. | Yes, we already applied |
| 2. | Yes, we intend to apply |
| 3. | Uncertain whether we will apply |
| 4. | No, we will not apply |
| **PAYDRA** |  |
| Text: | **In which year did your ASC first apply for meaningful use payments?** |
| 1. | 2011 |
| 2. | 2012 |
| 3. | Unknown |
|  |  |
| **PAYYRA** |  |
| Text: | **In which year does your ASC expect to apply for the meaningful use payments?** |
| 1. | 2012 |
| 2. | 2013 or later |
| 3. | Unknown**REMACCA** If PAYHITA=1Text: **Now I’d like to ask you some questions about your ASC’s electronic health records system. Can this system be accessed from the outside by entities not associated with the ASC?**1. Yes
2. Unsure (will have to check and get back to interviewer)
3. No – Skip to ASL\_SPEC\_GRP
4. Unknown

**REMREPA** Text: **Would your ASC be willing to allow CDC’s contractor to obtain password access to your ASC’s electronic health records system and load the charting software onto desktop computers at their headquarters? The contractor’s Data Security Plan complies with all relevant laws, regulations, and policies governing the security of data and protection of confidentiality.**1. Yes
2. Unsure (will have to check and get back to interviewer)
3. No
4. Unknown
 |
|  |  |
| **ASL\_SPEC\_GRP** |  |
| Text: | **\*\* SHOW ONLY \*\*** |
| 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\_STRET** |  |
| Text: | **What is (name)'s address or the address where the abstractions will be done?**  (Abstractions can be done at one location for multiple ASL's) |
|  |  |
| **ASL\_PHONE** |  |
| Text: | **What is (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 |
| **TE** |  |
| Text: | **\*\* NOT DISPLAYED \*\*** |
|  |  |
| **RS** |  |
| Text: | **\*\* NOT DISPLAYED \*\*** |
|  |  |
| **TOTAL\_VISITS** |  |
| Text: | **\*\* NOT Displayed \*\*** |
|  |  |
| **PRF\_WKLD** |  |
| Text: | **\*\* NOT DISPLAYED \*\*** |
|  |  |
| **MULTIASCFLAG** |  |
| Text: | **\*\* Not Displayed \*\*** |
|  |  |
| **EXIT\_REFUSAL** |  |
| Text: | Are you exiting this case because of a refusal? |
| 1. | Yes, potential refusal |
| 2. | No |
|  |  |
| **CALLBACKNOTES** |  |
| Text: | **I'd like to schedule a DATE to (conduct the interview/complete the interview/follow-up on missing items) 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   (Appointment information) |
|  |  |
| **CALLBACKNOTES** |  |
| Text: | **I'd like to schedule a DATE to (conduct the interview/complete the interview/follow-up on missing items). 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   (Appointment information) |
|  |  |
| **THANKYOU** |  |
| Text: | **This concludes the interview.  Thank you for your patience, and for taking the time to answer our questions.** |
| **ELIGFS** |  |
| Text: |   Does this facility have an eligible ASC? |
| 1. | Yes |
| 2. | No |
|  |  |
| **VSFS101** |  |
| Text: | **How many visits are expected during the reporting period?** |
|  |  |
| **VSFSLY** |  |
| Text: | **How many visits were there to this ASC last year?** |
|  |  |
| **REFUSE** |  |
| Text: | **\*\* Not Displayed \*\*** |
|  |  |
| **WHOMAS** |  |
| Text: |   By Whom?  |
| 1. | ASC administrator |
| 2. | ASC Director |
| 3. | Approval board or official |
| 4. | Other ASC official |
|  |  |
| **TELPERAS** |  |
| Text: |   Was the refusal by telephone or in person?  |
| 1. | Telephone |
| 2. | In Person |
|  |  |
| **REASONAS** |  |
| Text: |   What reason was given?  |
|  |  |
| **CONVAS** |  |
| Text: | Was conversion attempted? |
| 1. | Yes |
| 2. | No |
|  |  |
| Text: | * After completion of the pretest, ask the FSASC director), if he/she would be willing to

 participate in the survey in 2013) |

**PARTASC** Text: **Now that your ASC has completed the pretest, would your ASC be willing to participate in the ambulatory surgery component of the National Hospital Care Survey beginning in 2013?**

1. Yes, all
2. Yes, some
3. Unsure
4. No