Section VI – NONINTERVIEW

18. Where did the nonresponse occur?

(Mark (X) both boxes 2 and 3 if applicable)

1 ☐ Hospital – *Ask item 19*
2 ☐ Clinic(s)
3 ☐ Emergency service area(s) } *SKIP to item 20*

19. What is the reason the hospital did not participate in this study?

1 ☐ Hospital closed
2 ☐ Hospital not eligible } *END INTERVIEW*
3 ☐ Hospital refused – *SKIP to item 20*
4 ☐ Other – *Specify* ↙

END INTERVIEW

20a. At what point in the interview did the refusal/breakoff occur?

Mark (X) appropriate box(es)	Hospital	ED	OPD
(1) During the telephone screening	1 ☐		
(2) During the hospital induction	2 ☐		
(3) During the ED/OPD induction	3 ☐	3 ☐	3 ☐
(4) After the ED/OPD induction, but prior to assigned reporting period	4 ☐	4 ☐	4 ☐
(5) During the assigned reporting period	5 ☐	5 ☐	5 ☐

b. By whom?

Mark (X) appropriate box(es)	Hospital	ED	OPD
(1) Hospital administrator	1 ☐	1 ☐	1 ☐
(2) ED/OPD director		2 ☐	2 ☐
(3) Approval board or official	3 ☐	3 ☐	3 ☐
(4) Other hospital official	4 ☐ *Specify* ↙	4 ☐ *Specify* ↙	4 ☐ *Specify* ↙
(5) Was the refusal by telephone or in person?	5 ☐ Telephone 6 ☐ In person	5 ☐ Telephone 6 ☐ In person	5 ☐ Telephone 6 ☐ In person

c. What reason was given? *Please specify hospital, ED, or OPD (from item 20a) before recording responses.*

d. Was conversion attempted?

Hospital	ED	OPD
1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No	1 ☐ Yes 2 ☐ No

Form Approved OMB No. 0920-0278 Exp. Date 5/31/2007 CDC 64.151

1. Label

FORM **NHAMCS-101**
(3-10-2006)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

2006 PANEL

2a. Hospital contact information	**b.** ED contact information	**c.** OPD contact information
Name	Name	Name
Title	Title	Title
Telephone number *(Area code and number)*	Telephone number *(Area code and number)*	Telephone number *(Area code and number)*
FAX number	FAX number	FAX number

Section I – TELEPHONE SCREENER

3. Field representative information

	Code
Telephone screener	
Hospital induction	
ED/OPD inductions	

4. Record of telephone calls

Call	Date	Time	Results
1			
2			
3			
4			

5. Final outcome of hospital screening

1 ☐ Appointment

Day	Date	Time a.m. p.m.
Place		

2 ☐ Noninterview – *Complete sections V and VI, beginning on page 19.*

During your initial call to the hospital, attempt to speak to the contact person (as provided in item 2a). If the contact person is not available at this time, determine when he/she can be reached and call again at the designated time. If, after several attempts, you are still unable to talk to the contact or have determined the contact is no longer an appropriate respondent, begin the interview with a representative of the contact person or new contact, as appropriate. Record ED and OPD contact information in items 2b and 2c.

Section I – TELEPHONE SCREENER – Continued

Part A. INTRODUCTION
Good (morning/afternoon) . . . My name is *(Your name).* **I am calling for the Centers for Disease Control and Prevention concerning their study of hospital outpatient and emergency departments. You should have received a letter from Dr. Edward J. Sondik, the director of the National Center for Health Statistics, describing the study.** *(Pause)* **You've probably also received a letter from the Census Bureau, which is collecting the data for the study.**

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

1 ☐ Yes – *Skip to Statement A*
2 ☐ No
3 ☐ Don't know

7a. Let me verify that I have the correct name and address for your hospital. Is the correct name *(Read name from item 1.)***?**

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

b. Is your hospital located at *(Read address from item 1.)***?**

1 ☐ Yes 2 ☐ No → *Enter hospital location* ↙

Number and street

City State ZIP Code

c. Is this also the mailing address?

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

Number and street

City State ZIP Code

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

Section V – DISPOSITION AND SUMMARY – Continued

AMBULATORY UNIT CHECKLIST

- *COMPLETE 15a and 15b FOR* ***EMERGENCY*** *DEPARTMENT ONLY*

15a. How many emergency service areas were selected for sample?

INSTRUCTION – *Enter 0 if no ESAs were selected for sample.*

Did you include a NHAMCS-101(U) for each?

_____ Number of ESAs

1 ☐ Yes
2 ☐ No – *Explain* ↙

b. Total number of ESA sampling units

If ED has 5 or fewer ESAs, enter the number of ESAs.

If ED has more than 5 ESAs, transcribe "No. of Sampling Units" from the Sampling Plan.

_____ Total Number of ESA Sampling Units

- *COMPLETE 15c and 15d FOR* ***OUTPATIENT*** *DEPARTMENT ONLY*

c. How many clinics were selected for sample?

INSTRUCTION – *Enter 0 if no clinics were selected for sample.*

Did you include a NHAMCS-101(U) for each?

_____ Number of Clinics

1 ☐ Yes
2 ☐ No – *Explain* ↙

d. Total number of clinic sampling units

If OPD has 5 or fewer clinics, enter the number of clinics.

If OPD has more than 5 clinics, transcribe "No. of Sampling Units" from the Sampling Plan.

_____ Total Number of Clinic Sampling Units

FORMS COMPLETED

16a. Number of ED Patient Record Forms completed _____ Number of ED PRFs

b. Number of OPD Patient Record Forms completed _____ Number of OPD PRFs

17a. FINAL DISPOSITION

1 ☐ All eligible units completed Patient Record Forms *(END)*
2 ☐ Some eligible units completed Patient Record Forms } *GO to 17b*
3 ☐ Hospital refused
4 ☐ Hospital closed
5 ☐ Hospital ineligible } *Complete Section VI, NONINTERVIEW on page 20*

b. NATURE OF REFUSAL

1 ☐ Entire ED refused
2 ☐ Entire OPD refused
3 ☐ Some ESAs refused
4 ☐ Some clinics refused
} *Complete Section VI, NONINTERVIEW on page 20*

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – *Continued*

Now I would like to ask you some questions about your OPD.

14n. Does your OPD use electronic MEDICAL RECORDS (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No,
4 ☐ Unknown
} *SKIP to item 14q*

o. Does your OPD's electronic medical record system include –	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Computerized orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are there warnings of drug interactions or contraindications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Computerized orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are out of range levels highlighted?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are electronic images returned?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Do they include medical history and follow-up notes?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Do they include reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	3 ☐

p. Are there any of the above features of your system that your OPD does NOT use or has turned off?

1 ☐ Yes – *Please specify* ↙

FR NOTE – Indicate in item 14o, last column, any components turned off.

2 ☐ No
3 ☐ Unknown

q. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

CHECK ITEM A

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

INTRO-DUCTION STATEMENT B1

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

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

INTRO-DUCTION STATEMENT B2

The National Center for Health Statistics of the Centers for Disease Control and Prevention is conducting an annual study of hospital-based ambulatory care. The study began data collection in 1992. They have contracted with the Census Bureau to collect the data. *(Name of hospital)* **has been selected to participate in the study. I am calling to arrange an appointment to discuss this hospital's participation. The study is authorized under the Public Health Service Act and the information will be held strictly confidential. Participation is voluntary.**

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

8a. Is this facility a licensed hospital?

1 ☐ Yes
2 ☐ No – *SKIP to Check Item B on page 4*

b. Is this hospital voluntary non-profit, government, or proprietary?

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

c. Is this a teaching hospital?

1 ☐ Yes
2 ☐ No

d. Has this hospital merged with any OTHER hospital in the past 2 years?

1 ☐ Yes
2 ☐ No – *SKIP to item 9 on page 4*
3 ☐ Unknown – *SKIP to item 9 on page 4*

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

Hospital name

Number and street

City | State | ZIP Code

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

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

Section I – TELEPHONE SCREENER – Continued

Part B. VERIFICATION OF ELIGIBILITY

9a. Does this hospital provide emergency services that are staffed 24 HOURS each day either here at this hospital or elsewhere?
1 ☐ Yes – *SKIP to item 9c*
2 ☐ No

b. Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day?
1 ☐ Yes
2 ☐ No

c. What is the trauma level rating of this hospital?
1 ☐ Level I
2 ☐ Level II
3 ☐ Level III
4 ☐ Level IV or V
5 ☐ Other/unknown
6 ☐ None

10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?
1 ☐ Yes
2 ☐ No – *SKIP to Check Item B*

b. Does this OPD include physician services?
1 ☐ Yes
2 ☐ No

CHECK ITEM B

Mark (X) all that apply.

1 ☐ ED meets eligibility requirements (item 9a is YES) . . . .
2 ☐ OPD meets eligibility requirements (item 9a is NO and item 9b is YES, or items 10a and b are YES) . . . .
} *SKIP to Check Item B-1*

3 ☐ Hospital is ineligible because it is not licensed (item 8a is NO) –*Go to CLOSING STATEMENT B1 below.*

4 ☐ Hospital is ineligible because it has NEITHER an ED nor OPD (items 9a, 9b, and 10a and/or 10b are NO) – *Go to CLOSING STATEMENT B2 below.*

CHECK ITEM B-1

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

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

Eligible ED?
1 ☐ Yes – ________ expected visits
2 ☐ No

b. Determine whether hospital has an eligible OPD and if so, inquire as to how many visits are expected during the reporting period.

Eligible OPD?
1 ☐ Yes – ________ expected visits
2 ☐ No

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

________ ED visits last year ________ OPD visits last year

Go to Section VI, NONINTERVIEW on page 20.

CLOSING STATEMENT B1 ▶ **Thank you . . ., but it seems that our information was incorrect. Since** *(Name of hospital)* **is not a licensed hospital it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete sections V and VI beginning on page 19.*

CLOSING STATEMENT B2 ▶ **Thank you . . ., but it seems that our information was incorrect. Since** *(Name of hospital)* **does not have 24-hour emergency services or outpatient clinics, it should not have been chosen for our study. Thank you very much for your cooperation.** *Terminate telephone call and complete sections V and VI beginning on page 19.*

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

CHECK ITEM D-2
1 ☐ At least one GM or OB/GYN clinic was selected for sample.
2 ☐ No GM or OB/GYN clinics were selected for sample – *SKIP to 14n*

List the GM or OB/GYN clinics selected for sample and ask the clinic director this question. →

AU No.	Outpatient department clinic name	Does your clinic offer any type of cervical cancer screening?
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown
		1 ☐ Yes – *Leave NHAMCS-906* 2 ☐ No 3 ☐ Unknown

NOTES

CHECK ITEM D

1 ☐ At least one OPD Clinic in-scope.
2 ☐ All OPD Clinics out-of-scope.– *SKIP to Section V, DISPOSITION AND SUMMARY on page 19*

CHECK ITEM D-1

Is the total number of expected OPD visits during the reporting period between

_____ **and** _____ **?**

1 ☐ Yes – ***SKIP to Check Item D-2 on page 17.***
2 ☐ No, it is **MORE THAN** the range – *GO to a*
3 ☐ No, it is **LESS THAN** the range – *SKIP to c*

a. Compare to previous sampling plan. Are there more clinics this year compared to last year? *(If "Yes" then verify scope and ownership of the new clinics this year, make changes if needed, and then check one of the following responses.)*

1 ☐ Yes, this is correct, some clinics have opened or should have been included last year. – *List*

2 ☐ No, the number of clinics has not increased.

b. Is the number of expected visits to any of the clinics more than twice the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have increased this year or were too low last year. – *Explain*

2 ☐ No, the number of visits has not increased dramatically.

☆ ***SKIP to Check Item D-2 on page 17***

c. Compare to previous sampling plan. Are there fewer clinics this year compared to last year?

1 ☐ Yes, this is correct, some clinics have closed or shouldn't have been included last year. – *List*

2 ☐ No, the number of clinics has not decreased.

d. Is the number of expected visits to any of the clinics less than half of the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have decreased this year or were too high last year. – *Explain*

2 ☐ No, the number of visits has not decreased dramatically.

Part C. STUDY DESCRIPTION

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

INSTRUCTIONS

Provide the administrator or other hospital representative with a brief description of the study.

Cover following points –

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

(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

(3) Nationwide sample of about 600 hospitals

(4) Four-week data collection period

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

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

CHECK ITEM B-2

Hospital **HAS MERGED** with another in the past two years? *(Item 8d is YES.)*

1 ☐ Yes – *Go to CLOSING STATEMENT C1 below.*
2 ☐ No – *Go to CLOSING STATEMENT C2 below.*

CLOSING STATEMENT C1

Since your hospital has merged within the last 2 years, I need to get further instructions from the Centers for Disease Control and Prevention (CDC) on how to proceed. I will call you back within a week and let you know which parts of your hospital will be in the survey. Thank you for your cooperation! *Telephone your Regional Office to report the Hospital Name and ID Number.*

CLOSING STATEMENT C2

I would like to arrange to meet with you so that I can better present the details of the study. Is there a convenient time within the next week or so that I could meet with you or your representative?

Thank you . . . for your cooperation. I am looking forward to our meeting. *Record day, date, time, and place of appointment in item 5, page 1; and terminate telephone call.*

NOTES

Section II – INDUCTION INTERVIEW

Part A. INTRODUCTION

I would like to begin with a brief review of the background for this study.

INSTRUCTIONS

Provide the administrator or other hospital representative with a brief introduction to the study and a general overview of procedures.

Cover the following points –

(1) NHAMCS is an extension of the National Ambulatory Medical Care Survey (NAMCS). The NAMCS collects data on visits to physicians in office-based practices

(2) NAMCS and NHAMCS are sponsored by the National Center for Health Statistics of the Centers for Disease Control and Prevention

(3) NAMCS and NHAMCS data are used extensively by health services planners, researchers and educators

(4) Patient visits to hospital emergency and outpatient departments account for almost 200 million visits annually

(5) Census Bureau is acting as the data collection agent for the study

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

(7) Participation is voluntary

(8) All information, including the name of hospital, is held in strict confidence

(9) NO patients' names or identifiers are collected

(10) The study was approved by the NCHS Research Ethics Review Board

(11) Data from the study will be used only in statistical summaries

(12) NHAMCS covers hospital facilities on and off hospital grounds

(13) NHAMCS covers care provided by or under the direct supervision of a physician

(14) NHAMCS excludes office-based physicians (these are covered under the NAMCS)

(15) NHAMCS excludes visits to clinics where only ancillary services are provided, e.g., X-ray, laboratories, and pharmacies, and where physician services are not provided, e.g., physical, speech, and occupational therapy, and dental and podiatry clinics. Ambulatory surgery centers and same day surgery clinics are also excluded.

(16) Only a 4-week data collection period

(17) On average, sample of approximately 100 ED and 150 to 200 OPD visits per hospital

SHOW PATIENT RECORD FORMS

(18) Form takes only 5 minutes to complete

(19) Forms to be completed by hospital staff at their convenience

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

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

FR NOTE

OPD Specialty Groups include:

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

INSTRUCTIONS – *Complete columns (d) and (e) after developing the sampling plan. See page 4 of the NHAMCS-124, Sampling and Information Booklet.*

Line No.	Outpatient department clinic name (a)	Specialty group (b)	Expected No. of visits from ____ to ____ (c)	Take every number (d)	Random start number (e)
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
	TOTAL →				

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION

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

(1) *If the hospital has previously participated, simply verify that the clinic(s) listed on page 15 is (are) still operating in the hospital by:*

- **(a)** *crossing through any clinics on the list which no longer exist or are no longer operational in that hospital.*
- **(b)** *adding the names of any new clinics which have been created or have become operational in that hospital. For each new clinic added to the list, be sure to obtain the proper specialty code. Remember, include only ELIGIBLE clinics.*
- **(c)** *obtaining an estimate of visits **for each clinic**, covering the 4-week period. Enter the estimate in column (c) of the attached listing.*
- **(d) If this Outpatient Department has more than 5 clinics –** *FAX the updated list to your regional office. The regional office will choose the clinics for sample and provide you with the sampling instructions. Upon receiving the instructions, attach a copy of the completed clinic listing showing sampled clinics, the Take Every and Random Start numbers, etc., to page 15 of the NHAMCS-101, Questionnaire.*

(2) *If the hospital has not previously participated or a clinic list is not attached to this 101, obtain a complete listing of all **eligible** outpatient clinics along with their corresponding specialty group code, and expected number of visits **for each clinic** during the 4-week reporting period. Record this information in columns (a), (b), and (c) below.*

NOTES

Section II – INDUCTION INTERVIEW – Continued

Now I would like to ask you a few more questions about your hospital.

11a. Did your hospital receive any Medicaid Disproportionate Share Program funds in 2005?

1 ☐ Yes – *Specify amount received* $ _____
2 ☐ No
3 ☐ Unknown

b. Has your hospital received any funding for bioterror hospital preparedness from your state or municipal health department within the last 2 years?

1 ☐ Yes – *Specify amount received* $ _____
2 ☐ No
3 ☐ Unknown

c. Has your hospital participated in any internal mass casualty drill(s), simulation(s), or exercise(s) in the past year?

1 ☐ Yes
2 ☐ No
3 ☐ Unknown

} *SKIP to Part B. Survey Implementation on page 8*

d. What scenario(s) did the drill(s)/simulation(s)/exercise(s) address? *(Mark (X) all that apply.)*

1 ☐ General disaster and emergency response
2 ☐ Biologic attack
3 ☐ Severe epidemic
4 ☐ Chemical release
5 ☐ Nuclear/radiologic attack
6 ☐ Explosive/incendiary attack

NOTES

Part B. SURVEY IMPLEMENTATION

As I mentioned earlier, I would like to discuss the plan for conducting the study. This hospital has been assigned to a 4-week data collection period beginning on Monday, (____ / ____).
Month *Day*

First, I would like to discuss the steps needed to obtain approval for the study.

12. Are there any additional steps needed to obtain permission for the hospital to participate in the study?

1 ☐ No
2 ☐ Yes – *Specify the necessary steps below* ↙

NOTES

14e. How many levels are in your ED's nursing (R.N. and L.P.N.) triage system?
1 ☐ Three
2 ☐ Four
3 ☐ Five
4 ☐ Other – *Specify* _____
5 ☐ Do not conduct nursing triage

f. What percent of nursing (R.N. and L.P.N.) positions are currently vacant in your ED?
____ %
1 ☐ Unknown

g. Are the physicians working in your ED employed by an outside contractor or agency?
1 ☐ Yes, all
2 ☐ Yes, some
3 ☐ No
4 ☐ Unknown
} *SKIP to 14i*

h. For how many years has your hospital's emergency department employed the current contractor or agency?
____ Number of years
1 ☐ Unknown

i. Approximately what percent of physicians working in your emergency department are certified by the American Board of Emergency Medicine?
____ %
1 ☐ Unknown

j. What is the total number of hours that your hospital's emergency department was on ambulance diversion in 2005?
____ Total number of hours
1 ☐ Data not available

k. In the last two years, has your ED increased the number of standard treatment spaces?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

l. In the last two years, has your ED's physical space been expanded?
1 ☐ Yes – *SKIP to Check Item C-2*
2 ☐ No
3 ☐ Unknown

m. Do you have plans to expand your ED's physical space within the next two years?
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

CHECK ITEM C-2

1 ☐ The hospital has an organized outpatient department that provides physician services. (Yes in items 10a and b) – *SKIP to Section IV, OUTPATIENT DEPARTMENT DESCRIPTION on page 14.*

2 ☐ The hospital does not have an organized outpatient department that provides physician services. (No in items 10 a or 10b) – *SKIP to Section V, DISPOSITION AND SUMMARY on page 19.*

NOTES

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

Now I would like to ask you some questions about your ED.

14a. Does your ED use electronic MEDICAL RECORDS (not including billing records)?

1 ☐ Yes, all electronic
2 ☐ Yes, part paper and part electronic
3 ☐ No
4 ☐ Unknown
} *SKIP to 1item 4d*

b. Does your ED's electronic medical record system include –

	Yes	No	Unknown	Turned off
(1) Patient demographic information?	1 ☐	2 ☐	3 ☐	4 ☐
(2) Computerized orders for prescriptions?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Are there warnings of drug interactions or contraindications provided?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Are prescriptions sent electronically to the pharmacy?	1 ☐	2 ☐	3 ☐	4 ☐
(3) Computerized orders for tests?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are orders sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐
(4) Lab results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are out of range levels highlighted?	1 ☐	2 ☐	3 ☐	4 ☐
(5) Imaging results?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are electronic images returned?	1 ☐	2 ☐	3 ☐	4 ☐
(6) Clinical notes?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – **(a)** Do they include medical history and follow-up notes?	1 ☐	2 ☐	3 ☐	4 ☐
(b) Do they include reminders for guideline-based interventions and/or screening tests?	1 ☐	2 ☐	3 ☐	4 ☐
(7) Public health reporting?	1 ☐	2 ☐	3 ☐	4 ☐
If Yes, ask – Are notifiable diseases sent electronically?	1 ☐	2 ☐	3 ☐	4 ☐

c. Are there any of the above features of your system that your ED does NOT use or has turned off?

1 ☐ Yes – *Please specify* ↙

FR NOTE – Indicate in item 14b, last column, any components turned off.

2 ☐ No
3 ☐ Unknown

d. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?

1 ☐ Yes
2 ☐ No
3 ☐ Maybe
4 ☐ Unknown

Section II – INDUCTION INTERVIEW – Continued

13. Now I would like to make arrangements to obtain the information needed for sampling. I will need to (know/verify) how your (emergency department/(and) outpatient department) (is/are) organized and obtain an estimate of the number of patient visits expected during the 4-week reporting period. Would you prefer I (get/verify) this information from you or someone else?

1 ☐ Respondent – *Go to Check Item C below*
2 ☐ Someone else – *Specify below* ↙

If different respondent(s), arrange to obtain data today if possible. Otherwise arrange an appointment with designated person(s). Briefly explain the study to the new respondent(s). Then proceed with Section III, Emergency Department Description or Section IV, Outpatient Department Description, as appropriate. Thank current respondent for his/her time and cooperation.

Name

Title

Department

Telephone number

Name

Title

Department

Telephone number

CHECK ITEM C

1 ☐ The hospital provides emergency services that are staffed 24 hours each day. (Yes in item 9a) –
GO to Section III, EMERGENCY DEPARTMENT DESCRIPTION on page 10.

2 ☐ The hospital DOES NOT provide emergency services that are staffed 24 hours each day. (No in item 9a) –
SKIP to Section IV, OUTPATIENT DEPARTMENT DESCRIPTION on page 14.

NOTES

Section III – EMERGENCY DEPARTMENT DESCRIPTION

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

(1) *If this hospital has previously participated, simply verify that the emergency service area(s) listed below (is/are) still operating in the hospital. If the hospital no longer operates one or more of the following emergency service areas, line through the appropriate service area(s). If new emergency service areas have been added, record the name(s), or other unique identifier(s) such as location, on the next available line.*

After verifying and/or updating the list below for the emergency department, request and record the ESA type in column (b) and the expected number of visits in column (c) for the 4-week reporting period for each emergency service area.

(2) *If this hospital has not previously participated, obtain a complete listing of all eligible emergency service areas along with their type and expected number of visits during the 4-week reporting period. Record this information in columns (a), (b), and (c) below.*

FR NOTE ESA types include:
- General
- Adult
- PED
- Urgi-/Fast track
- PSYC
- Trauma
- Other

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

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

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

CHECK ITEM C-1

Is the total number of expected ED visits during the reporting period between _____ and _____ ?

1 ☐ Yes – *SKIP to item 14a on page 12*
2 ☐ No, it is **MORE THAN** the range – *GO to a*
3 ☐ No, it is **LESS THAN** the range – *GO to b*

a. Is the number of expected visits to any of the ESAs more than twice the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have increased this year or were too low last year. – *Explain* ↙

2 ☐ No, the number of visits has not increased dramatically.

☆ *SKIP to item 14a on page 12*

b. Is the number of expected visits to any of the ESAs less than half of the number shown on last year's sampling plan?

1 ☐ Yes, this is correct, visits have decreased this year or were too high last year. – *Explain* ↙

2 ☐ No, the number of visits has not decreased dramatically.

NOTES