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1. Label

FORM **NHAMCS-101**
(11-15-2007)

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
2008 PANEL**

| 2a. Hospital contact information | | b. ED contact information | | c. OPD contact information | |
|--|-------------------------------|--|-------------------------------|--|-------------------------------|
| Name | RECORD ON CONTROL CARD | Name | RECORD ON CONTROL CARD | Name | RECORD ON CONTROL CARD |
| 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 | | 4. Record of telephone calls | | | |
|--|---------|-------------------------------------|------|------|---------|
| | | Call | Date | Time | Results |
| Telephone screener | FR Code | 1 | | | |
| Hospital induction | FR Code | 2 | | | |
| ED/OPD inductions | FR Code | 3 | | | |
| | | 4 | | | |

5. Final outcome of hospital screening

1 Appointment

| | | | |
|-----|------|------|--------------|
| Day | Date | Time | a.m. p.m. |
|-----|------|------|--------------|

2 Noninterview – Complete sections V and VI, beginning on page 18.

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

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*

INTRODUCTION 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:

INTRODUCTION 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 hospital owned, operated, or managed by a health care corporation that owns multiple health care facilities (eg., HCA or Health South)?

- 1 Yes
- 2 No
- 3 Unknown

d. Is this a teaching hospital?

- 1 Yes
- 2 No

e. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years?

- 1 Yes, merged
 - 2 Yes, separated
 - 3 No
 - 4 Unknown
- } *SKIP to item 9 on page 4*

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

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

Hospital name
 Number and street
 City State ZIP Code

RECORD ON CONTROL CARD

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 <input type="checkbox"/> Yes – <i>SKIP to item 9c</i> 2 <input type="checkbox"/> No |
| b. Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |
| c. What is the trauma level rating of this hospital? | 1 <input type="checkbox"/> Level I 3 <input type="checkbox"/> Level III 5 <input type="checkbox"/> Other/unknown 2 <input type="checkbox"/> Level II 4 <input type="checkbox"/> Level IV or V 6 <input type="checkbox"/> None |

| | |
|---|---|
| 10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No – <i>SKIP to CHECK ITEM B</i> |
| b. Does this OPD include physician services? | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No |

| | | |
|---|---------------------|-------------------------------|
| c. This year we are conducting a special supplement on pandemic and emergency response preparedness and would like to have the name of the person responsible for your hospital's emergency response plan. | CONTACT INFORMATION | |
| | Name | RECORD ON CONTROL CARD |
| | Title | |
| Telephone <small>Area Code and Number</small> | | |

| | |
|---------------------|---|
| CHECK ITEM B | <i>Mark (X) all that apply.</i> |
| | 1 <input type="checkbox"/> ED meets eligibility requirements (item 9a is YES) |
| | 2 <input type="checkbox"/> OPD meets eligibility requirements (item 9a is NO and item 9b is YES, or items 10a and b are YES) |
| | 3 <input type="checkbox"/> Hospital is ineligible because it is not licensed (item 8a is NO) – <i>Go to CLOSING STATEMENT B1 below.</i> |
| | 4 <input type="checkbox"/> Hospital is ineligible because it has NEITHER an ED nor OPD (items 9a, 9b, and 10a and/or 10b are NO) – <i>Go to CLOSING STATEMENT B2 below.</i> |

| | | |
|-----------------------|---|---|
| CHECK ITEM B-1 | Hospital refused <input checked="" type="checkbox"/> | |
| | 1 <input type="checkbox"/> Yes – <i>SKIP to item a</i> | |
| | 2 <input type="checkbox"/> No – <i>SKIP to Part C. STUDY DESCRIPTION on page 5</i> | |
| | 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 <input type="checkbox"/> Yes – [] expected visits 2 <input type="checkbox"/> 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 <input type="checkbox"/> Yes – [] expected visits 2 <input type="checkbox"/> 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 19.

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 18.**

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 18.**

Section I – TELEPHONE SCREENER – Continued

Part C. STUDY DESCRIPTION

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

INSTRUCTIONS

Provide the administrator or other 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, Federation of American Hospitals
(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 or SEPARATED from 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 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! 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 and time of appointment in item 5, page 1; and terminate telephone call.

NOTES

Blank lined area for 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 6 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

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 | Record on Control Card |
| Title | |
| Department | |
| Telephone number | |
| Name | Record on Control Card |
| Title | |
| Department | |
| Telephone number | |

- 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.

INSTRUCTION:

- Only record generic ESA names in column (a) (e.g., pediatric emergency department). If the ESA has a formal/proper name, enter a generic name in (a) and record the Line No. and the formal/proper name on page 2 of the control card.

| FR NOTE | ESA types include: | | | | |
|--------------------|---|-----------------------------|--|------------------------------|--------------------------------|
| | • General • Adult | • PED • Urgi-/Fast track | • PSYC • Trauma | • Other | |
| Line No. | Emergency service area name (Generic) (a) | ESA type (b) | Expected No. of visits from <input style="width: 40px;" type="text"/> to <input style="width: 40px;" type="text"/> (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 item a
- 3 No, it is **LESS THAN** the range - SKIP to item 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

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

| | | | | | |
|--|---|---|----------------------------|----------------------------|----------------------------|
| Now I would like to ask you some questions about your ED. | | | | | |
| 14a. Does your ED use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)? | | 1 <input type="checkbox"/> Yes, all electronic 2 <input type="checkbox"/> Yes, part paper and part electronic 3 <input type="checkbox"/> No 4 <input type="checkbox"/> Unknown | | | |
| b. Does your ED have a computerized system for – | | Yes | No | Unknown | Turned off |
| (1) Patient demographic information? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Does this include patient problem lists? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (2) Orders for prescriptions? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | (a) Are there warnings of drug interactions or contraindications provided? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| | (b) Are prescriptions sent electronically to the pharmacy? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (3) Orders for tests? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Are orders sent electronically? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (4) Viewing of lab results? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Are out of range levels highlighted? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (5) Viewing of imaging results? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Are electronic images returned? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (6) Clinical notes? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Do they include medical history and follow-up notes? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (7) Reminders for guideline-based interventions and/or screening tests? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (8) Public health reporting? | | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> | Are notifiable diseases sent electronically? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| c. Are there any of the above features of your system that your ED does NOT use or has turned off? | | 1 <input type="checkbox"/> Yes FR NOTE – Indicate in item 14b, last column, any components turned off. 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown | | | |
| d. Are there plans for installing a new EMR system or replacing the current system within the next 3 years? | | 1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Maybe 4 <input type="checkbox"/> Unknown | | | |

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

| | |
|--|--|
| <p>14e. Does your ED have an observation or clinical decision unit?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown } <i>SKIP to item 14g</i></p> |
| <p>f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?</p> | <p>1 <input type="checkbox"/> Part of the ED 2 <input type="checkbox"/> Part of the inpatient side of the hospital 3 <input type="checkbox"/> Unknown</p> |
| <p>g. Are admitted ED patients ever "boarded" for more than 2 hours in the ED while waiting for an inpatient bed?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>h. If the ED is critically overloaded, are admitted ED patients ever "boarded" in inpatient hallways or in another space outside the ED?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>i. What is the total number of hours that your hospital's ED was on ambulance diversion in 2007?</p> | <p><input type="text"/> Total number of hours 1 <input type="checkbox"/> Data not available 2 <input type="checkbox"/> ED did not go on ambulance diversion in 2007 – <i>SKIP to item 14l</i></p> |
| <p>j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>l. In the last two years, has your ED increased the number of standard treatment spaces?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>m. In the last two years, has your ED's physical space been expanded?</p> | <p>1 <input type="checkbox"/> Yes – <i>SKIP to item 14o</i> 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>n. Do you have plans to expand your ED's physical space within the next two years?</p> | <p>1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown</p> |
| <p>o. Which of the following procedures does your ED use?</p> <p><i>Show flashcard on page 27 of the NHAMCS-124.</i></p> <p><i>Mark (X) all that apply.</i></p> | <p>1 <input type="checkbox"/> Bedside registration 2 <input type="checkbox"/> Computer-assisted triage 3 <input type="checkbox"/> Separate fast track unit for nonurgent care 4 <input type="checkbox"/> Separate operating room dedicated to ED patients 5 <input type="checkbox"/> Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources) 6 <input type="checkbox"/> Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment) 7 <input type="checkbox"/> Zone nursing (i.e., all of a nurse's patients are located in one area) 8 <input type="checkbox"/> "Pool" nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand) 9 <input type="checkbox"/> Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed) 10 <input type="checkbox"/> None of the above</p> |

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 10a or 10b) – *SKIP to Section V, DISPOSITION AND SUMMARY on page 18.*

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 (d) on the next page.

NOTES

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Section IV - OUTPATIENT DEPARTMENT DESCRIPTION - Continued

**FR
NOTE**

OPD Specialty Groups include:

- **GM** - General Medicine
- **SURG** - Surgery

- **PED** - Pediatrics
- **OBG** - Obstetrics/Gynecology

- **SA** - Substance Abuse
- **OTHER** - Other

INSTRUCTIONS

- Only record generic clinic names in column (a) (e.g., pediatric clinic). If the clinic has a formal/proper name, enter a generic clinic name in (a) and record the Line No. and the formal/proper name on page 2 of the control card.
- Complete columns (b) and (c) using pages 7 to 17 of the NHAMCS-124, Sampling and Information Booklet. Complete columns (e) and (f) after developing the sampling plan. See page 4 of the NHAMCS-124 for instructions.

| Line No. | Outpatient department clinic name (Generic) (a) | Specialty group (b) | NHAMCS-124 Specialty Group Scope (c) | Expected No. of visits from <input style="width: 40px;" type="text"/> to <input style="width: 40px;" type="text"/> (d) | Take every number (e) | Random start number (f) |
|----------------|---|------------------------|--|--|--------------------------|----------------------------|
| 1 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 2 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 3 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 4 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 5 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 6 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 7 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 8 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 9 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 10 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 11 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 12 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 13 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 14 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| 15 | | | <input type="checkbox"/> In-Scope <input type="checkbox"/> Out-of-Scope | | | |
| TOTAL → | | | | | | |

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

**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 18*

**CHECK
ITEM D1**

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

and **?**

- 1 Yes – *SKIP to 14p on page 17.*
- 2 No, it is **MORE THAN** the range – *GO to item a*
- 3 No, it is **LESS THAN** the range – *SKIP to item 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 item 14p 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.

Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued

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

14p. Does your OPD use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)?

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

q. Does your OPD have a computerized system for –

| | Yes | No | Unknown | Turned off |
|--|----------------------------|----------------------------|----------------------------|----------------------------|
| (1) Patient demographic information? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Does this include patient problem lists? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (2) Orders for prescriptions? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> (a) Are there warnings of drug interactions or contraindications provided? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (b) Are prescriptions sent electronically to the pharmacy? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (3) Orders for tests? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Are orders sent electronically? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (4) Viewing of lab results? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Are out of range levels highlighted? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (5) Viewing of imaging results? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Are electronic images returned? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (6) Clinical notes? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Do they include medical history and follow-up notes? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (7) Reminders for guideline-based interventions and/or screening tests? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| (8) Public health reporting? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| <i>If "Yes," ask –</i> Are notifiable diseases sent electronically? | 1 <input type="checkbox"/> | 2 <input type="checkbox"/> | 3 <input type="checkbox"/> | 4 <input type="checkbox"/> |

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

- 1 Yes
- FR NOTE** – *Indicate in item 14q, last column, any components turned off.*
- 2 No
- 3 Unknown

s. 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 V – DISPOSITION AND SUMMARY

AMBULATORY UNIT CHECKLIST

• COMPLETE 15a FOR **EMERGENCY DEPARTMENT ONLY**

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

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 ↴

• COMPLETE 15b FOR **OUTPATIENT DEPARTMENT ONLY**

b. How many clinics were selected for sample?

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 ↴

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 } SKIP to item 17c
 2 Some eligible units completed Patient Record Forms } GO to Item 17b
 3 Hospital refused } Complete Section VI,
 4 Hospital closed } NONINTERVIEW on page 19
 5 Hospital ineligible }

b. NATURE OF REFUSAL

Mark (X) all that apply.

- 1 Entire ED refused
 2 Entire OPD refused
 3 Some ESAs refused
 4 Some clinics refused

c. DISPOSITION OF NHAMCS-907 Pandemic and Emergency Response Preparedness Supplement

- 1 Completed
 2 Refused
 3 Not applicable

FR NOTE – If one or more responses are marked in 17b, complete Section VI, NONINTERVIEW on page 19. If no responses marked, END INTERVIEW.

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
- (2) During the hospital induction
- (3) During the ED/OPD induction
- (4) After the ED/OPD induction, but prior to assigned reporting period
- (5) During the assigned reporting period

| | | |
|----------------------------|----------------------------|----------------------------|
| 1 <input type="checkbox"/> | | |
| 2 <input type="checkbox"/> | | |
| 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 4 <input type="checkbox"/> | 4 <input type="checkbox"/> | 4 <input type="checkbox"/> |
| 5 <input type="checkbox"/> | 5 <input type="checkbox"/> | 5 <input type="checkbox"/> |

b. By whom?

- (1) Hospital administrator
- (2) ED/OPD director
- (3) Approval board or official
- (4) Other hospital official

| | | |
|---|---|---|
| 1 <input type="checkbox"/> | 1 <input type="checkbox"/> | 1 <input type="checkbox"/> |
| 2 <input type="checkbox"/> | 2 <input type="checkbox"/> | 2 <input type="checkbox"/> |
| 3 <input type="checkbox"/> | 3 <input type="checkbox"/> | 3 <input type="checkbox"/> |
| 4 <input type="checkbox"/> Specify ↴ | 4 <input type="checkbox"/> Specify ↴ | 4 <input type="checkbox"/> Specify ↴ |

| | | |
|--|--|--|
| | | |
| | | |

(5) Was the refusal by telephone or in person?

| | | |
|--------------------------------------|--------------------------------------|--------------------------------------|
| 5 <input type="checkbox"/> Telephone | 5 <input type="checkbox"/> Telephone | 5 <input type="checkbox"/> Telephone |
| 6 <input type="checkbox"/> In person | 6 <input type="checkbox"/> In person | 6 <input type="checkbox"/> 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 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> Yes | 1 <input type="checkbox"/> Yes |
| 2 <input type="checkbox"/> No | 2 <input type="checkbox"/> No | 2 <input type="checkbox"/> No |

NOTES

Lined area for notes.