

**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 } END INTERVIEW  
2  Hospital not eligible }  
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
<b>(1)</b> During the telephone screening	1 <input type="checkbox"/>		
<b>(2)</b> During the hospital induction	2 <input type="checkbox"/>		
<b>(3)</b> During the ED/OPD induction	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
<b>(4)</b> After the ED/OPD induction, but prior to assigned reporting period	4 <input type="checkbox"/>	4 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(5)</b> During the assigned reporting period	5 <input type="checkbox"/>	5 <input type="checkbox"/>	5 <input type="checkbox"/>

**b.** By whom?

Mark (X) appropriate box(es)

	Hospital	ED	OPD
<b>(1)</b> Hospital administrator	1 <input type="checkbox"/>	1 <input type="checkbox"/>	1 <input type="checkbox"/>
<b>(2)</b> ED/OPD director		2 <input type="checkbox"/>	2 <input type="checkbox"/>
<b>(3)</b> Approval board or official	3 <input type="checkbox"/>	3 <input type="checkbox"/>	3 <input type="checkbox"/>
<b>(4)</b> Other hospital official	4 <input type="checkbox"/> Specify ↴	4 <input type="checkbox"/> Specify ↴	4 <input type="checkbox"/> Specify ↴

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

	Hospital	ED	OPD
5 <input type="checkbox"/> Telephone			
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			
2 <input type="checkbox"/> No			

**NOTICE** –Public reporting burden of this collection of information is estimated to average 60 minutes per response, including the 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 currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to CDC/ATSDR Reports Clearance Officer; 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

**Assurance of confidentiality** – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used only by persons engaged in and for the purpose of the survey and will not be disclosed or released to other persons or used for any other purpose without the consent of the individual or the establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m).

**1.** Label

FORM **NHAMCS-101**  
(10-16-2006)

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  
2007 PANEL**

<b>2a.</b> Hospital contact information	<b>b.</b> ED contact information	<b>c.</b> 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**

<b>3.</b> Field representative information	<b>4.</b> Record of telephone calls			
	Call	Date	Time	Results
Telephone screener Code	1			
Hospital induction Code	2			
ED/OPD inductions Code	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.*

**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.

<b>6. Did you receive the letter(s)?</b> <i>(If "No" or "DK," offer to send or deliver another copy)</i>	1 <input type="checkbox"/> Yes – Skip to Statement A 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Don't know
<b>7a. Let me verify that I have the correct name and address for your hospital. Is the correct name</b> <i>(Read name from item 1.)?</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No → Enter correct name ↴ <input type="text"/>
<b>b. Is your hospital located at</b> <i>(Read address from item 1.)?</i>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> No → Enter hospital location ↴ Number and street City State ZIP Code
<b>c. Is this also the mailing address?</b>	1 <input type="checkbox"/> Yes 2 <input type="checkbox"/> 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.

**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?

**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.

• 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?

**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.

FORMS COMPLETED

**16a.** Number of ED Patient Record Forms completed

**b.** Number of OPD Patient Record Forms completed

**17a.** FINAL DISPOSITION

Number of ESAs

1  Yes  
2  No – Explain ↴

  


Total Number of ESA Sampling Units

Number of Clinics

1  Yes  
2  No – Explain ↴

  


Total Number of Clinic Sampling Units

Number of ED PRFs

Number of OPD PRFs

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

Mark (X) all that apply.

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

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
<b>(1) Patient demographic information?</b>	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"/>
<b>(2) Orders for prescriptions?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>If Yes, ask – (a) Are there warnings of drug interactions or contraindications provided?</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<i>(b) Are prescriptions sent electronically to the pharmacy?</i>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(3) Orders for tests?</b>	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"/>
<b>(4) Viewing of lab results?</b>	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"/>
<b>(5) Viewing of imaging results?</b>	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"/>
<b>(6) Clinical notes?</b>	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"/>
<b>(7) Reminders for guideline-based interventions and/or screening tests?</b>	1 <input type="checkbox"/>	2 <input type="checkbox"/>	3 <input type="checkbox"/>	4 <input type="checkbox"/>
<b>(8) Public health reporting?</b>	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

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 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*

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

1  Yes  
 2  No  
 3  Unknown

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

Hospital name \_\_\_\_\_

Number and street \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP Code \_\_\_\_\_

**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    3  Level III    5  Other/unknown  
 2  Level II    4  Level IV or V    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 <input type="checkbox"/> At least one GM or OB/GYN clinic was selected for sample. 2 <input type="checkbox"/> No GM or OB/GYN clinics were selected for sample – SKIP to 14p		
	List the GM or OB/GYN clinics selected for sample and ask the clinic director this question. →	Does your clinic offer any type of cervical cancer screening?	
AU No.	Outpatient department clinic name	Eligibility	906 Disposition
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused
		1 <input type="checkbox"/> Yes – Leave NHAMCS-906 → 2 <input type="checkbox"/> No 3 <input type="checkbox"/> Unknown	1 <input type="checkbox"/> Completed on paper 2 <input type="checkbox"/> Completed on web 3 <input type="checkbox"/> Refused

NOTES

**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 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.

**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
- (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, 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 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

**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 (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 (a)	Specialty group (b)	NHAMCS-124 Speciality Group Scope (c)	Expected No. of visits	Take every number (e)	Random start number (f)
				from _____ to _____ (d)		
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			
<b>TOTAL</b> →						

**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**

**CHECK ITEM B3**

- 1  Check Item B = 1 (ED meets eligibility requirements)
- 2  Check Item B = 2, 3, or 4 (ED does NOT meet eligibility requirements) – *SKIP to Item 12 on page 8.*

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

**1 1 a. How many days in a week are elective surgeries scheduled?**

Number of days  
1  Unknown

**b. Does your hospital have a bed coordinator, sometimes referred to as a bed czar?**

- 1  Yes
- 2  No
- 3  Unknown

**C. How often are hospital bed census data available?**

*(Read answers categories.)*

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

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

**b. Does your ED have a computerized system for –**

Yes                      No                      Unknown                      Turned off

**(1)** Patient demographic information?

1                       2                       3                       4

*If Yes, ask –*

Does this include patient problem lists?

1                       2                       3                       4

**(2)** 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)** Orders for tests?

1                       2                       3                       4

*If Yes, ask –*

Are orders sent electronically?

1                       2                       3                       4

**(4)** Viewing of lab results?

1                       2                       3                       4

*If Yes, ask –*

Are out of range levels highlighted?

1                       2                       3                       4

**(5)** Viewing of 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 –*

Do they include medical history and follow-up notes?

1                       2                       3                       4

**(7)** Reminders for guideline-based interventions and/or screening tests?

1                       2                       3                       4

**(8)** 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
- 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      • PED                      • PSYC                      • Other
- Adult         • Urgi-/Fast track      • Trauma

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

**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

\_\_\_\_\_