**Section VI – NONINTERVIEW**

18. Where did the nonresponse occur?

<table>
<thead>
<tr>
<th></th>
<th>Hospital – Ask item 19</th>
<th>Clinic(s)</th>
<th>Emergency service area(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

SKIP to item 20

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

<table>
<thead>
<tr>
<th></th>
<th>Hospital closed</th>
<th>Hospital not eligible</th>
<th>Hospital refused – SKIP to item 20</th>
<th>Other – Specify</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

END INTERVIEW

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

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) During the telephone screening</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) During the hospital induction</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) During the ED/OPD induction</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>(4) After the ED/OPD induction, but prior to assigned reporting period</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>(5) During the assigned reporting period</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Mark (X) appropriate box(es)

b. By whom?

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Hospital administrator</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(2) ED/OPD director</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td></td>
<td>(3) Approval board or official</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>(4) Other hospital official</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Mark (X) appropriate box(es)

Was the refusal by telephone or in person?

<table>
<thead>
<tr>
<th></th>
<th>Telephone</th>
<th>In person</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Specify ☐ ☐ ☐

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

Was conversion attempted?

<table>
<thead>
<tr>
<th></th>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>(1) Yes</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>(2) No</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

Section I – TELEPHONE SCREENER

3. Field representative information

<table>
<thead>
<tr>
<th></th>
<th>Telephone screener Code</th>
<th>Hospital induction Code</th>
<th>ED/OPD inductions Code</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

4. Record of telephone calls

<table>
<thead>
<tr>
<th></th>
<th>Call</th>
<th>Date</th>
<th>Time</th>
<th>Results</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Telephone screener</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>Hospital induction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td></td>
<td>ED/OPD inductions</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Final outcome of hospital screening

<table>
<thead>
<tr>
<th></th>
<th>☐ Appointment</th>
<th>Day</th>
<th>Date</th>
<th>Time</th>
<th>a.m.</th>
<th>p.m.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>☐ Noninterview – Complete sections V and VI, beginning on page 19.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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.

6. Did you receive the letter(s)?
   (If "No" or "OK," offer to send or deliver another copy)
   □ Yes – Skip to Statement A
   □ No

7a. Let me verify that I have the correct name and address for your hospital. Is the correct name (Read name from item 1)?
   □ Yes
   □ No – Enter correct name

b. Is your hospital located at (Read address from item 1)?
   □ Yes
   □ No – Enter hospital location

   Number and street
   City
   State
   ZIP Code

c. Is this also the mailing address?
   □ Yes
   □ 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.
### Part A. Verification of Eligibility

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.

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?
- Yes
- No – SKIP to Check Item B on page 4

#### b. Is this hospital voluntary non-profit, government, or proprietary?
- Nonprofit (includes church-related, nonprofit corporation, other nonprofit ownership)
- State or local government (includes state, county, city, city-county, hospital district or authority)
- Proprietary (includes individually or privately owned, partnership or corporation)

#### c. Is this a teaching hospital?
- Yes
- No

#### d. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years?
- Yes, merged
- Yes, separated
- No
- 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?
- Yes
- No
- Unknown

#### f. What is the name and address of this OTHER hospital?
- Hospital name
- Number and street
- City
- State
- ZIP Code

### Part B. Verification of Eligibility – Continued

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:

#### 8a. Is this facility a licensed hospital?
- Yes
- No – SKIP to Check Item B on page 4

#### b. Is this hospital voluntary non-profit, government, or proprietary?
- Nonprofit (includes church-related, nonprofit corporation, other nonprofit ownership)
- State or local government (includes state, county, city, city-county, hospital district or authority)
- Proprietary (includes individually or privately owned, partnership or corporation)

#### c. Is this a teaching hospital?
- Yes
- No

#### d. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years?
- Yes, merged
- Yes, separated
- No
- 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?
- Yes
- No
- Unknown

#### f. What is the name and address of this OTHER hospital?
- Hospital name
- Number and street
- City
- State
- ZIP Code

---

**Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued**

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
<th>Unknown</th>
<th>Turned off</th>
</tr>
</thead>
<tbody>
<tr>
<td>q. Does your OPD have a computerized system for –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(1) Patient demographic information?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does this include patient problem lists?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are there warnings of drug interactions or contraindications provided?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(2) Orders for prescriptions?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are prescriptions sent electronically to the pharmacy?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(3) Orders for tests?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are orders sent electronically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(4) Viewing of lab results?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are out of range levels highlighted?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(5) Viewing of imaging results?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are electronic images returned?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(6) Clinical notes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Do they include medical history and follow-up notes?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(7) Reminders for guideline-based interventions and/or screening tests?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(8) Public health reporting?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>If Yes, ask –</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Are notifiable diseases sent electronically?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>r. Are there any of the above features of your system that your OPD does NOT use or has turned off?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>s. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---

**Section I – TELEPHONE SCREENER – Continued**

14p. Does your OPD use ELECTRONIC MEDICAL RECORDS (EMR) (not including billing records)?
- Yes, all electronic
- Yes, part paper and part electronic
- No
- Unknown

---

**Section IV – OUTPATIENT DEPARTMENT DESCRIPTION – Continued**

Now I would like to ask you some questions about your OPD.
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 – SKIP to Check Item B

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

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

Mark (X) all that apply.

1. ED meets eligibility requirements (item 9a is YES) – SKIP to Check Item B-1
2. OPD meets eligibility requirements (item 9a is NO) – 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

ED visits last year

Go to Section VI, NONINTERVIEW on page 20.

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
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
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 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?

<table>
<thead>
<tr>
<th>AU No.</th>
<th>Outpatient department clinic name</th>
<th>Eligibility</th>
<th>906 Disposition</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes – Leave NHAMCS-906</td>
<td>1</td>
<td>Completed on paper</td>
</tr>
<tr>
<td>2</td>
<td>No</td>
<td>2</td>
<td>Completed on web</td>
</tr>
<tr>
<td>3</td>
<td>Unknown</td>
<td>3</td>
<td>Refused</td>
</tr>
</tbody>
</table>

NOTEs
NOTES
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.

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

CHECK ITEM D-2
Hospital HAS MERGED with or SEPARATED from another in the past two years? (Item Bd is YES.)
☐ Yes – Go to CLOSING STATEMENT C1 below.
☐ 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.
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

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.

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Outpatient department clinic name</th>
<th>Specialty group</th>
<th>NHAMCS-124 Group Scope</th>
<th>Expected No. of visits from</th>
<th>Take every number</th>
<th>Random start number</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>In-Scope</td>
<td>In-Scope</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>In-Scope</td>
<td>In-Scope</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>In-Scope</td>
<td>In-Scope</td>
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<tr>
<td>4</td>
<td>In-Scope</td>
<td>In-Scope</td>
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<tr>
<td>5</td>
<td>In-Scope</td>
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<tr>
<td>6</td>
<td>In-Scope</td>
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<tr>
<td>7</td>
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<tr>
<td>8</td>
<td>In-Scope</td>
<td>In-Scope</td>
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<tr>
<td>9</td>
<td>In-Scope</td>
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<td>10</td>
<td>In-Scope</td>
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<tr>
<td>11</td>
<td>In-Scope</td>
<td>In-Scope</td>
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</tr>
<tr>
<td>12</td>
<td>In-Scope</td>
<td>In-Scope</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13</td>
<td>In-Scope</td>
<td>In-Scope</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>In-Scope</td>
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<td>In-Scope</td>
<td>In-Scope</td>
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</tbody>
</table>

TOTAL
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.

NOW I WOULD LIKE TO ASK YOU A FEW MORE QUESTIONS ABOUT YOUR HOSPITAL.

11a. How many days in a week are elective surgeries scheduled?

   Number of days
   1 Unknown

11b. Does your hospital have a bed coordinator, sometimes referred to as a bed czar?

   1 Yes
   2 No
   3 Unknown

11c. 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
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, ( ______ / ______ ).

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?
   - [ ] No
   - [ ] Yes – Specify the necessary steps below:

   -
   -
   -
   -
   -

PART C – SURVEY IMPLEMENTATION

f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?
   - [ ] Part of the ED
   - [ ] Part of the inpatient side of the hospital
   - [ ] Unknown

h. If the ED is critically overloaded, are admitted ED patients ever “boarded” in inpatient hallways or in another space outside the ED?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

i. What is the total number of hours that your hospital’s ED was on ambulance diversion in 2006?
   - [ ] Data not available
   - [ ] ED did not go on ambulance diversion in 2006 – SKIP to item 14j

j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

l. In the last two years, has your ED increased the number of standard treatment spaces?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

m. In the last two years, has your ED’s physical space been expanded?
   - [ ] Yes – SKIP to item 14o
   - [ ] No
   - [ ] Unknown

n. Do you have plans to expand your ED’s physical space within the next two years?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

o. Which of the following does your ED use?
   
   Show flashcard. Mark (X) all that apply.
   - [ ] Bedside registration
   - [ ] Computer-assisted triage
   - [ ] Separate fast track unit for nonurgent care
   - [ ] Separate operating room dedicated to ED patients
   - [ ] Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources)
   - [ ] Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)
   - [ ] Zone nursing (i.e., all of a nurse’s patients are located in one area)
   - [ ] “Pool” nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)
   - [ ] Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed)
   - [ ] None of the above

   - [ ] 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.
   - [ ] 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 19.
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)?

- Yes, all electronic
- Yes, part paper and part electronic
- No
- Unknown

b. Does your ED have a computerized system for –

(1) Patient demographic information?

- Yes
- No
- Unknown
- Turned off

(2) Orders for prescriptions?

- Yes
- No
- Unknown
- Turned off

(3) Orders for tests?

- Yes
- No
- Unknown
- Turned off

(4) Viewing of lab results?

- Yes
- No
- Unknown
- Turned off

(5) Viewing of imaging results?

- Yes
- No
- Unknown
- Turned off

(6) Clinical notes?

- Yes
- No
- Unknown
- Turned off

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

- Yes
- No
- Unknown
- Turned off

(8) Public health reporting?

- Yes
- No
- Unknown
- Turned off

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

- Yes
- No
- Unknown

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

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

- Yes
- No
- Maybe
- Unknown

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(s)] 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?

- Respondent – Go to Check Item C below
- 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.

1. **Name**
2. **Title**
3. **Department**
4. **Telephone number**

**Check Item C**

- 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.
- 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**
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.

<table>
<thead>
<tr>
<th>Line No.</th>
<th>Emergency service area name</th>
<th>ESA type</th>
<th>Expected No. of visits from __________ to __________</th>
<th>Take every number</th>
<th>Random start number</th>
<th>TOTAL ESA type</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
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<td></td>
<td></td>
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<td>2</td>
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<td>10</td>
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</tr>
</tbody>
</table>

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

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.

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.
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.

<table>
<thead>
<tr>
<th>FR No.</th>
<th>Emergency service area name</th>
<th>ESA type</th>
<th>Expected No. of visits from ________ to ________</th>
<th>Take every number</th>
<th>Random start number</th>
</tr>
</thead>
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<tr>
<td>TOTAL</td>
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</tbody>
</table>

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

CHECK ITEM C-1

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

☐ Yes — SKIP to item 14a on page 12
☐ No, it is MORE THAN the range – GO to a
☐ 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?

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

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

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?

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

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

NOTES
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?

Respondent – Go to Check Item C below
Someone else – Specify below

The hospital provides emergency services that are staffed 24 hours each day. (Yes in item 9a) –

The hospital DOES NOT provide emergency services that are staffed 24 hours each day. (No in item 9a) –

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.
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?
   - [ ] No
   - [ ] Yes – Specify the necessary steps below:

   [ ] ___ / ___
   [ ] [ ] Month
   [ ] [ ] Day

---

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14e. Does your ED have an observation or clinical decision unit?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown SKIPl to 14g

f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?
   - [ ] Part of the ED
   - [ ] Part of the inpatient side of the hospital
   - [ ] Unknown

12. Are there any additional steps needed to obtain permission for the hospital to participate in the study?
   - [ ] No
   - [ ] Yes – Specify the necessary steps below:

   [ ] ___ / ___
   [ ] [ ] Month
   [ ] [ ] Day

---

j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14e. Does your ED have an observation or clinical decision unit?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

h. If the ED is critically overloaded, are admitted ED patients ever “boarded” in inpatient hallways or in another space outside the ED?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14e. Does your ED have an observation or clinical decision unit?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

n. Do you have plans to expand your ED’s physical space within the next two years?
   - [ ] Yes – SKIP to item 14o
   - [ ] No
   - [ ] Unknown

---

Section III – EMERGENCY DEPARTMENT DESCRIPTION – Continued

14e. Does your ED have an observation or clinical decision unit?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

f. Is your observation or clinical decision unit administratively a part of the ED or the inpatient side of the hospital?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

j. Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

k. Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?
   - [ ] Yes
   - [ ] No
   - [ ] Unknown

---

o. Which of the following does your ED use?

Show flashcard. Mark (X) all that apply.

   1. [ ] Bedside registration
   2. [ ] Computer-assisted triage
   3. [ ] Separate fast track unit for nonurgent care
   4. [ ] Separate operating room dedicated to ED patients
   5. [ ] Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources)
   6. [ ] Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)
   7. [ ] Zone nursing (i.e., all of a nurse’s patients are located in one area)
   8. [ ] “Pool” nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)
   9. [ ] Full capacity protocol (i.e., allows some admitted patients to move from the ED to inpatient corridors while awaiting a bed)
   10. [ ] None of the above

---

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 19.
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

☐ Check Item B = 1 (ED meets eligibility requirements)
☐ 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.

11a. 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

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 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.

Line No. | Outpatient department clinic name | Specialty group | NHAMCS-124 Specialty Group Scope | Expected No. of visits | Take every number | Random start number |
---|---|---|---|---|---|---|
1 | | In-Scope | Out-of-Scope |
2 | | In-Scope | Out-of-Scope |
3 | | In-Scope | Out-of-Scope |
4 | | In-Scope | Out-of-Scope |
5 | | In-Scope | Out-of-Scope |
6 | | In-Scope | Out-of-Scope |
7 | | In-Scope | Out-of-Scope |
8 | | In-Scope | Out-of-Scope |
9 | | In-Scope | Out-of-Scope |
10 | | In-Scope | Out-of-Scope |
11 | | In-Scope | Out-of-Scope |
12 | | In-Scope | Out-of-Scope |
13 | | In-Scope | Out-of-Scope |
14 | | In-Scope | Out-of-Scope |
15 | | In-Scope | Out-of-Scope |

TOTAL
NOTES

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.
### 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?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes – SKIP to item 9c</td>
<td>No</td>
</tr>
</tbody>
</table>

**b. Does this hospital operate any emergency service areas that are not staffed 24 HOURS each day?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**c. What is the trauma level rating of this hospital?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Level I</th>
<th>Level II</th>
<th>Level III</th>
<th>Level IV or V</th>
<th>Other/Unknown</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

**10a. Does this hospital operate an organized outpatient department either at this hospital or elsewhere?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No – SKIP to Check Item B</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**b. Does this OPD include physician services?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**Check Item B**

Mark (X) all that apply.

1. ED meets eligibility requirements (item 9a is YES) — SKIP to Check Item B-1

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?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

**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?**

<table>
<thead>
<tr>
<th>Item</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Yes</td>
<td>No</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Item</th>
<th>ED visits last year</th>
<th>OPD visits last year</th>
</tr>
</thead>
</table>

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

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

- Yes, all electronic
- Yes, part paper and part electronic
- No
- Unknown

<table>
<thead>
<tr>
<th>Q. Does your OPD have a computerized system for –</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Patient demographic information?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(2) Orders for prescriptions?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(3) Orders for tests?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(4) Viewing of lab results?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(5) Viewing of imaging results?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(6) Clinical notes?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(7) Reminders for guideline-based interventions and/or screening tests?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>(8) Public health reporting?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>1</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>r. Are there any of the above features of your system that your OPD does NOT use or has turned off?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>s. Are there plans for installing a new EMR system or replacing the current system within the next 3 years?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

---

### 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 conducting an 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 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:

<table>
<thead>
<tr>
<th>8a. Is this facility a licensed hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>b. Is this hospital voluntary non-profit, government, or proprietary?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>c. Is this a teaching hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>d. Has this hospital either merged with or separated from any OTHER hospital in the past 2 years?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes, merged</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>e. Does YOUR hospital have its own medical records department that is separate from that of the OTHER hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>f. What is the name and address of this OTHER hospital?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hospital name</td>
</tr>
<tr>
<td>City</td>
</tr>
</tbody>
</table>
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 “OK,” offer to send or deliver another copy)
   □ Yes – Skip to Statement A
   □ No

7a. Let me verify that I have the correct name and address for your hospital. Is the correct name (Read name from item 1)?
    □ Yes □ No

7b. Is your hospital located at (Read address from item 1)?
    □ Yes □ No

7c. Is this also the mailing address?
    □ Yes □ No

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 VI – NONINTERVIEW

18. Where did the nonresponse occur?
   - Hospital – Ask item 19
   - Clinic(s)
   - Emergency service area(s) SKIP to item 20
   (Mark X) both boxes 2 and 3 if applicable

19. What is the reason the hospital did not participate in this study?
   - Hospital closed
   - Hospital not eligible
   - Hospital refused – SKIP to item 20
   - Other – Specify
   END INTERVIEW

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

<table>
<thead>
<tr>
<th>Mark (X) appropriate box(es)</th>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) During the telephone screening</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(2) During the hospital induction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(3) During the ED/OPD induction</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(4) After the ED/OPD induction, but prior to assigned reporting period</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(5) During the assigned reporting period</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

b. By whom?

<table>
<thead>
<tr>
<th>Mark (X) appropriate box(es)</th>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>(1) Hospital administrator</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(2) ED/OPD director</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(3) Approval board or official</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>(4) Other hospital official</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Specify</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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

| ☐ Telephone | ☐ In person | ☐ Telephone | ☐ In person |

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


### d. Was conversion attempted?

<table>
<thead>
<tr>
<th>Hospital</th>
<th>ED</th>
<th>OPD</th>
</tr>
</thead>
<tbody>
<tr>
<td>☐ Yes</td>
<td>☐ Yes</td>
<td>☐ Yes</td>
</tr>
<tr>
<td>☐ No</td>
<td>☐ No</td>
<td>☐ No</td>
</tr>
</tbody>
</table>

### Section I – TELEPHONE SCREENER

3. Field representative information

4. Record of telephone calls

<table>
<thead>
<tr>
<th>Call</th>
<th>Date</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Telephone screener</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Hospital induction</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ED/OPD inductions</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

5. Final outcome of hospital screening

| ☐ Appointment |

| ☐ Noninterview – Complete sections V and VI, beginning on page 19 |

| ☐ Number |

| ☐ Name |

| ☐ Title |

| ☐ Telephone number (Area code and number) |

| ☐ FAX number |

**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).