Attachment U. Pulling and Refiling Patient records

There is no form attached to this activity. The facility locates, pulls and refiles medical records only. The activity is described in this Instruction Booklet.

Form Approved OMB No. 0920-0278

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

NHAMCS-126

2009 NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

Ambulatory Surgery Center Instruction Booklet

Reporting Period

Data Collection Begins:	Data Collection Ends:

On the first day of data collection, begin completing Patient Record Forms with the _____ patient listed on the log for that day.

Select every _____ patient listed on the log during the rest of the reporting period.

Table of Contents

SECTION I IDENTIFICATION AND GENERAL INSTRUCTIONS/INFORMATION

A. Clinic name or description

B. Sampling

1. LISTING PATIENT VISITS - Keep daily lists of **all** patient visits beginning at midnight on the first date of the reporting period (provided on the cover of this booklet) and continuing through the last date of the reporting period (also provided on the cover). For additional information on how and who to list, refer to page 5 - "Listing Patient Visits" and page 6 - "Eligible Visits".

2. SELECTION OF PATIENT VISITS - Select a sample of patient visits following the instructions on the cover of this booklet. (See page 6 - "Sampling Procedures" for additional information on sampling patient visits.)

C. Patient Record Forms Numbers

1. Folio Number:

Additional Folio Number:

2. Contact the field representative when additional pads of Patient Record Forms are needed. **DO NOT USE A PAD THAT HAS BEEN ASSIGNED TO ANOTHER UNIT.**

3. Check the Patient Record Forms to make sure that they are yellow.

4. Instructions - General instructions for completing Patient Record forms are on page 8. Instructions for the individual items begin on page 9. Job Aids for completing the Patient Record forms are found in the NHAMCS-250, Job Aid Booklet.

D. Field Representative Information

Name

_____

Phone Number

_____

E. Other Contact

Name

_____

Phone Number

_____

SECTION II INTRODUCTION

Purpose and Background

Every year in the United States, there are approximately 235 million visits made to hospital emergency and outpatient departments, including ambulatory surgery centers. However, adequate data on the hospital component of ambulatory medical care did not exist until the initiation of the National Hospital Ambulatory Medical Care Survey (NHAMCS) by the Centers for Disease Control and Prevention's (CDC) National Center for Health Statistics (NCHS) in December 1991. This study is the principal source of information on the utilization of hospital emergency departments (EDs), outpatient departments (OPDs), and hospital-based ambulatory surgery centers which were added to NHAMCS in 2009. Moreover, it is the **only** source of nationally representative estimates on the demographic characteristics of outpatients, diagnoses, diagnostic services, medication therapy, and the patterns of use of emergency and outpatient services in hospitals which differ in size, location, and ownership. Data collected through this study are essential to plan health services, improve medical education, and determine health care workforce needs.

The study of hospital-based ambulatory care is one of several health care studies sponsored by the CDC's National Center for Health Statistics. The National Hospital Ambulatory Medical Care Survey complements the National Ambulatory Medical Care Survey which collects data on patient visits to physicians in office-based practices. The hospital study is now bridging the gap which existed in coverage of ambulatory medical care data and is further expanding its uses to include hospital-based ambulatory surgery centers. This need is further accentuated by the increasing efforts at cost containment, the rapidly aging population, the growing number of persons without health insurance, the introduction of new medical technologies, and the shift from hospital inpatient to outpatient surgery. The Federation of American Hospitals, the Surgeon General's Office, the Ambulatory Surgery Center Association, the American College of Surgeons, the American Health Information Management Association, the American Academy of Ophthalmology, and the Society for Ambulatory Anesthesia have endorsed this study. Letters of endorsement are provided in Exhibits A, B, C, D, E, F, and G on pages E-1 to E-7.

Scope

An annual sample of approximately 480 hospitals across the country is selected for participation in the National Hospital Ambulatory Medical Care Survey. Each hospital collects data for a specified 4-week period in the survey year. These hospitals are revisited in subsequent years to measure changes in the public's use of medical care services from year to year. Eligible hospitals consist of non-federal, short-stay, and general hospitals with emergency service areas, outpatient clinics, and/or ambulatory surgery centers.

The study includes a sample of ambulatory units, that is, emergency service areas, outpatient clinics, and ambulatory surgery centers, within each hospital. Medical care must be provided by or under the direct supervision of a physician for the unit to be considered eligible. Dental clinics, physical, speech, and occupational therapy, podiatry, optometry, social work, and other clinics where physician services are not typically provided are not included. Ancillary services, such as pharmacy, diagnostic x-ray, or radiation therapy are also excluded from the study. Private practice offices and facilities that might have some association with the hospital, but are not considered hospital clinics are ineligible.

Study Roles

The National Center for Health Statistics has contracted with the U.S. Census Bureau to implement the data collection activities for the National Hospital Ambulatory Medical Care Survey. Trained Census Bureau field representatives will:

- contact selected hospitals to screen them for eligibility and arrange an appointment with the hospital administrator or other designated representative to further discuss the study;
- assist the hospital as requested in obtaining necessary approval for participation in the study;
- obtain basic information on the hospital's emergency and outpatient departments and ambulatory surgery centers, and select the ambulatory care units to be included in the data collection;
- show hospital staff how to select a sample of patient visits and record the data; and
- monitor the data collection procedures during the reporting period.

We are asking the hospital staff to do the following two activities:

- select a sample of patient visits during a specific 4-week reporting period following the specific sampling guidelines provided; and
- complete a one-page form for each selected visit.

A Census Bureau field representative will visit each week to resolve any problems with sampling patient visits or completing Patient Record Forms, and to collect any forms already completed. If any problems arise, or assistance is otherwise needed between these weekly visits, contact the field representative or other contact (as listed in items D and E on page 1) immediately.

Data Uses

As mentioned earlier, the information collected on patient visits to hospital emergency, outpatient departments and ambulatory surgery centers through the National Hospital Ambulatory Medical Care Survey will complement the study of office-based ambulatory care and the study of inpatient care. When combined with surgical data from the National Hospital Discharge Survey (NHDS), The ambulatory surgery data collected here complements the inpatient surgery data obtained through the NHDS, and expands the coverage of the National Health Care Survey. The uses of data from a study covering both the office-based and ambulatory surgical segments of ambulatory care are shown in EXHIBIT C on page E-3. The list of data users is quite extensive and includes medical associations, universities and medical schools, and government agencies.

Authorization and Assurance of Confidentiality

The National Center for Health Statistics has authority to collect data concerning the public's use of physicians' services under Section 306 (b) (1) (F) of the Public Health Service Act (42 USC 242k).

Any information which could identify the hospital, participating ambulatory unit, or patient is held strictly confidential and seen only by those persons involved with the implementation of the National Hospital Ambulatory Medical Care Survey. Furthermore, the names or any other identifying information for individual patients are never collected. Assurance of confidentiality is provided to all respondents according to Section 308 (d) of the Public Health Service Act (42 USC 242m).

The requirements of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule on health information permits you to make disclosures of protected health information without patient authorization for (1) public health purposes, or (2) research that has been approved by an Institutional Review Board, or (3) under a data use agreement with NCHS. There are several things that you must do to assure compliance with the Privacy Rule including providing a privacy notice to your patients that indicates that patient information may be disclosed for either research or public health purposes, and a record that a disclosure of information to CDC for the NHAMCS was made. More specific information can be obtained about Privacy Rule disclosure requirements on our website mentioned below.

NHAMCS Participant Web Page

The National Center for Health Statistics has a web page devoted to the common questions and concerns of hospital staff participating in the National Hospital Ambulatory Medical Care Survey. The participant web site can be accessed by logging on to www.cdc.gov/nhamcs. Refer to EXHIBIT K on page E-12 for the Table of Contents.

SECTION III SAMPLING

Overview

The hospitals, hospital-based ambulatory surgery centers, and visits chosen for the study are selected by well-established statistical methods. The sample design is comprised of multiple stages to ensure that the sample of hospitals, ambulatory surgery centers, and visits selected are representative of those throughout the United States. The participation of each hospital is crucial, since each hospital in the sample represents many others in the country. All ambulatory surgery centers in a selected hospital are included in the study. In each of the ambulatory surgery centers, a sample of patient visits is chosen.

Keeping respondent burden and survey costs as low as possible are always important considerations when designing a study. Sampling allows us to make national estimates of the volume and characteristics of patient visits from a small sample of visits to hospital-based ambulatory surgery centers and hospitals, while reducing both the cost of the study and the work asked of the hospital staff. However, sampling procedures must be implemented accurately or large errors will result, adversely affecting the data. The National Center for Health Statistics selects the hospitals to be used for the study. The responsibility for sampling patient visits within the selected hospital-based ambulatory surgery centers lies with the hospital staff. Procedures for selecting patient visits have been designed to be simple and easy to implement. Census Bureau field representatives will instruct the hospital staff on these procedures.

Patient visits are systematically selected over the 4-week reporting period. The sampling procedures are designed so that on average, approximately 100 visits are selected from all ambulatory surgery centers combined. The sampled visits are spread over the ambulatory surgery centers, if the hospital has multiple ambulatory surgery centers. The number sampled for each ambulatory surgery center is dependent on the ambulatory surgery center's patient volume.

Listing Patient Visits

A daily listing of all patient visits must be kept or constructed by each participating unit so that a sample of visits can be selected using the prescribed methods. The list of patient visits may be taken from an operating room log or other source of recording patient visits. The order in which the patients are listed is not important. However, it is crucial to have a **complete** listing of all patients receiving treatment during all hours of operation. The list should include those patients who came without previously being scheduled, but it should exclude persons who canceled appointments or were "no shows," were originally admitted as inpatients, or were admitted through the emergency department. The Census Bureau field representative will review the method used for listing patient visits (or constructing patient lists) in each unit to determine if patient sampling can be done properly. In some instances, the Census Bureau field representative will provide an Optional Patient Log (EXHIBIT D on page E-4) to assist the ambulatory unit with visit sampling.

Once visit sampling begins, the order of the names must not change. Sampling procedures require that each visit be selected at a predetermined interval (for example, every 2nd patient, every 10th patient, every 15th patient, etc.). This is the "Take Every" pattern. If a patient is inserted into the list after sampling has already been done, the pattern will be off and the visits must be resampled.

Eligible Visits

A "visit" is defined as a direct, personal exchange between an ambulatory patient and a physician, or a staff member acting under the direct supervision of a physician, for the purpose of seeking care and rendering health services. Visits solely for administrative purposes and visits in which no medical care is provided are not eligible. The following are types of visits/contacts which should be **excluded:**

- persons who visit only to leave a specimen, pick up a prescription or medication, or other visit where medical care is not provided;
- persons who visit to pay a bill, complete insurance forms, or for some other administrative reason;
- telephone calls from patients; and
- visits by persons currently admitted as inpatients to any other health care facility on the premises, that is, the sample hospital.
- visits by persons who were originally admitted through the emergency department.
- visits by patients who left the hospital prior to the receipt of anesthesia and/or commencement of the procedure.

It may be helpful to provide a brief reason for the patient's visit on the patient visit list to ensure the exclusion of these visits from the sample. If you discover that an ineligible visit has been accidentally included in the sample and a Patient Record form has been completed, mark "VOID" across the front of the Patient Record form and continue to sample as normal.

Sampling Procedures

The 4-week reporting period for this unit is recorded on the cover of this booklet. It includes the date for beginning data collection, as well as the date for completing data collection. To determine which patient visit to sample first, refer to the instructions at the bottom of this booklet's cover. The first part of the instruction directs staff to begin with the patient listed on a specific line number of the log **on the first day of data collection**. Locate this patient visit on the list and mark the name to indicate that it is the first patient visit sampled.

To continue sampling, refer once again to the instructions on the cover. Select every nth patient. Continue counting down the patient list until you arrive at the nth patient name listed. This is the second patient selected for the sample. This process is repeated to select subsequent patient visits for the sample.

For example, if the sampling instructions indicate that you begin with the 3rd patient listed, and select every 15th patient, you would select the 3rd, 18th, 33rd and so forth. See EXHIBIT I on page E-10 for an Optional Patient Log marked with an example of a sampling pattern. **Be sure to follow the sampling pattern given on the cover of this booklet.**

After each selection, mark or circle the patient name to indicate its inclusion in the sample, and to indicate where to begin for sampling the next patient visit. This pattern of selecting every nth patient is

called the “Take Every” pattern. The pattern remains consistent throughout the remainder of the reporting period and should be followed continuously (from shift to shift, and day to day). Do not start fresh with a new "Start With" after the end of a shift or day.

SECTION IV COMPLETING PATIENT RECORD FORMS

Organizing Visit Sampling and Data Collection

A Patient Record form is completed for every patient visit selected in the sample during the 4-week reporting period. The Ambulatory Surgery Center Patient Record is a one-page form consisting of 9 items which require only short answers. It should take approximately six minutes to complete each form. These forms will require even less time to complete as staff become more familiar with the items. The sampling procedures are designed so that all of the ambulatory surgery centers combined will complete approximately 100 Patient Record forms during the reporting period. If multiple ambulatory surgery centers exist, forms are distributed among the various ambulatory surgery centers.

The Patient Record forms may be completed either during the patient's visit, immediately after the patient's visit, at the end of the shift, day, etc., or in some combination of these, whichever is most convenient for the staff. In some cases, a nurse or clerk may furnish the information for certain items prior to the patient's visit, leaving the remainder of the items to be completed by the attending health care provider during or immediately after the visit. In other situations, it may be more convenient to complete all records at the end of the shift or day by one designated person. Whatever method you choose, it is strongly suggested that the forms be completed at least on a daily basis. Retrieving the records at a later date may prove to be difficult and time-consuming. Also, patient information will be fresher in the minds of the staff in case clarification is needed.

Staff members completing Patient Record forms must be familiar with medical terms and procedures since most items on the form are clinical in nature. They must also know where to locate the information necessary for completing the forms. To ensure that complete coverage is provided for all shifts and days, the responsibility for data collection may require the participation of several staff. We ask that each participating hospital-based ASC appoint a Data Coordinator to coordinate the personnel involved in the study and their activities. The Data Coordinator's responsibilities will include supervising and/or conducting the selection of the sample visits and the completion of the Patient Record forms.

Prior to the clinic's assigned reporting period, the Census Bureau field representative will meet with the director of each ambulatory surgery center and discuss the organization of sampling and the process of completing the Patient Record forms. The director then determines which staff will be needed in the data collection activities. The Census Bureau field representative will train the staff on sampling and data collection.

Completing the Patient Record Form

The Ambulatory Surgery Center (ASC) Patient Record Form is a one-page form consisting of two sections separated by a perforated line. (See EXHIBIT J on page E-11 for an example of the ASC Patient Record Form.) The top section of the form contains two items of identifying information about the patient - the patient's name and the patient's medical record number. It is helpful to enter the information for these items immediately following the selection of the patient visit into the sample. The top section of the form remains attached to the bottom until the entire form is completed. To ensure patient confidentiality, hospital staff should detach and keep the top section before the Patient Record Forms are collected by the Census Bureau field representative. The Data Coordinator should keep this portion of the form for a period of four weeks following the reporting period. Should the field representative discover missing or unclear information while editing the forms, he or she may recontact the Data Coordinator to retrieve this information. The top section can be matched to the bottom by the seven-digit identification number printed on both sections of the form. The field representative will give you this identification number when requesting information.

The bottom section of the ASC form consists of 9 brief items designed to collect data on the patient's demographic characteristics, diagnosis, procedure, anesthesia, etc. Item-by-item instructions begin on page 9 of these instructions. To ensure patient confidentiality, please do not record any patient identifying information on the bottom portion of the form.

Each hospital-based ambulatory surgery center receives a folio containing a pad of Patient Record Forms specifically assigned to that center. An ample supply of forms is included in the event that some are damaged or destroyed, or the hospital-based ambulatory surgery center sees a much higher volume of patient visits than expected. Should the supply of forms for this hospital-based ambulatory surgery center run low, please contact the Census Bureau field representative or other contact provided in items D and E on page 1 of this booklet. **Do not borrow Patient Record Forms from other participating emergency service areas, clinics or ambulatory surgery centers in this hospital. Check the Patient Record Forms to make sure that they are yellow and have "Ambulatory Surgery Center" printed at the top.**

Item-by-Item Instructions and Definitions for Completing the ASC Patient Record Form

1. PATIENT INFORMATION

ITEM 1a. DATE OF VISIT

Record the month, day, and year of visit in figures, for example, 05/20/2009 for May 20, 2009.

ITEM 1b. ZIP CODE

Enter 5-digit ZIP Code from patient's mailing address.

ITEM 1c. DATE OF BIRTH

Record the month, day, and year of the patient's birth in figures, for example, 05/17/2007 for May 17, 2007. In the rare event the date of birth is unknown, the year of birth should be estimated as closely as possible. Enter 4-digit year.

ITEM 1d. SEX

Check the appropriate category based on observation or your knowledge of the patient or from information on the medical record.

ITEM 1e. ETHNICITY

Ethnicity refers to a person's national or cultural group. The ASC Patient Record Form has two categories for ethnicity, Hispanic or Latino and Not Hispanic or Latino.

Mark the appropriate category according to your hospital's usual practice or based on your knowledge of the patient or from information in the medical record. You are not expected to ask the patient for this information. If the patient's ethnicity is not known and is not obvious, mark the box which in your judgment is most appropriate. The definitions of the categories are listed below. Do not determine the patient's ethnicity from their last name.

	Ethnicity	Definition
1	Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin, regardless of race.
2	Not Hispanic or Latino	All other persons.

ITEM 1f. RACE

Mark all appropriate categories based on observation or your knowledge of the patient or from information in the medical record. You are not expected to ask the patient for this information. If the patient's race is not known or not obvious, mark the box(es) which in your judgment is (are) most appropriate. Do not determine the patient's race from their last name.

	Race	Definition
1	White	A person having origins in any of the original peoples of Europe, the Middle East or North Africa.
2	Black or African American	A person having origins in any of the black racial groups of Africa.
3	Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
4	Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5	American Indian or Alaskan Native	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

ITEM 1g. EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT

Mark ALL appropriate expected source(s) of payment.

	Expected Source(s) of Payment	Definition
1	Private insurance	Charges paid in-part or in-full by a private insurer (e.g., Blue Cross/Blue Shield) either directly to the hospital or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan.
2	Medicare	Charges paid in-part or in-full by a Medicare plan. Includes payments directly to the hospital as well as payments reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan.
3	Medicaid/SCHIP	Charges paid in-part or in-full by a Medicaid plan. Includes payments made directly to the hospital as well as payments reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid

	Expected Source(s) of Payment	Definition
		plan or the State Children's Health Insurance Program (SCHIP).
4	Worker's compensation	Includes programs designed to enable employees injured on the job to receive financial compensation regardless of fault.
5	Self-pay	Charges, to be paid by the patient or patient's family, which will not be reimbursed by a third party. "Self-pay" is perhaps a poor choice of wording since we really have no interest in whether the patient actually pays the bill. This category is intended to include visits for which the patient is expected to be ultimately responsible for most of the bill. DO NOT check this box for a co-payment or deductible.
6	No charge/Charity	Visits for which no fee is charged (e.g., charity, special research or teaching). Do not include visits paid for as part of a total package (e.g., prepaid plan visits and post-operative visits included in a surgical fee). Mark the box or boxes that indicate how the services were originally paid.
7	Other	Any other sources of payment not covered by the above categories, such as CHAMPUS, state and local governments, private charitable organizations, and other liability insurance (e.g., automobile collision policy coverage).
8	Unknown	The primary source of payment is not known.

ITEM 1h. Time

Record the hour and minutes for each phase of the surgical visit in (1)–(6). For example, enter 01:15 for 1:15 a.m. or 1:15 p.m. Also, check the appropriate box (a.m., p.m., or Military) when recording the times. It is important that this item be recorded correctly. Please pay special attention to the a.m., p.m., and Military boxes. Also, cross-check item (1) Time in to operating room with item (2) Time surgery began through item (6) Time out of postoperative care. For example, the time out of postoperative care should be after the time in to operating room.

2. FINAL DIAGNOSIS

As specifically as possible, list diagnoses related to this visit including chronic conditions.

(1) Primary
(2) Other
(3) Other
(4) Other
(5) Other

This is one of the most important items on the Patient Record Form. Item 2(1) refers to the provider's primary diagnosis for this visit. While the diagnosis may be tentative, provisional, or definitive, it should represent the provider's best judgment at this time, expressed in acceptable medical terminology including "problem" terms. If the patient was not seen by a physician, then the diagnosis by the main health care provider should be recorded.

Space has been allotted for four "other" diagnoses. If the hospital-based ASC coded the diagnoses using International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) codes and entered the codes on the face sheet, discharge summary/instructions or operative report, record these codes. **Do not provide ICD-9-CM codes instead of narratives, unless the narratives are not included in the medical record.**

3. EXTERNAL CAUSE OF INJURY

As specifically as possible, describe the injury that preceded the visit or the adverse effect that occurred during the visit.

Provide a brief description of the ***who, what, when, where, and why*** associated with the injury or the adverse effects of medical treatment or surgical procedures including adverse drug events (e.g., allergy to penicillin). Refer to page 2 in the NHAMCS-250, which is a Job Aid designed to assist you with Item 3 of the Patient Record form. Indicate the place of the injury (e.g., residence, recreation or sports area, street or highway, school, hospital, public building, or industrial place). Include any post-surgical complications and if it involved an implant, specify what kind. If safety precautions were taken, describe them (e.g., seat belt use). Be sure to include the mechanism that caused the injury (e.g., farm equipment, fire, arsenic, knife, pellet gun). If it was a work-related injury or poisoning, specify the industry of the patient's employment (e.g., food service, agricultural, mining, health services, etc.).

Describe in detail the circumstances that caused the injury (e.g., fell off monkey bars, motor vehicle collision with another car, spouse beaten with fists by spouse). Include information on the role of the patient associated with the injury (e.g., bicyclist, pedestrian, unrestrained driver or passenger in a motor vehicle, horseback rider), the specific place of occurrence (e.g., lake, school football field),

and the activity in which the patient was engaged at the time of the injury (e.g., swimming, boating, playing football).

Also include what happened to the patient and identify the proximate cause of the injury or injuries for which the patient sought treatment. The proximate cause of injury is the mechanism of injury that is temporarily or immediately responsible for the injury. An example is a laceration caused by a broken piece of glass. Include, in addition, the underlying or precipitating cause of injury (i.e., the event, mechanism, or external cause of injury that initiated and led to the proximate cause of injury). An example is a house fire that caused a person to jump out of the window. Both the precipitating or underlying cause (house fire) and the proximate cause (fall from roof) would be important to record. The National Center for Health Statistics will use the information collected to classify the cause of the injury using the International Classification of Diseases, Supplementary Classification of External Causes of Injury and Poisoning codes (ICD-9-CM E-Codes).

If the ASC coded the external cause of injury using ICD-9-CM E-Codes and entered the codes on the face sheet, discharge summary/instructions or operative report, record these codes. **Do not provide ICD-9-CM E-Codes instead of narratives, unless the narratives are not included in the medical record.**

Mark the "NONE" box, if the procedure is not related to a previous injury or an adverse effect did not occur during the visit.

---

4. PROCEDURES

As specifically as possible, list all diagnostic and surgical procedures performed during this visit.

Abstract the procedures from the face sheet or discharge summary dictated by the surgeon, although they may be listed on a variety of forms within the medical record. Transcribe the surgeon's exact wording for each procedure in the space provided. Report all procedures.

If a primary procedure is specified, enter the physician's exact terminology next to the caption "Primary" on the Patient Record Form. If the physician did not enter a primary procedure, record the first procedure shown as the primary procedure.

Next to "Other," enter all procedures listed, using the operating physician's exact wording. If the ASC coded these surgical procedures using ICD-9-CM and/or CPT-4 (Current Procedural Terminology, 4th Revision) and entered the codes on the face sheet, discharge summary/instructions or operative report, record these codes. **Do not provide codes instead of narratives unless the narratives are not included in the medical record.**

---

5. MEDICATIONS & ANESTHESIA

ITEM 5a. INCLUDE RX AND OTC DRUGS, ANESTHETICS, AND OXYGEN THAT WERE ORDERED, SUPPLIED, OR ADMINISTERED DURING THE VISIT OR AT DISCHARGE.

If medications or anesthetics were ordered, supplied, or administered at this visit, list up to 8 in the space provided using either the brand or generic names. Record the exact drug name (brand or generic) written on any prescription or on the medical record. Do not enter broad drug classes, such as "anesthetic," "laxative," "analgesic," or "antibiotic." If no medication or anesthetic was prescribed or provided, then mark (X) the "NONE" box and continue.

Medication and anesthesia, broadly defined, includes the specific name of any:

- prescription ***and*** over-the-counter medications, anesthetics, hormones, vitamins, immunizations, allergy shots, and dietary supplements.
- medications which the physician/provider ordered, supplied, or administered during the visit or at discharge.

For each medication or anesthetic, record if it was administered during the visit or at discharge.

ITEM 5b. TYPE OF ANESTHESIA

Record all of the types of anesthesia used during surgery when they are clearly documented in the record. Mark all that apply.

Type of Anesthesia	**Definition**
1 NONE	No medications or anesthesia were ordered, supplied, or administered during the visit.
2 General	General anesthesia causes the whole body to lose sensation. There are two ways that general anesthesia is administered. Inhalation is the most common form of general anesthesia in which the patient inhales gas or vapor. The other technique for administering general anesthesia is intravenously, where anesthetics are injected directly into a patient's vein.
3 Topical	Topical anesthesia numbs only part of the body. Feeling is numbed by temporarily blocking nerves at or near the site of the operation.
4 IV sedation	Intra-venous sedation.
5 MAC	Monitored Anesthesia Care uses sedatives and other agents, but the dosage is low enough that patients remain responsive and breathe

		without assistance. MAC is often used to supplement local and regional anesthesia, particularly during simple procedures and minor surgery.
Regional		
6	Epidural	Anesthesia is injected into the spine continuously or intermittently over a period of time.
7	Spinal	Anesthesia is injected into cerebrospinal fluid in a one-time procedure.
8	Retrobulbar block	Retrobulbar block a technique used in eye surgeries to immobilize the muscles around the eye and eliminate pain sensation..
9	Peribulbar block	Peribulbar block is a technique used in eye surgeries to immobilize the muscles around the eye and eliminate pain sensation.
10	Other block	Other type of block, not retrobulbar or peribulbar.
11	Other	Any other type of anesthesia not included in the above list.

6. PROVIDER(S) OF ANESTHESIA

If there is a clear indication in the medical record of the specialty of the person(s) administering anesthesia (Anesthesiologist, Certified Registered Nurse Anesthetist (CRNA), Surgeon), mark all that apply. If not indicated, mark "Unknown."

7. SYMPTOMS PRESENT DURING OR AFTER SURGERY

Mark all symptoms that were present during or after the procedure(s). Read through the progress or operative notes of the nurse or physician and the anesthesia notes to determine whether the patient had any of the symptoms listed.

8. DISPOSITION

Mark the appropriate box.

Many facilities do not record the patient's status or disposition on the chart. The information about the patient's disposition might be recorded only in the nurse's or physician's notes on the operative report or the discharge summary. In most situations, the patient will be discharged to their customary residence, but read the notes carefully to determine if the patient was admitted to the hospital. Mark the appropriate box to indicate the disposition of the patient upon discharge from the ambulatory surgery center.

	Disposition	Definition
1	Routine discharge to customary residence	Patient was discharged to their normal place of residence, i.e., home, nursing home, prison, etc.
2	Discharge to observation status	Patient was kept at the facility for up to 72 hours for observation but was not considered inpatients by the facility.
3	Discharge to post-surgical/recovery care facility	Patient was discharged to an organized recovery care center.
4	Admitted to hospital as inpatient	Patient was admitted to the hospital as an inpatient after the ambulatory surgical procedure was performed. If the patient was ORIGINALLY admitted as an inpatient, this case is out-of-scope. Record "O/S" on the Sample Listing Sheet, column (f), for the sampled case. In addition, record "O/S" at the top of the Patient Record form, giving an abbreviated reason for this, and discontinue abstracting for this sampled case.
5	Referred to ED	Patient was referred to an emergency department.
6	Surgery cancelled	Patient was a "no-show" or left prior to the receipt of anesthesia and/or commencement of the procedure.
7	Surgery terminated	Patient was scheduled for ambulatory surgery, appeared at the designated time, received anesthesia and/or began the procedure, but the procedure was terminated prior to completion.
8	Other	Status/disposition of the patient is something other than categories 1-7.
9	Unknown	Patient's disposition is not indicated.

9. FOLLOW-UP INFORMATION

Information on follow-up of the patient after they are discharged may be found in the discharge summary/instructions.

Most ambulatory surgery centers will contact the patient or the patient's caregiver within 24 hours after the surgery to make sure the patient is feeling okay and does not have any problems post-surgery. This phone call should be documented in the patient's medical record, typically in the discharge summary/instructions.

ITEM 9a. DID SOMEONE ATTEMPT TO FOLLOW-UP WITH THE PATIENT WITHIN 24 HOURS AFTER THE SURGERY?

If the medical record indicates that someone from the ambulatory surgery center attempted to contact the patient within 24 hours after the surgery, mark "Yes." If there is no indication that someone attempted to follow-up with the patient within 24 hours after the surgery, mark "No." Mark "Unknown" if it cannot be determined whether someone from the ambulatory surgery center attempted to contact the patient within 24 hours after the surgery.

ITEM 9b. WHAT WAS LEARNED FROM THIS FOLLOW-UP?

Use information in the medical record to complete this item and mark all that apply. If the medical record indicates that a message was left on an answering machine or voicemail and the patient did not return the call, then mark "Unable to reach patient."

Mark "Other" what was learned from the follow-up is something other than categories 1-6.

Mark "Unknown" if what was learned from the follow-up is not indicated.

*All names and examples referenced in this instruction booklet are fictional and in no way represent actual situations or individuals

EXHIBIT A

ENDORSEMENT LETTER FROM THE SURGEON GENERAL'S OFFICE

EXHIBIT B

ENDORSEMENT LETTER FROM THE FEDERATION OF AMERICAN HOSPITALS

EXHIBIT C

ENDORSEMENT LETTER FROM THE ASSOCIATION OF AMBULATORY SURGERY CENTERS

EXHIBIT D

ENDORSEMENT LETTER FROM THE AMERICAN COLLEGE OF SURGEONS

EXHIBIT E

ENDORSEMENT LETTER FROM THE AMERICAN HEALTH INFORMATION MANAGEMENT ASSOCIATION

EXHIBIT F

ENDORSEMENT LETTER FROM THE AMERICAN ACADEMY OF OPHTHALMOLOGY

EXHIBIT G

ENDORSEMENT LETTER FROM THE SOCIETY FOR AMBULATORY ANESTHESIA

EXHIBIT H

Illustrative Uses of NHAMCS Data

Health Care Facilities

Long Island Jewish Medical Center	Published article in *Clinical Infectious Diseases* on adherence to the Infectious Diseases Society of America guidelines in the treatment of urinary tract infection.
Kaiser Permanente	Studied the utilization of physician assistants and nurse practitioners in outpatient departments.
VA Greater Los Angeles Health Care System and the UCLA, Geffen School of Medicine	Examined the impact of the aging population on the demand for surgical procedures

Universities and Medical Schools

University of Pittsburgh	Published article in *Obstetrics and Gynecology* on evaluating the impact of diabetes on the provision of contraceptive counseling.
Vanderbilt University	Published article in *Pediatrics* on the national impact of universal childhood immunization with pneumococcal conjugate vaccine on U.S. outpatient visits.
University of Pittsburgh	Published an article in *American Journal of Obstetrics and Gynecology* on characteristics of patients seen and services provided in primary care visits in obstetrics and gynecology.
University of Rochester, School of Medicine	Published article in the *Archives of Pediatric and Adolescent Medicine* on national healthcare visit patters of adolescents; implications for delivery of new adolescent vaccines.
Ohio State University and University of Pittsburgh	Published article in *American Journal of Obstetrics and Gynecology* on ambulatory surgery for urinary incontinence in women over time.

Government Agencies

U.S. Congress	NHAMCS data were used in two reports to Congress – The National Healthcare Quality Report and the National Health Disparities Report.
Centers for Disease Control and Prevention	Requested that a supplement be added to the NHAMCS OPD to collect information on cervical cancer screening practices.

Centers for Disease Control and Prevention	Examined the number and rates of tubal sterilization in the US.
VA Medical Center	Published article in *Archives of Internal Medicine* on antibiotic treatment for urinary tract infections in women.

Broadcast and Print Media

U.S. News and World Report	Cited NHAMCS data on antibiotic prescriptions in an article on antibiotic resistance.

EXHIBIT I

OPTIONAL PATIENT LOG FORM (EXAMPLE)

EXHIBIT J

ASC PATIENT RECORD FORM

EXHIBIT K

NHAMCS PARTICIPANT WEB PAGE