Supporting Statement B for Request for Clearance:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

OMB No. 0920-0278

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B. Collections of Information Employing Statistical Methods

The primary goal of the National Hospital Ambulatory Medical Care Survey (NHAMCS) is to collect data on visits to emergency departments (EDs), outpatient departments (OPDs) and hospital-based and freestanding ambulatory surgery centers (ASCs). Based on data from the NHAMCS, the estimated total number of visits to hospital EDs and OPDs in 2007 was 206 million. According to the 2006 National Survey of Ambulatory Surgery (NSAS) report, there were 34.7 million surgery visits to hospital-based and freestanding ASCs. The NHAMCS uses a four-stage probability design based on samples of geographic Primary Sampling Units (PSUs), hospitals within PSUs, OPD clinics within hospitals, and patient visits within OPD clinics, ASC locations, and ED units.

1. Respondent Universe and Sampling Methods

The universe for the NHAMCS consists of non-Federal hospitals in the 50 states and District of Columbia which have six or more beds staffed for inpatient use which are either general hospitals or have an average length of stay for all patients of less than 30 days, but are not institutional hospitals. Until 2003, the hospital sampling frame was constructed from the SMG Hospital Market Database. Beginning with 2003, the sample frame sources are the annual "Verispan Healthcare Market Index" and Verispan's "Second Quarter, Hospital Market Profiling Solution." The initial NHAMCS sample of hospitals was selected in 1991 from the 1991 SMG data file. According to the 1991 SMG file, there were about 6,250 NHAMCS-eligible hospitals of which about 5,600 had EDs. The hospital sample was updated for 2001, 2004, and 2007 by extending the sampling process to new hospitals as if they had been in the sampling frame for 1991, when the original NHAMCS hospital sample was selected. The hospital universe and sample were most recently updated for the 2008-09 NHAMCS using hospital data from Verispan, L.L.C., specifically their "Healthcare Market Index, Updated May 15, 2006" and their "Hospital Market Profiling Solution, Second Quarter, 2006." These products were formerly known as the SMG Hospital Database. Using the 2006 data to update the sample allowed for the inclusion of hospitals that had opened or changed their eligibility status since the previous sample was updated for 2004. The sample will be updated in 2010.

The NHAMCS sample is a multi-stage design with a first stage sample of two of the four PSU panels in the 1985-94 National Health Interview Survey (NHIS).
The first-stage sample consists of 112 PSUs. From the sample PSUs, a stratified sample of approximately 600 hospitals was selected for the NHAMCS with hospital strata defined by whether hospitals had either EDs or OPDs according to the sampling frame data. Sample hospitals are randomly assigned to 16 4-week reporting periods as described below. We expect approximately 482 hospitals to be in-scope.

Hospitals

Non-Federal, short-stay, and general hospitals in the sample PSUs are eligible for inclusion in the sample. Institutional hospitals and hospitals with fewer than 6 beds for inpatient use are excluded from the sample. Hospitals are stratified by whether they have an ED and/or OPD vs. have neither an ED nor OPD and by certainty status (self representing vs. non-self representing) of the sample area for their location. Prior to sampling, hospitals are arrayed within PSUs by type of ownership (voluntary nonprofit, non-Federal government, proprietary) and size, where size is measured by combined volume of ED and OPD visits reported in the hospital sampling frame (constructed from SMG data through 2002 and from Verispan data starting in 2003). From the arrayed hospital list, five hospitals are selected in each PSU without replacement and with probability proportional to the visit volume. If there are five or fewer hospitals, then all hospitals in the PSU are selected.

A sample of approximately 600 hospitals is randomly divided into 16 groups of hospitals (i.e., 37-38 hospitals in each group) in order to avoid hospitals participating during the same time period each year. One hospital group is assigned to each of the four-week reporting periods during 2010 through 2011, meaning that each hospital will be inducted approximately every 15 months. Substitution of the reporting period is not permitted. The hospital response rate for the 2006 NHAMCS was 89% (weighted and unweighted). Based on the results of the 2006 NHAMCS, the projected unweighted and weighted response rates for 2010 are 87% and 89% for the ED and 80% and 82% for the OPD, respectively. The projected unweighted and weighted response rates for ASCs are 75% and 84%, respectively, based on 2006 NSAS response rates.

Outpatient Clinics, Emergency Service Areas, and Hospital-Based Ambulatory Surgery Centers

Within each selected hospital, outpatient departments, emergency departments, and hospital-based ambulatory surgery centers are inducted into the survey. For each OPD, a sample of clinics is selected if more than 5 clinics exist. Clinics are in-scope if ambulatory medical care is provided under the supervision of a physician and under the auspices of the hospital. Clinics providing only ancillary services, such as diagnostic X-rays or radiation therapy, are out-of-scope. Services provided in dental or dental surgery clinics, pharmacies, or other settings in which physician services are not typically provided also are out-of-scope. In addition, freestanding medical clinics or physician groups that are physically located within a hospital, but not affiliated with the hospital (i.e., the hospital basically serves as landlord) are out-of-scope since they are included in the National Ambulatory Medical Care Survey (NAMCS). Emergency services contracted by the hospital under the "hospital as landlord" arrangement, however, are eligible for the ED component of the study.

During the visit by a field representative to induct a hospital into the survey, a list of all outpatient clinics is obtained from the sample hospital. Hospitals may determine

what constitutes a distinct clinic differently, for example, by physical location within the hospital, staff providing the services, specialty or subspecialty, schedules, or patients' source of payment. Because of these differences, "separate clinics" in the NHAMCS are defined as the smallest administrative units for which the hospital keeps separate patient volume statistics. Each clinic's function, specialty, and expected number of visits during the assigned reporting period are also collected. This clinic frame is stratified by specialty: general medicine, surgery, pediatrics, obstetrics/gynecology, substance abuse, and other clinics. For sampling purposes, clinics with very low volumes are combined to form clinic sampling units of a minimum size. If a sample hospital has more than 5 clinic sampling units, then 2 units from each of the 6 specialty strata are selected with probability proportionate to the total expected number of visits to the clinics. If there are 5 or fewer clinic sampling units, then all are included in the sample. On average, hospitals in the sample have 3.6 clinics per OPD.

Within the hospital's ED, a list of all emergency service areas (ESAs) is obtained during the hospital induction interview. ESAs are defined as the smallest administrative unit of an ED where separate patient statistics are kept. It may be located on hospital grounds or operated off site by the hospital. The ED is treated as a separate stratum and all ESAs within a sample hospital are included.

The ambulatory surgery center (ASC) within hospitals is treated as a separate stratum. A list of ASC locations within the hospital and satellite locations is obtained during the hospital induction. In-scope locations include all dedicated ambulatory surgery rooms, cystoscopy and endoscopy units, cardiac catheterization labs, laser procedure, and pain block rooms. Out-of-scope locations include those dedicated exclusively to dentistry, podiatry, abortion, births, family planning, and small procedures (sometimes referred to as "lump and bump" rooms).

Freestanding ASCs

Ambulatory surgery centers that are not affiliated with a hospital are considered to be freestanding ASCs. The universe of freestanding ASCs includes ones that are regulated by the states or certified by the Centers for Medicare and Medicaid Services (CMS) for Medicare participation. Out-of-scope freestanding ASCs include those dedicated exclusively to dentistry, podiatry, abortion, births, and family planning. The sampling frame for the 2006 NSAS consisted of facilities listed in the 2005 Verispan Freestanding Outpatient Surgery Center Database and Medicare-certified facilities listed in the CMS Provider-of-Services (POS) file.

The 2010-12 sample of freestanding ASCs will be selected from the 2006 NSAS sample freestanding ASCs which are also located within the NHAMCS sample areas. The freestanding ASC sample will be stratified by 5 ASC specialty groups, i.e., general, multi-specialty, ophthalmic, gastroenterologic, and other. Freestanding ASCs will be inducted through a facility induction form that is similar to the hospital

induction form. A list of surgery locations within the facility and satellite locations will be obtained during the ASC induction.

Visits in all locations

Within sampling units, patient visits are systematically selected over the 4-week reporting period assigned to hospitals and freestanding ASCs. A visit is defined as a direct, personal exchange between an ambulatory patient and a physician, or a staff member acting under a physician's direction, for the purpose of seeking care and rendering health services. Visits solely for administrative purposes, such as payment of a bill, and visits in which no medical care is provided, such as visits to deliver a specimen, are out-of-scope.

Samples of approximately 100 visits are targeted from EDs and ASCs and 150-200 visits are targeted from OPDs. If there are more than five clinics in a hospital, then up to 30 visits are targeted from each clinic included in the survey. In clinics with volumes higher than these desired figures, visits are sampled by a systematic procedure which selects every nth visit after a random start. Sampling rates are determined from the expected number of patients to be seen during the reporting period and the desired number of sample records. This basic procedure is adapted, as necessary, to the record keeping systems of the particular hospitals. Previous studies found that many clinics keep their own logs which are used as the sampling frame for visits. In cases where such a log is not available, the field representative supplies the clinic with a visit log form which can be used to record patient names (Attachment K). The names of patients are kept confidential and forms containing names remain in the hospital.

The procedures used to select ambulatory surgery visits are the same as that for EDs and OPDs. Sampled visits will be drawn from all in-scope locations within a facility where ambulatory surgery is performed.

Cervical Cancer Screening

The Cervical Cancer Screening Supplement (CCSS) sample will use a three-stage probability design with samples of geographic Primary Sampling Units (PSUs), hospitals within PSUs, general medicine and obstetrics/gynecology clinics within OPDs. One form will be completed by each eligible clinic. The supplement collects only facility-level information.

2. Procedures for the Collection of Information

Training

Training in data collection procedures is conducted at different times with four different types of staff. Census Bureau Headquarters staff are responsible for training

the Regional Office staff. Regional Office staff have the primary responsibility for training the field representatives and supervising hospital data collection activities. Field representative training covers the following topics: inducting hospitals, confidentiality, Health Insurance Portability and Accountability Act (HIPAA), clinic sampling procedures, determination of the "take every" and "random start" numbers, instructing hospital staff, supervising patient visit sampling, editing completed forms, retrieving missing data, and medical record abstraction. Field representatives induct the hospitals and train the hospital staff on visit sampling and completion of the Patient Record forms. However, if hospital staff are unable to complete the forms, field representatives abstract the data.

Census Bureau Headquarters staff are responsible for writing the field manual which contains the following: the purposes of the survey; interviewing techniques; a description of the NHAMCS induction questionnaire and related forms; and the procedures for inducting hospitals, conducting hospital visits, sampling clinics, determining the take every and random start numbers, instructing hospital staff, supervising patient visit sampling, editing completed forms, and retrieving missing data (Attachment L).

Initial Contact

An introductory letter is sent from the Director of NCHS (Attachment F) to the chief executive officer of each sampled hospital or freestanding ASC. The letter describes the purpose of the survey, the authority for data collection, that participation is voluntary and that all collected information is confidential including the identity of the hospital [308(d) confidentiality requirements] or freestanding ASC. It also covers requirements related to Health Insurance Portability and Accountability Act (HIPAA). Patient names or other identifying information are not collected and at no time are the patients contacted to obtain information. Letters of endorsement by the American College of Emergency Physicians, Society for Academic Emergency Medicine, Emergency Nurses Association, American College of Osteopathic Emergency Physicians, American College of Surgeons (ACS), American Health Information Management Association (AHIMA), American Academy of Ophthalmology (AAO), Society for Ambulatory Anesthesia (SAMBA), and the Surgeon General (Attachment G) are included in the mailing.

Hospital Induction

The introductory letter is followed by a telephone call from the field representative to verify hospital eligibility for the survey and to arrange for an appointment with the chief executive officer, directors of the ED, OPD, and ASC, and whoever is designated as hospital coordinator for this survey. During the meeting, the field representative explains the purpose of the survey, describes the data collection methods and length of data collection, and obtains both general descriptive information about the organization of the ED, OPD, and ASC and specific information needed to sample ambulatory units within the hospitals. The NHAMCS-

101 Questionnaire (Attachment H) is administered to screen sample hospitals, verify the hospital sampling frame information, induct the sample hospitals, and obtain ED, OPD, and ASC data.

On the NHAMCS-101, item 14h was revised to ask for the type of physicians who make decisions for patients in this observation or clinical decision unit. Items 15a and b were added to ascertain if the hospital has satellite ambulatory surgery centers (ASC) and, if yes, their names and locations. Check Item F was added so that respondents with only one ASC location can skip the questions regarding the generation of a single log. A space was added for the name and telephone number of the ASC IT person; however, this will be recorded on the NHAMCS-101 Control Card.

The field representative explains the designated reporting period and the data collection methods, which may be either prospective or retrospective. In the prospective approach to data collection, the hospital/ASC staff sample patient visits, then complete the Patient Record forms, largely through observation, during or shortly after the sample visits. In the retrospective approach, hospital/ASC staff sample visits after the patients have been seen, then complete the Patient Record forms through medical record abstraction. Since hospital staff have experience abstracting data from medical records, they are encouraged to perform this task. However, field representatives may abstract the data if the hospital staff are too busy. Approximately 45% of ED records and 49% of OPD records require Census abstraction. It is expected that a third of ASC records will be abstracted by Census field representatives.

After the preliminary visit, the field representative contacts the hospital coordinator to review the sample selection and to arrange for induction of the sample ESAs, clinics, and ASC locations and for instruction of the hospital staff.

Outpatient Department Clinic, Emergency Service Area (ESA), and Hospital-Based Ambulatory Surgery Center (ASC) Induction

After the OPD clinics, emergency service areas (ESAs), and hospital-based ambulatory surgery locations are selected for each hospital, the field representative arranges for induction visits to the sampled OPD clinics, ESAs, and ambulatory surgery locations, through the hospital coordinator. At these visits, the purpose and uses of the survey data are explained, the visit sampling procedures and Patient Record forms are described, and an NHAMCS-101U - Ambulatory Unit Record (Attachment J) is completed for each clinic, ESA, and ambulatory surgery location selected for the sample. In some circumstances, a blank NHAMCS-103 Patient Visit Log (Attachment K) may be used by the hospital staff to record visits prior to sampling. In order to assure patient confidentiality, the NHAMCS-103 Patient Visit Log is not collected by the field representative, but retained by the hospital. The field representative uses the NHAMCS-124 Sampling & Information Booklet (Attachment L, to be later reprinted to reflect minor changes to ED and ASC PRFs) to determine

the "random start" and "take every" numbers for the clinics and emergency service areas. Hospital staff are responsible for sampling patient visits by using hospital logs or other records. The field representative assists when necessary.

Freestanding Ambulatory Surgery Center (ASC) Induction

The introductory letter (Attachment F) to the freestanding ambulatory surgery center director is followed by a telephone call from the field representative to verify ASC eligibility for the survey and to arrange for an appointment with the director and whoever is designated as ASC coordinator for this survey. During the meeting, the field representative explains the purpose of the survey and describes the data collection methods and length of data collection. The NHAMCS-101(FS) Induction Form (Attachment I) is administered to screen sample ASCs, verify ASC sampling frame information, induct the sample ASC locations, and obtain general descriptive information about the organization of the ASC.

Completion of Patient Record Forms

Staff are instructed how to complete each item by the field representative. Patient visit data are recorded for each sample visit using either the ED Patient Record form (PRF) (Attachment M), OPD PRF (Attachment N), or ASC PRF (Attachment O). Instructions on completing the PRFs and definitions of terms are provided in the NHAMCS-122 Emergency Service Area Instruction Booklet (Attachment Q), NHAMCS-123 Outpatient Department Clinic Instruction Booklet (Attachment R), and NHAMCS-126 Ambulatory Surgery Center Instruction Booklet (Attachment S).

The Patient Record forms for the NHAMCS routinely collect data on patient characteristics such as age, sex, race, and ethnicity, and visit characteristics such as date of visit, reason for visit in patient’s own words, physician diagnoses, medications provided or prescribed, and expected source of payment. Periodically specific items on diagnostic tests, procedures or non-medication therapies are added or deleted. There will be no changes to the 2010-2011 ED Patient Record (Attachment M) except for minor rewording of several checkboxes. In item 12, checkboxes 4 and 5 were modified, i.e., “triage” was substituted for “medical screening exam.” In item 13a, “or telemetry” was deleted from checkbox 2. The OPD Patient Record form (Attachment N**)** will be modified to include the return of the cancer stages checkboxes in item 5b and the radiation therapy checkbox in item 9. In item 12, checkbox 1 “No show/Left without being seen” was deleted. On the ASC Patient Record form (Attachment O), item 5a “Was oxygen administered during this visit?” was added. Also, the listing of medications and anesthetics was divided into two items, 5b and 5d. No change in burden is expected due to the modifications to the ED, OPD, and ASC Patient Record forms.

Cervical Cancer Screening Supplement

The Cervical Cancer Screening Supplement (CCSS) (Attachment T) to the OPD component of the NHAMCS will continue to be conducted. The supplement collects information on cervical cancer screening practices. When NHAMCS hospitals are contacted for participation, the OPD director will be asked which of the general medicine and obstetrics/gynecology clinics selected for sample performs cervical cancer screening. OPD representatives from these sampled clinics will then be asked to complete the CCSS as a self-administered form. Upon reviewing the introductory letter and questionnaire, the OPD representative will decide which clinician would be most appropriate to complete the supplement (i.e., a person who performs Pap tests or who is involved in setting practice guidelines). The respondent will be asked to complete the CCSS at the end of the 4-week reporting period, so as not to bias the data collected on the Patient Record form.

Monitoring Data Collection and Quality Control

Census Bureau Headquarters staff from the Demographic Surveys Division, Housing Surveys Branch, is responsible for overseeing the data collection. Census Bureau Headquarters staff, Field Division, is responsible for the supervision of staff in the Bureau's 12 Regional Offices who in turn supervise the field representatives.

The field representative visits the sampled ESAs, clinics, and ASC locations each week during the data collection period and maintains telephone contact with the staff involved in the data collection effort. An essential part of this effort is quality control which focuses on the completeness of the patient sampling frame, adherence to the sampling procedures, and assurance that a Patient Record form is completely filled out for every sample patient visit. The field representative reviews the log, or other records used for visit sampling, to determine if any cases are missing and also edits completed forms for missing data. Attempts are made to retrieve both missing cases and missing data on specific cases, either by consulting with the appropriate staff or, if possible, by reviewing the pertinent medical records. A record of this retrieval effort is also made.

Completed survey materials are sent on a weekly basis from the regional offices to the Census Bureau's National Processing Center (NPC) in Jeffersonville, Indiana. NPC is responsible for completing a quality control edit before packaging and shipping work to our contractor where further editing, coding and data entry are done. Keying and data entry activities are performed under contract. All medical and drug coding, as well as all data entry operations, are subject to quality control procedures —specifically, a 10-percent quality control sample of survey records are independently keyed and coded. Computer edits for code ranges and inconsistencies are also performed.

For some items, missing values are imputed by randomly assigning a value from Patient Record forms with similar characteristics. For the ED data, imputations for

birth year and sex are based on ED volume, geographic region, immediacy with which patient should be seen, and the three-digit ICD-9-CM code for primary diagnosis and for immediacy it is based on ED volume, region, and primary diagnosis. For the OPD data, all imputations are based on geographic region, OPD volume by clinic type, and the three-digit ICD-9-CM code for primary diagnosis. For the ASC data, all imputations will be based on geographic region, ASC volume, and the three-digit ICD-9-CM code for primary diagnosis.

Estimation Procedures

Separate national estimates will be produced for visits to hospital EDs, OPDs, and hospital-based and freestanding ASCs. The estimation procedure has three basic components: (a) inflation by reciprocals of the sampling selection probabilities, (b) adjustments for nonresponse, and (c) calibration ratio adjustment. Beginning in 1997, the calibration ratio adjustment for OPD estimates was replaced by an adjustment that controls for effects of rotating hospital sample panels into and out of the sample each year. (The full NHAMCS hospital and freestanding ASC samples are partitioned into 16 panels that are rotated into the sample over 16 periods of 4 weeks each so that only 13 panels are used in any one year.) Also, beginning with 1997 data, the sampling weights of some OPDs were permanently trimmed to prevent single OPDs from contributing more than 15% of their region's total to OPD visit estimates. For visits to EDs, the calibration adjustments are based on current ED visit counts recorded in the Verispan Healthcare Market Index and Verispan's "Second Quarter, Hospital Market Profiling Solution" for hospitals in the NHAMCS universe.

Separate national estimates for both hospital-based and freestanding ASCs will be produced. For the hospital-based and the freestanding ASC components of NHAMCS, the weighting will be similar to that used for visits to EDs described above.

Beginning in 2004, the nonresponse adjustment factor was changed to account for the seasonality of the reporting period. Extra weights for nonresponding hospitals were shifted to responding hospitals in reporting periods within the same quarter of the year. The shift in nonresponse adjustment did not significantly affect any of the overall annual estimates.

Sampling Errors

Standard errors are calculated using a first-order Taylor series approximation method as applied in SUDAAN variance software.

3. Methods to Maximize Response Rates and Deal with Nonresponse

Based on the results of the 2006 NHAMCS, the projected unweighted and weighted response rates for 2010 are 87% and 89% for the ED and 80% and 82% for the OPD,

respectively. The projected unweighted and weighted response rates for ASCs are 75% and 84%, respectively, based on 2006 NSAS response rates. Endorsements were solicited from several prominent national organizations, including the American College of Emergency Physicians, Society for Academic Emergency Medicine, Emergency Nurses Association, American College of Osteopathic Emergency Physicians, American College of Surgeons (ACS), American Health Information Management Association (AHIMA), American Academy of Ophthalmology (AAO), Society for Ambulatory Anesthesia (SAMBA), and the Surgeon General. NCHS developed a participant web page at www.cdc.gov/nhamcs, which gives a brief background on the NHAMCS, as well as provides information regarding selection and participation, confidentiality and privacy, the HIPAA Privacy Rule, new data components, data utilization, and contact information.

Data collection procedures are designed to minimize response burden, a major concern and influence on response rates. This survey does require commitment from a large number of persons within each hospital and freestanding ASC, including the director, clinic, ESA, and ASC directors, and medical and clerical staff. Refusals to participate may occur at any one of the stages of induction or data collection. At the time of refusal, a refusal report is completed and the Census Bureau Regional Office is notified. Reasons for refusal vary considerably, necessitating refusal conversion procedures which are flexible and responsive to individual concerns. In general, the following survey features are stressed: the data are needed by the hospital and medical professions for a variety of purposes and do not exist elsewhere; all data about hospitals, clinics, and patients are kept confidential; and every effort is made to minimize the disruption of hospital routine. Based on earlier experiences, these features are often persuasive in converting refusals.

As described in Section A. 9, NCHS would like to offer modest monetary support upon request to hospitals and freestanding ASCs for pulling and refiling medical records, and performing data abstraction. During the 2006 NSAS, approximately 15% of participating facilities received some payment. This payment was only offered in cases where the facility would not have participated without it; therefore, response rates would have been lower without the reimbursement. Even with the payment option, the response rates for ASCs were about 75%, which is lower than those for OPDs and EDs. Payment will be offered to ASCs, OPDs and EDs as a last resort so as to treat each provider type the same.

4. Tests of Procedures or Methods to be Undertaken

In the 2010 NHAMCS, an experiment will be conducted among freestanding ASCs to determine if the response rate differs between a group that may receive payment upon request and a group that is denied payment when requested. Freestanding ASCs will be randomly assigned to one of thirteen 4-week reporting periods. When requested, payment will be provided to freestanding ASCs that fall into odd-numbered reporting periods, but denied to those participating during even-numbered reporting periods. Payment for facilities will be within the same range (updated by a small amount) as was approved previously for NSAS, that is, up to

$5 per record without obtaining special NCHS approval, and up to $7 with NCHS approval. If the facility just pulls the records, but does not actually do the abstracting, it will be paid $1 to $2 per record. This payment, if requested by the facility contact person as a requirement for survey participation, will be negotiated at the time of the facility's induction. Compensation for participants will not bias the responses to data items because the data are not subjective; data are abstracted from medical records and are not provided by a respondent as in population interview surveys. We will report to OMB a comparison of response rates between the groups that are and are not paid upon request.

This experiment was approved by the NCHS Research Ethics Review Board on May 6, 2009 under Protocol #2003-06, Amendment #11 (Attachment E.)

5. Individuals Consulted on Statistical Aspects and Individuals Collecting and/or Analyzing Data

The statistician responsible for the survey sample design is:
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ATTACHMENTS

A. Public Health Service Act, Section 306

B. List of NHAMCS Publications

C. Federal Register 60-Day Notice

D. List of Consultants for NHAMCS

E. CDC #2003-06 IRB Approval for Continuation of Protocol

F. (1) Introductory Letters to NHAMCS Hospitals

   (2) Introductory Letter to Free-standing ASCs

G. NHAMCS Endorsing Letters

H. NHAMCS-101 Hospital Induction Form

I. NHAMCS-101FS Free-standing Ambulatory Surgery Center Induction Form

J. NHAMCS-101U Ambulatory Unit Record.

K. NHAMCS-103 Patient Visit Log

L. NHAMCS-124 Sampling & Information Booklet

M. NHAMCS-100(ED) Emergency Department Patient Record form

N. NHAMCS-100(OPD) Outpatient Department Patient Record form

O. NHAMCS-100(ASC) Ambulatory Surgery Center Patient Record form

P. Pulling and Refiling Medical Records

Q. NHAMCS-122 Emergency Service Area Instruction Booklet

R. NHAMCS-123 Outpatient Department Clinic Instruction Booklet

S. NHAMCS-126 Ambulatory Surgery Center Instruction Booklet

T. NHAMCS-906 Cervical Cancer Screening Supplement