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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-122
(10/2008)

2009 NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

Emergency Service Area 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. Emergency service area 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 "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 Form Numbers

1. Folio Number:

3						

Additional Folio Number:

3						

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 olive green.

4. Instructions - General instructions for completing Patient Record forms are on page 7. 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, and hospital-based 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 (ASCs) 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 care data and is further expanding its uses. This need is further accentuated by the increasing efforts at cost containment, the rapidly aging population, the growing number of persons without health insurance, and the introduction of new technologies. The American College of Emergency Physicians, Society for Academic Emergency Medicine, Emergency Nurses Association, American College of Osteopathic Emergency Physicians, Surgeon General's Office, and Federation of American Hospitals have endorsed this study. (Letters of Endorsement are provided in EXHIBITS A, B, C, D, E, and F on pages E-1 to E-6.)

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 ambulatory medical care services from year to year. Eligible hospitals consist of non-federal, short-stay, and general hospitals with emergency service areas and/or 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 therapy, 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 the 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 and outpatient departments and ambulatory surgery centers through the National Hospital Ambulatory Medical Care Survey will complement the study of physician office-based ambulatory care. The uses of ED data are shown in EXHIBIT G on page E-7. The list of data users is quite extensive and includes medical associations, universities and medical schools, government agencies, broadcast and print media, and advocacy groups.

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 identifiable information will be held confidential and will only be used by NCHS staff, contractors, or agents, only when necessary and with strict controls, and will not be disclosed to anyone else without the consent of your hospital. By law, every employee as well as every agent has taken an oath and is subject to a jail term of up to five years, a fine up to $250,000, or both if he or she willfully discloses ANY identifiable information about your hospital's patients. 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 the hospital 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 J on page E-10 for the table of contents.

SECTION III SAMPLING

Overview

The hospitals, EDs, 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, EDs, 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. In each emergency service area, 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 EDs 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 emergency service areas 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 the emergency department. The sampled visits are spread over the emergency department, if the hospital has multiple emergency service areas. The number of visits sampled for each emergency service area is dependent on the area'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 arrival 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." 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 H on page E-8) 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 or e-mail messages from patients;
- visits by persons currently admitted as inpatients to any other health care facility on the premises, that is, the sample hospital.

It may be helpful to provide a brief reason for the patient's visit on the patient visit list/log to ensure the exclusion of these types of visits from the sample. If you discover that an ineligible visit has been accidentally included in the sample and a Patient Record form completed, write "VOID" in the white space of the top margin of the Patient Record form to the right of the “Incorrect” box. Do NOT write “VOID” ACROSS the Patient Record form for any reason.

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 start 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 H (page E-8) 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 sampling the next patient visit. The “Take Every” 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 ED Patient Record form is a single paged two-sided form consisting of 14 items which require only short answers. It should take approximately seven 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 an emergency department of average size will complete approximately 100 Patient Record forms during the reporting period. If multiple emergency service areas exist within the emergency department, fewer forms will be completed in each emergency service area with the total department completing 100 forms.

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 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 emergency service area 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 emergency service area's assigned reporting period, the Census Bureau field representative will meet with the director of each emergency service area 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 ED Patient Record form consists of two sections separated by a perforated line. (See EXHIBIT I on page E-9 for an example of the 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 (beginning with 3) printed on both sections of the form. The field representative will give you this identification number when requesting information.
The bottom section of the ED form consists of 14 items designed to collect data on the patient's demographic characteristics, reason for visit, diagnosis, etc. Item-by-item instructions begin on page 8 of this instruction booklet. To ensure patient confidentiality, please do not record any patient-identifying information on the bottom portion of the form.

Each emergency service area receives a folio containing a pad of Patient Record forms specifically assigned to that area. An ample supply of forms is included in the event that some are damaged or destroyed or the unit sees a much higher volume of patient visits than expected. Should the supply of forms for this emergency service area 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 or from outpatient department clinics or ambulatory surgery centers in this hospital. Check the Patient Record forms to make sure that they are shaded in olive green and have "Emergency Department" printed at the top.**

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

1. PATIENT INFORMATION

ITEM 1a. DATE AND TIME OF VISIT

(1) Arrival – Record the month, day, and 2-digit year of arrival in figures, for example, 05/17/09 for May 17, 2009. Record the hour and minutes when the patient first arrived. For example, enter 01:15 for 1:15 a.m. or 1:15 p.m. and check the appropriate box (a.m. or p.m. or Military). Enter the first time listed in the medical record (i.e., arrival/registration/triage).

(2) Seen by MD/DO/PA/NP – Record the month, day, and 2-digit year the patient was first seen by a physician, physician assistant, or nurse practitioner in figures, for example, 05/17/09 for May 17, 2009. Record the hour and minutes when the patient was first seen first by a physician, physician assistant, or nurse practitioner. For example, enter 01:45 for 1:45 a.m. or 1:45 p.m. and check the appropriate box (a.m. or p.m. or Military).

(3) ED discharge – Record the month, day, and 2-digit year the patient was discharged from the ED in figures, for example, 05/17/09 for May 17, 2009. Record the hour and minutes when the patient was discharged. For example, enter 04:30 for 4:30 a.m. or 4:30 p.m. and check the appropriate box (a.m. or p.m. or Military). The ED discharge time should accurately reflect the actual time that the patient left the ED.

It is important that this item be recorded correctly. Pay special attention to the Military, a.m., and p.m. boxes. Cross-check Arrival Time (item 1a(1)), Time seen by MD/DO/PA/NP (item 1a(2)), and ED discharge (item 1a(3)). For example, time of ED discharge should be after the time the patient entered ED.

ITEM 1b. ZIP CODE

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

ITEM 1c. DATE OF BIRTH

Record the month, day, and 4-digit year of the patient's birth in figures, for example, 06/26/2007 for June 26, 2007. In the rare event the date of birth is unknown, the year of birth should be estimated as closely as possible.

ITEM 1d. PATIENT RESIDENCE

	Residence	Definition
1	Private residence	The patient's current place of residence is a private home (such as an apartment, single-family home, townhouse, etc.). This includes the patient staying at the private home of a friend or relative. A P.O. box should be considered a private residence, unless there is information to the contrary.
2	Nursing home	The patient's current place of residence is a nursing home.
3	Homeless	The patient has no home (e.g., lives on the street) or patient's current place of residence is a homeless shelter.
4	Other	The patient's current place of residence is a hotel, college dormitory, assisted-living center, or an institution other than a nursing home (such as a prison, mental hospital, group home for the mentally retarded or physically disabled, etc.).
5	Unknown	If you cannot determine the patient's current residence, mark "Unknown."

ITEM 1e. SEX

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

ITEM 1f. ETHNICITY

Ethnicity refers to a person's national or cultural group. The ED 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 1g. 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, 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 Alaska 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 1h. ARRIVAL BY AMBULANCE

	Ambulance	Definition
1	Yes	The patient arrived in an ambulance, either air or ground. This includes private and public ambulances that can provide either Advanced Life Support or Basic Life Support.
2	No	The patient did not arrive by ambulance.
3	Unknown	The mode of arrival is unknown.

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

Mark the expected source or sources of payment that will pay for *this visit*. This information may be in the patient's file; however, in some hospitals, the billing information may be kept in the business office.

Mark **all** sources of payment that apply.

Primary Expected Source 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. Summacare is a health plan servicing the Akron, Ohio area and is sometimes utilized in lieu of Medicare for that area.
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 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" includes visits for which the patient is expected to be ultimately responsible for most of the bill, even though the patient never actually pays it. DO NOT check this box for a copayment 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, postoperative visits included in a surgical fee, and pregnancy visits included in a flat fee charged for the entire pregnancy). 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.

2. TRIAGE

ITEM 2a. INITIAL VITAL SIGNS

Record the following initial vital signs as assessed in triage:

(1) Temperature (check the appropriate box - degrees C or F).
(2) Heart rate – beats per minute.
(3) Respiratory rate – breaths per minute.
(4) Blood pressure – systolic and diastolic.
(5) Pulse oximetry (percent of oxyhemoglobin saturation; value is usually 80-100%).
(6) On oxygen (at time of arrival and/or before pulse oximetry was performed)
(7) Glasgow Coma Scale (range is 3-15; 3-8 indicates that patient is in a coma; 15 is normal).

ITEM 2b. TRIAGE LEVEL

Enter the triage level assigned by the triage nurse upon ED arrival. Most ED patients will be assigned a number from 1-5 with the lowest number indicating the most urgent cases. The triage level may be expressed as a Roman numeral.

Mark "No triage," if the emergency service area does not perform triage or the patient arrived DOA. Mark "Unknown,"if the triage level is unknown.

ITEM 2c. PAIN SCALE

Enter a number from 0 (no pain)-10 (worst pain imaginable) that indicates the level of the patient's pain at triage as recorded in the medical record. Mark "Unknown," if pain level is unknown.

The pain scale for children may consist of 6 faces (0=no hurt to 5=hurts worst). If this is used by the ED, then adapt it to the 11-point scale by multiplying the value on the faces scale by 2 (e.g., for 5 on the faces scale, enter 10). For 0 on the faces scale, enter 0.

3. PREVIOUS CARE

ITEM 3a. HAS PATIENT BEEN –

(1) SEEN IN THIS ED WITHIN THE LAST 72 HOURS?

Indicate whether the patient has been seen in this emergency department within the 72 hours prior to the current visit using the check boxes provided. If you are unable to determine whether the patient has been seen in this time period, please mark "Unknown."

(2) DISCHARGED FROM ANY HOSPITAL WITHIN THE LAST 7 DAYS?

Indicate whether the patient has been discharged from any hospital within the last 7 days prior to the current visit by using the check boxes provided. If you are unable to determine whether the patient was discharged from any hospital within the last 7 days, mark "Unknown."

ITEM 3b. HOW MANY TIMES HAS PATIENT BEEN SEEN IN THIS ED WITHIN THE LAST 12 MONTHS?

Record how many times the patient has been seen in this ED within the last 12 months. Do not include the current visit in your **total**. If you cannot determine how many past visits were made, mark "Unknown."

4. REASON FOR VISIT

ITEM 4a. PATIENT'S COMPLAINT(S), SYMPTOM(S), OR OTHER REASON(S) FOR THIS VISIT (*use patient's own words*.)

Enter the Patient's complaint(s), symptom(s), or other reason(s) for this visit ***in the Patient's own words***. Space has been allotted for the "most important" and two "other" complaints, symptoms, and reasons as indicated below.

(1) Most important
(2) Other
(3) Other

The ***Most Important*** reason should be entered in (1). Space is available for two other reasons in (2) and (3). By "most important" we mean the problem or symptom which, in the physician's judgment, was most responsible for the patient making this visit. Since we are interested only in the patient's ***most important complaints/ symptoms/ reasons,*** it is not necessary to record more than three.

This is one of the most important items on the Patient Record form. No similar data on emergency department visits are available in any other survey and there is tremendous interest in the findings. Please take the time to be sure you understand what is wanted--especially the following two points:

- We want the patient's principal complaint(s), symptom(s) or other reason(s) in the patient's own words. The physician may recognize right away, or may find out after the examination, that the real problem is something entirely different. In item 4a we are interested in how the patient defines the reason for the visit (e.g., "cramps after eating," "fell and twisted my ankle").

- The item refers to the patient's complaint(s), symptom(s), or other reason(s) for ***this visit.*** Conceivably, the patient may be undergoing a course of treatment for a serious illness, but if his/her principal reason for this visit is a cut finger or a twisted ankle, then that is the information we want.

There will be visits by patients for reasons other than some complaint or symptom. Examples might be follow-up for suture removal or recheck of a heart condition. In such cases, simply record the **reason for the visit**.

Reminder: If the reason for a patient's visit is to pay a bill, ask the physician to complete an insurance form, or drop off a specimen, then the patient is not eligible for the sample. A Patient Record form should not be completed for this patient.

ITEM 4b. EPISODE OF CARE

The "Episode of care" attempts to measure the nature of the care provided at the visit, an initial visit versus a follow-up visit. An episode of care begins with the initial visit for care for a particular problem and ends when the patient is no longer continuing treatment. A problem may recur later, but that is considered a new episode of care. An initial visit may be diagnostic in nature whereas a follow-up visit may be to check progress or continue therapy.

	Episode of care	**Definition**
1	Initial visit for problem	This is the FIRST VISIT by this patient for care of this particular problem or complaint.
2	Follow-up visit for problem	Care was previously provided for this problem. This is the second or subsequent visit for this problem or complaint.
3	Unknown	Cannot determine if this is the first or follow-up visit for this problem.

Visits for follow-up care for injuries such as removal of casts would be reported under "Follow-up visit." An initial visit for a new episode of a chronic problem flare-up would be listed under "Initial

visit" whereas a follow-up visit for a chronic problem flare-up would be listed under "Follow-up visit."

5. INJURY/POISONING/ADVERSE EFFECT

ITEM 5a. IS THIS VISIT RELATED TO AN INJURY, POISONING, OR ADVERSE EFFECT OF MEDICAL TREATMENT?

Mark the "Yes" or "No" box to indicate whether the patient's visit was due to any type of injury, poisoning, or adverse effect of medical treatment. The injury/poisoning/adverse effect does not need to be recent. It can include those visits for follow up of previously treated injuries and visits for flare-ups of problems due to old injuries. This not only includes injuries or poisonings, but also adverse effects of medical treatment or surgical procedures (e.g., unintentional cut during a surgical procedure, foreign object left in body during procedure, and adverse drug events). Include any prescription, over-the-counter medication or illegal drugs involved in an adverse drug event (e.g., allergies, overdose, medication error, drug interactions). If the box is marked "No," skip to item 6.

ITEM 5b. IS THIS INJURY/POISONING INTENTIONAL?

Indicate whether the injury was intentional (i.e., self inflicted or an assault), unintentional, or unknown.

ITEM 5c. CAUSE OF INJURY, POISONING OR ADVERSE EFFECT

Provide a brief description of the ***who, what, when, where, and why*** associated with the injury, poisoning 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 5 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 mechanism of injury that was immediately responsible for the injury. In addition, record the underlying or precipitating cause of injury (i.e., the event, or external cause of injury that initiated and led to the mechanism 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 mechanism (fall from roof) would be important to record. It is especially important to record as much detail about falls and motor vehicle crashes as possible. For fall, indicate what the fall was from (e.g., steps) and where the patient landed (e.g., pavement). For motor vehicle crash, indicate if it occurred on the street or highway versus a driveway or parking lot. 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).

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6. PROVIDER'S DIAGNOSIS FOR THIS VISIT

ITEM 6a. As specifically as possible, list diagnoses related to this visit including chronic conditions.

This is one of the most important items on the Patient Record form. Item 6(1) refers to the physician's primary diagnosis for this visit. While the diagnosis may be tentative, provisional, or definitive it should represent the physician'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 medical provider should be recorded. If a patient appears for ***postoperative*** care (follow up visit after surgery), record the postoperative diagnosis as well as any other. The postoperative diagnosis should be indicated with the letters "P.O."

(1) Primary diagnosis
(2) Other
(3) Other

Space has been allotted for two "other" diagnoses. In items 6(2) and 6(3) list the diagnosis of **other conditions related to this visit**. Include chronic conditions (e.g., hypertension, depression, etc.) if related to this visit.

ITEM 6b. Does the patient have –

Mark all that apply.

	Condition	Definition
1	Cerebrovascular disease/History of stroke	Includes stroke, transient ischemic attacks (TIAs), and history of stroke.
2	Congestive heart failure	Congestive heart failure or cardiomyopathy. Does not include asystole or cardiac arrest.

3	Condition requiring dialysis	Includes end-stage renal disease (ESRD) and chronic kidney failure due to diabetes or hypertension that requires the patient to be on kidney dialysis. Include both hemodialysis and peritoneal dialysis.
4	HIV	Human immunodeficiency virus and AIDS.
5	Diabetes	Includes both insulin dependent diabetes mellitus (IDDM) and noninsulin dependent diabetes mellitus (NIDDM). DoesNOT include diabetes insipidus.
6	None of the above	Mark (X) if none of the conditions above exist.

7. DIAGNOSTIC/SCREENING SERVICES

Mark all services that were ordered or provided during ***this visit*** for the purpose of screening (i.e., early detection of health problems in asymptomatic individuals) or diagnosis (i.e., identification of health problems causing individuals to be symptomatic). EACH SERVICE ORDERED OR PROVIDED SHOULD BE MARKED.

Mark the "NONE" box if no blood tests, imaging services, or other tests were ordered or provided.

If services were ordered or provided but not listed, mark the "Other blood test," "Other test/service," or "Other imaging" boxes.

Services meriting special attention are as follows:

Answer Box	Service	Special Instruction
	Blood tests	
2	CBC	CBC is a complete blood count and includes white blood cell (WBC) count, hemoglobin, hematocrit, platelets, and other indices.
3	BUN/Creatinine	BUN is blood urea nitrogen. BUN and creatinine are kidney tests.
4	Cardiac enzymes	May be abbreviated as CE.Include any of the following tests: CKMB (MB fraction of creatine kinase) or CPK-MB; troponin I or troponin T (Tnl, cTnl).
5	Electrolytes	Include any of the following 4 tests: sodium (Na), chloride (Cl), potassium (K), bicarbonate (HCO_3) or carbon dioxide (CO_2).
7	Liver function tests	May be abbreviated as LFT. Include any of the following tests: SGPT (serum glutamate pyruvate transaminase) or ALT (alanine transaminase), SGOT (serum glutamic-oxaloacetic transaminase) or AST (aspartate aminostransferase), GGT (gamma-glutamyl transpeptidase), and serum bilirubin.

Answer Box	Service	Special Instruction
8	Arterial blood gases	May be abbreviated as ABG. An artery is punctured, usually in the wrist (radial artery), and measures the levels of pH, oxygen (PO_2 or PaO_2) carbon dioxide (PCO_2 or $PaCO_2$), bicarbonate (HCO_3), and oxygen saturation (SaO_2). ABG is not the same as a venous blood gas (VBG).
9	Prothrombin time /INR	PT/INR. INR is International Normalized Ratio. Usually collected with PTT (partial thromboplastin time). May be called "coags."
10	Blood culture	May be abbreviated as BC. Cx = culture. Determines if bacteria or fungi are present in the blood. Often obtained in sets of 2 or 3 at the same time.
	Other tests	
16	Influenza test	Includes any type of influenza test, i.e., nasal or throat swab (rapid), nasal culture, or serology (blood).
18	Toxicology screen	Tests for several drugs of abuse and is usually a urine sample, but could also be blood.
20	Wound culture	Used to detect and identify bacteria or fungi that may be infecting the skin or wound. Specimen is usually obtained by a cotton swab of pus or the wound base.

Basic blood chemistry panels (e.g., SMA7, Chem-1, CPBASIC, BMP) include kidney tests (BUN and creatinine), electrolytes (sodium, potassium, bicarbonate, and chloride), and glucose.

Comprehensive blood chemistry panels (e.g., SMA18, Chem-2, CPCOMP, CMP) include the 7 tests in the basic panel as well as others (e.g., bilirubin, alkaline phosphatase, etc.)

8. PROCEDURES

Mark all procedures provided at *this visit*. Mark the "NONE" box if no procedures were provided.

	Procedure	Definition
1	None	No procedures provided.
2	IV fluids	Administration of intravenous fluids.
3	Cast	Application of a rigid dressing made of plaster or fiberglass, molded to the body while pliable and hardening as it dries, to give firm support.
4	Splint or wrap	Application of a rigid or flexible appliance used to maintain in position a displaced or moveable part, or to keep in place and protect an injured

		part. May also be made of plaster, but is not circumferential.
5	Suturing/Staples	Process of using stitches, sutures, or staples to hold skin or tissue together.
6	Incision & drainage (I&D)	Incision and drainage (I&D) is a common treatment for skin infections and abscesses. A scalpel is inserted into the skin overlying the pus and the pus is drained.
7	Foreign body removal	Process of removing an object found in a part of the body where it does not naturally occur.
8	Nebulizer therapy	Therapy where bronchodilator (airway-opening) medications (e.g., albuterol, ipratropium) are delivered through a nebulizer which changes liquid medicine into fine droplets (in aerosol or mist form) that are inhaled through a mouthpiece or facemask. Used for patients with asthma or COPD (chronic obstructive pulmonary disease).
9	Bladder catheter	Any type of catheter used to obtain urine from the bladder (e.g., Foley).
10	Pelvic exam	An examination of the organs of the female reproductive system.
11	Central line	A central venous line (also known as central venous catheter or CVC) is usually inserted into a large vein in the neck, chest, or groin to administer medications or fluids and to obtain blood for testing and cardiovascular measurements.
12	CPR	Cardiopulmonary resuscitation.
13	Endotracheal intubation	Insertion of a laryngoscope into the mouth followed by a tube into the trachea. May sometimes be inserted through the nose.
14	Other	Mark if other procedures were provided but not listed.

9. MEDICATIONS & IMMUNIZATIONS

List up to 8 drugs given at this visit or prescribed at ED discharge, using either the brand or generic names. Include prescription and over-the-counter drugs, immunizations, and anesthetics.

Record the exact drug name (brand or generic) written on any prescription or medical record.

Do not enter broad drug classes, such as “laxative,” “cough preparation,” “analgesic,” “antacids,” “birth control pill,” or “antibiotics.” The one exception is “allergy shot.”

Limit entries to **drug name only**. Additional information such as dosage, strength, or regimen is **not** required. For example, the medication might be in the forms of pills, injections, salves or

ointments, drops, suppositories, powders, or skin patches, but this information should not be entered on the Patient Record form.
For each drug listed, mark the appropriate box indicating if the medication was given in the ED or prescribed at discharge. If the same drug was both given in the ED and prescribed at discharge, then mark (X) both boxes.

If more than eight drugs were given in the ED and/or prescribed at ED discharge, then record the medications/immunizations according to the following priority:

1. All medications (including OTC drugs)/immunizations associated with the listed diagnoses
2. All medications (including OTC drugs)/immunizations **given in the ED**, excluding vitamins and dietary supplements
3. All medications (including OTC drugs)/immunizations **prescribed at discharge**, excluding vitamins and dietary supplements
4. Vitamins and dietary supplements

10. PROVIDERS

Mark all providers seen during this visit. If care was provided, at least in part, by a person not represented in the seven categories, mark the "Other" box.

Answer Box	Provider	Provider (Definition)
3	Consulting physician	Physician who is called to the ED by the patient's ED provider and who may leave a consultation note.
7	EMT	EMT is emergency medical technician. Only mark this box if an EMT provided care in the ED as opposed to in the ambulance.
8	Mental health provider	Include psychologists, counselors, social workers, and therapists who provide mental health counseling. Exclude psychiatrists.

11. SERVICE LEVEL

Mark the level of emergency service. CPT (Current Procedural Terminology) codes are used by the ED physician for billing purposes.

Answer Box	Level	CPT Code (Definition)

1	1 (99281)	An ED visit for a self-limited or minor problem that includes a problem focused history, problem focused examination, and straightforward medical decision making.
2	2 (99282)	An ED visit for a problem of low to moderate severity that includes an expanded problem focused history, expanded problem focused examination, and medical decision making of low complexity.)
3	3 (99283)	An ED visit for a problem of moderate severity that includes an expanded problem focused history, expanded problem focused examination, and medical decision making of moderate complexity.
4	4 (99284)	An ED visit for a problem of moderate to high severity that includes a detailed history, detailed examination, and medical decision making of moderate complexity.
5	5 (99285)	An ED visit for a problem of high severity that includes a comprehensive history, comprehensive examination, and medical decision making of high complexity.
6	Critical care (99291)	Evaluation and management of a critically ill or injured patient.
7	Unknown	CPT Code is not indicated.

12. VISIT DISPOSITION

Mark all that apply.

	Visit Disposition	Definition
1	No follow-up planned	No return visit or telephone contact is scheduled or planned for the patient's problem.
2	Return if needed, PRN/appointment	The patient is instructed to return to the ED as needed; or the patient was told to schedule an appointment or was given an appointment to return to the ED at a particular time.
3	Return/Refer to physician/clinic for FU	The patient was referred to the ED by his or her personal physician or some other physician and is now instructed to consult with the physician who made the referral. The patient was screened, evaluated, stabilized, and then referred to another physician or clinic for followup.
4	Left before medical screening exam	The patient left before having a medical screening exam, the purpose of which is to determine if an emergency medical condition exists.
5	Left after medical	The patient left after having a medical screening exam, the purpose of

	screening exam	which is to determine if an emergency medical condition exists.
6	Left AMA	The patient left against medical advice, that is, the patient was evaluated by the hospital staff and advised to stay and receive or complete treatment.
7	DOA	The patient was dead on arrival (DOA). This patient is still included in the sample if listed on the arrival log.
8	Died in ED	The patient died in the ED. This patient is still included in the sample if listed on the arrival log.
9	Transfer to psychiatric hospital	The patient was transferred to a psychiatric hospital.
10	Transfer to other hospital	The patient was transferred to another non-psychiatric hospital.
11	Admit to this hospital	The patient was instructed that further care or treatment was needed and was admitted to this hospital. If "Admit to hospital" was marked, then continue with item 13 – HOSPITAL ADMISSION on the reverse side.
12	Admit to observation unit, then hospitalized	The patient was admitted to a designated observation unit operated by the ED for evaluation and management or to wait for an inpatient bed, and then was admitted to the hospital. If "Admit to observation unit, then hospitalized" was marked, then continue with item 13 – HOSPITAL ADMISSION on the reverse side.
13	Admit to observation unit, then discharged	The patient was admitted to a designated observation unit in the ED for evaluation and management, but was discharged from the ED and was never admitted to a hospital. If "Admit to observation unit, then discharged" was marked, then continue with item 14 – OBSERVATION UNIT STAY on the reverse side.
14	Other	Any other disposition not included in the above list.

13. HOSPITAL ADMISSION

If box either **"12 – Admit to observation unit, then hospitalized"** or **"13 – Admit to hospital"** in **ITEM 12. VISIT DISPOSITION** was marked, continue on the reverse side of the NHAMCS-100(ED) and complete **ITEM 13. HOSPITAL ADMISSION**. If the information for items 13e-13g are not available at the time of the abstraction, then complete the NHAMCS-105, Hospital Admission Log. If efforts have been exhausted to collect the data, mark the "Unknown" box for each item.

If box **"11 – Admit to observation unit, then discharged"** in **ITEM 12. VISIT DISPOSITION** was marked, continue on the reverse side of the NHAMCS-100(ED) and complete **ITEM 14. OBSERVATION UNIT STAY**.

ITEM 13a. ADMITTED TO:

	Type of Unit	Definition
1	Critical care unit	The patient was admitted to a critical care unit of the hospital (e.g., Intensive Care Unit (ICU), Coronary Care Unit (CCU), Pediatric Intensive Care Unit (PICU)).
2	Stepdown or telemetry unit	The patient was admitted to a stepdown or telemetry unit area of the hospital where special machines are used to closely monitor patients. The level of care is less intense than in the ICU, but is not present in all hospitals.
3	Operating room	The patient was sent directly to the operating room.
4	Mental health or detox unit	The patient was admitted to a mental health or psychiatric unit or a unit providing detoxification services for drugs and alcohol.
5	Cardiac catheterization lab	The patient was sent directly to the cardiac catheterization lab.
6	Other bed/unit	The patient was admitted to a bed/unit in the hospital not listed above (e.g., med/surg unit).
7	Unknown	Information is not available to determine where the patient was admitted.

ITEM 13b. ADMITTING PHYSICIAN

Indicate whether the admitting physician is a hospitalist. A hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients. A hospitalist oversees ED patients being admitted to the hospital. If the records do not indicate that the admitting physician is a hospitalist, mark "Unknown."

ITEM 13c. DATE AND TIME BED WAS REQUESTED FOR HOSPITAL ADMISSION

Record the month, day, and year in figures when a bed was requested for hospital admission, for example 05/17/09 for May 17, 2009. Record the hour and minutes when the bed request was made in figures. For example, enter 05:45 and check the appropriate box (a.m., p.m., or Military).

If the date and time when a bed was requested is unknown, mark the appropriate box.

ITEM 13d. DATE AND TIME PATIENT ACTUALLY LEFT ED

Record the month, day, and year in figures when the patient actually left the ED, for example 05/17/09 for May 17, 2009.

Record the hour and minutes when the patient actually left the ED in figures. For example, enter 06:00 for 6:00 a.m. or 6:00 p.m. and check the appropriate box (a.m., p.m., or Military).

If the date and time when the patient actually left the ED is unknown, mark the appropriate box.

ITEM 13e. HOSPITAL DISCHARGE DATE

Record the month, day, and year in figures when the patient was discharged from an inpatient stay in the hospital, for example, 05/17/09 for May 17, 2009. If the date and time when the patient was discharged from the hospital is unknown, mark the appropriate box.

ITEM 13f. PRINCIPAL HOSPITAL DISCHARGE DIAGNOSIS

Enter the principal hospital discharge diagnosis. If the discharge diagnosis is unknown, mark the appropriate box.

ITEM 13g. HOSPITAL DISCHARGE STATUS/DISPOSITION

Mark the appropriate box to indicate whether the patient was discharged alive, dead, the discharge status is unknown, or the data are unavailable. If the patient was discharged "Alive," mark one of the following:

	Status	Definition
1	Home/Residence	The patient was discharged to their normal place of residence (e.g., private home, assisted living, nursing home, college dormitory, homeless shelter, hospice, prison, or group home for mentally retarded or physically disabled).
2	Transferred	The medical record states that the patient was transferred to another facility that is not their normal place of residence (e.g., psychiatric hospital, detox, rehabilitation hospital, another short-term hospital, nursing home, skilled nursing facility (SNF), intermediate care facility (ICF), extended care facility, custodial).
3	Other	Any other disposition where the patient neither returned to their normal place of residence nor were transferred.
4	Unknown	Information is not available to determine where the patient was discharged to.

14. OBSERVATION UNIT STAY

ITEM 14. OBSERVATION UNIT STAY

COMPLETE THIS ITEM FOR PATIENTS WHO WERE DISCHARGED FROM THE OBSERVATION UNIT TO RETURN TO THEIR RESIDENCE.

Record the month, day, and year in figures when the patient was discharged from the observation unit, for example 05/17/09 for May 17, 2009.

Record the hour and minutes when the patient was discharged from the observation unit. For example, enter 05:45 for 5:45 a.m. or 5:45 p.m. and check the appropriate box (a.m., p.m., or Military).

If the date and time when the patient was discharged from the observation unit is unknown, mark the appropriate box.

*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 ACEP

Dear Emergency Department Director:

I am writing to urge you to participate in the National Hospital Ambulatory Medical Care Survey. This survey is part of an ongoing project sponsored by the Centers for Disease Control and Prevention's National Center for Health Statistics to gather data about medical care provided in outpatient and emergency facilities. The information gathered is used by medical educators, researchers, policy makers and health administrators to assess health needs and resources, and for planning and organizing health services.

The American College of Emergency Physicians has long recognized the need for national data describing emergency department visits and has supported the development of this survey. Data from the most recent survey clearly shows the rise in the number of visits to emergency departments (EDs) across the county while the number of hospital EDs has declined.

As EDs experience increasing demands on their resources, this survey will provide vital data for researchers, planners, and decision makers addressing these critical issues facing emergency medicine. I urge you to complete this survey.

Yours truly,

Linda L. Lawrence, MD, FACEP
President

HEADQUARTERS
Post Office Box 619911
Dallas, Texas 75261-9911

1125 Executive Circle
Irving, Texas 75038-2522

972-550-0911
800-798-1822
972-580-2816 (FAX)
www.acep.org

EXHIBIT B

ENDORSEMENT LETTER FROM SAEM

July 29, 2008

Dear Emergency Department Director:

We urge you to support the National Hospital Ambulatory Medical Care Survey, which is an ongoing project sponsored by the Centers for Disease Control and Prevention to gather data about outpatient and emergency department visits.

The mission of the Society for Academic Emergency Medicine is to improve patient care by advancing research and education in emergency medicine. The information collected in the survey is valuable for emergency care providers, researchers, educators, and administrators to address issues facing emergency medicine. On behalf of the more than 6,000 members SAEM represents, the Board of Directors urges you to complete the survey.

Sincerely,

Society for Academic Emergency Medicine

Katherine L. Heilpern, MD
President

901 N. Washington Ave • Lansing, MI 48906 • (517) 485-5484 • Fax (517) 485-0801
2009 Annual Meeting, May 14 - May 17, New Orleans, LA

EXHIBIT C

ENDORSEMENT LETTER FROM ENA

EMERGENCY NURSES ASSOCIATION

915 Lee Street
Des Plaines, IL 60016-6569
Telephone•847/460-4000
Fax•847/460-4001
Web site•www.ena.org

Dear Emergency Department Director:

I am writing to urge your participation in the National Hospital Ambulatory Medical Care Survey, which is part of an ongoing project to fill an information gap in our specialized area of health care. There is a vital need for a national database pertaining to ambulatory/emergency settings.

The Emergency Nurses Association and more than 34,500 emergency nurses it represents are pleased to support and encourage this effort. The data gathered will give direct care providers, managers, educators, researchers, administrators, and strategists an additional tool to better understand the provision of emergency care in outpatient departments and emergency care centers.

Please take a moment of your time and assist the National Center for Health Statistics to collect this information by completing this survey. Your contribution will become part of a database, which will be vital to future efforts in our area of health care.

Sincerely,

Denise King

Denise King, RN, MS, CEN
2008 President

EXHIBIT D

ENDORSEMENT LETTER FROM ACOEP

Dear Directors of Emergency Medicine:

The ACOEP is writing to urge you to participate in the National Hospital Ambulatory Medical Care Survey that you will be receiving in the next few months. This survey is an important part of an ongoing project of the National Center for Health Statistics of the Centers for Disease Control and Prevention and complements the current National Ambulatory Medical Care Survey of office based ambulatory to provide information on more than 95% of all ambulatory care encounters.

The information gathered by this survey is utilized by medical professionals to assess the health care needs and resources in their areas and provides them with information to plan and organize health care service needs for the next three years. Data from the 2002 survey has assisted many emergency medicine physicians, hospital administrators, researchers and health policy professionals to verify the increase in the number of emergency department visits across America and to project the Country's increasing needs for emergency medicine professionals.

As we face increasing demands on our hospital and physician resources, this important tool will provide needed statistics for hospital administration, researchers and health policy professionals to address areas of critical needs in their emergency medicine departments.

We encourage your support and participation in this survey.

Sincerely

Peter A. Bell, D.O., FACOEP
President

EXHIBIT E

ENDORSEMENT LETTER FROM THE SURGEON GENERAL'S OFFICE

DEPARTMENT OF HEALTH & HUMAN SERVICES

Public Health Service

Office of the Surgeon General
Rockville MD 20857

March 22, 2005

Dear Hospital Administrator:

I urge you to support the National Hospital Ambulatory Medical Care Survey (NHAMCS), an ongoing project of the Centers for Disease Control and Prevention to gather data about outpatient department (OPD) and emergency department (ED) visits. The survey is a valuable tool that can be utilized by physicians, researchers, educators, and administrators to address health care issues facing our communities.

NHAMCS data can be used to

- monitor trends in health care related to injuries and preventable diseases (such as heart disease, diabetes, and obesity)
- examine health disparities for all ethnic and racial groups (such as ED and OPD visit rates)
- study problems within our health care system (such as ED crowding and the use of the ED as a "safety net" for the uninsured)
- track national public health objectives (such as reducing the number of antibiotics prescribed for the common cold)
- examine prescribing practices (such as analgesic use in the ED)

Thank you for taking the time to participate in the National Hospital Ambulatory Medical Care Survey.

Sincerely,

Richard H. Carmona, M.D., M.P.H., F.A.C.S.
VADM, USPHS
United States Surgeon General

EXHIBIT F

ENDORSEMENT LETTER FROM THE FEDERATION OF AMERICAN HOSPITALS

Charles N. Kahn III
President

Dear Hospital Administrator:

The National Hospital Ambulatory Medical Care Survey (NHAMCS) is the nation's foremost study of ambulatory medical care in hospital emergency and outpatient departments and has been conducted annually since 1992. This survey, conducted by the Centers for Disease Control's National Center for Health Statistics, gathers data about care provided in outpatient and emergency facilities. Such data is an invaluable resource for policymakers, researchers, health administrators and others in assessing health needs and resources. For example, the survey allows researchers to gauge the annual rate of hospital outpatient department visits by patient age and race and ethnicity and the percentage of visits made by children under 18 years to hospital outpatient departments and physician offices with Medicaid or the state Children's Health Insurance Program as primary expected source of payment.

The Federation of American Hospitals supports this ongoing survey. As the number of outpatient surgical procedures continues to increase, the survey results will provide to policymakers, hospital administration and others vital data about how care is delivered in the United States and in our hospitals. By participating in the NHAMCS, you will be able to contribute to the nation's premier source of hospital-based ambulatory care. Therefore, I encourage you to take the time to complete this survey.

Sincerely,

801 Pennsylvania Ave., NW, Suite 245 Washington, DC 20004 • 202-624-1500 • FAX 202-737-6462 • www.fah.org

EXHIBIT G

Illustrative Uses of NHAMCS ED Data

Health Care Facilities

Kaiser Permanente	Studied the utilization of physician assistants and nurse practitioners in EDs**.**
Massachusetts General Hospital	Published article in *Academic Emergency Medicine* on declining antibiotic prescriptions for patients with upper respiratory infections seen in the ED.

Universities and Medical Schools

George Washington University Medical Center	Published article in *Annals of Emergency Medicine* on increasing rates of ED visits for elderly patients.
Harvard Medical School	Published article in *Health* Affairs on trends and predictors of the waiting time to see an ED physician.
University of California, San Francisco	Published article in the *Journal of the American Medical Association* on trends in opioid prescribing in the ED by race and ethnicity.

Government Agencies

U.S. Congress	NHAMCS data are used in two annual reports to Congress – The National Healthcare Quality Report and the National Health Disparities Report.
Institute of Medicine	Future of Emergency Care report cited ED data over 100 times.
Assistant Secretary for Planning and Evaluation, Department of Health and Human Services	Requested that a supplement be added to the NHAMCS to assess how well hospitals are prepared to provide services in the event of a pandemic, mass casualty, or terrorist attack.
Government Accountability Office	Requested ED trend data to examine ED crowding and to evaluate the Emergency Medical Treatment and Labor Act (EMTALA).

Broadcast and Print Media

NBC Nightly News, August 6, 2008	Reported on the increase in ED visits from 1996 through 2006.
Wall Street Journal, August 7, 2008	Reported on average ER waiting time jumping to nearly an hour.

Advocacy Groups

Center for Studying Health System Change	Used ED data in its issue brief "Insured Americans Drive Surge in Emergency Department Visits."
Council on the Economic Impact of Health System Change	Used ED data in its report on "Utilization and Overcrowding in Hospital Emergency Departments."

EXHIBIT H

OPTIONAL PATIENT LOG FORM (EXAMPLE)

OMB No. 0920-0278 Sheet_____of_____sheets

NOTICE – Public reporting burden of this collection of information is included in the 60 minute burden associated with the Ambulatory Unit Record, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden to: CDC/ATSDR Information Collection Review Office, 1600 Clifton Road, MS D-74, Atlanta, GA 30333, ATTN: PRA (0920-0278).

Assurance of confidentiality – All information which would permit identification of an individual, a practice, or an establishment will be held confidential, will be used for statistical purposes only by NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

FORM **NHAMCS-103** (10-20-2008)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS COLLECTING AGENT FOR THE
NATIONAL CENTER FOR HEALTH STATISTICS
CENTERS FOR DISEASE CONTROL AND PREVENTION

PATIENT VISIT LOG
NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

1. Clinic/Service Area/ASC Name: Pediatric Emergency Department
2. Sampling Take Every: 20
3. Random Start Number: 5

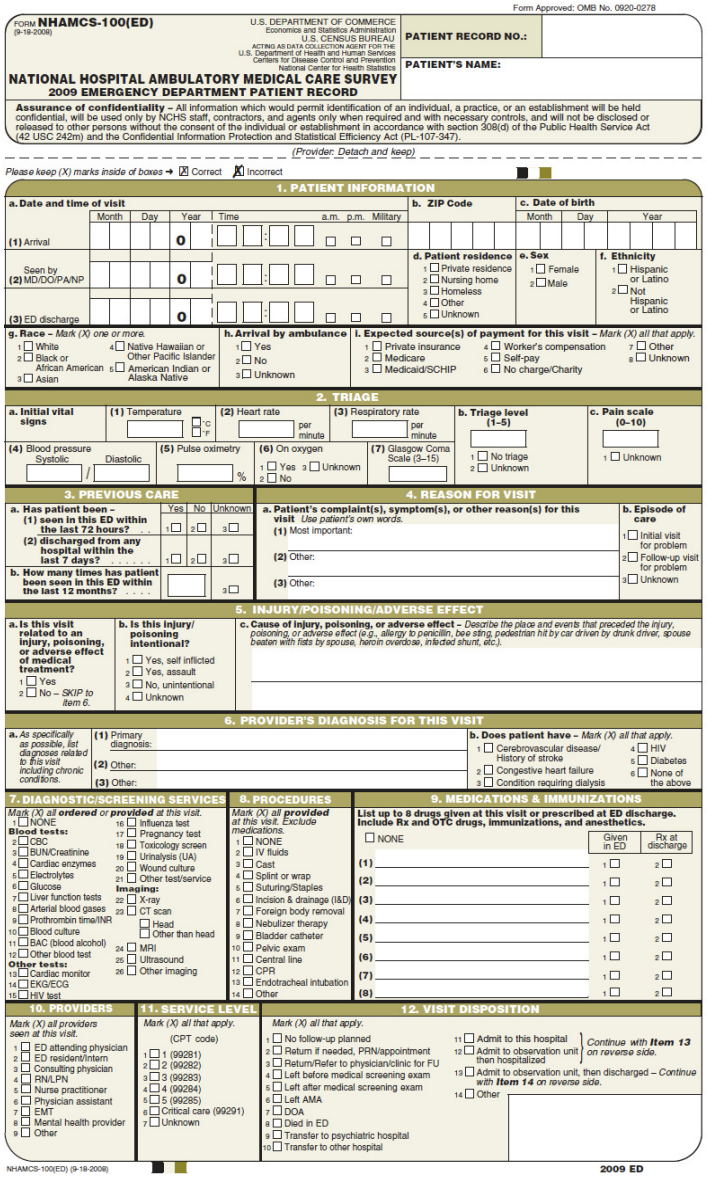
NOTE – Hospital is to retain log after completion of study. This log is for optional use. Put a check mark (✓) in column (f) "Sample" next to each patient selected for the sample of visits.

Line No. (a)	Date of visit (b)	Patient name (c)	Patient record/ identification number (d)	Remarks (e)	Sample *Mark (✓) for patient(s) selected for sample of visits.* (f)
1	2/23	Jeremy McCool			
2	2/23	David Voe			
3	2/23	Susan de Tal			
4	2/23	Michael Rudai			
5	2/23	Kathy Doe			✓
6	2/23	Lola Smith			
7	2/23	Elizabeth Citizen			
8	2/23	Joe Ceert			
9	2/23	Daniel Bleau			
10	2/23	Mario WumingShi			
11	2/23	Laura Nom			
12	2/23	Jamie Public			
13	2/23	Alicia Boe			
14	2/23	Wakenya Persona			
15	2/23	Jean Naamalum			
16	2/23	Ami Loe			
17	2/23	Alexander Poe			
18	2/23	Grant del Pueblo			
19	2/23	Robert Humano			
20	2/23	Marc Coe			
21	2/23	Andy Zoe			
22	2/23	Tom Individuo			
23	2/24	Chris Indivduos			
24	2/24	Rebecca Woe			
25	2/24	Sean Noe			✓
26	2/24	Dave David			
27	2/24	Vicki Svieto			
28	2/24	Kristin Goe			

USCENSUSBUREAU

EXHIBIT I

ED PATIENT RECORD FORM



Form Approved: OMB No. 0920-0278

FORM **NHAMCS-100(ED)** (9-18-2008)

U.S. DEPARTMENT OF COMMERCE
Economics and Statistics Administration
U.S. CENSUS BUREAU
ACTING AS DATA COLLECTION AGENT FOR THE
U.S. Department of Health and Human Services
Centers for Disease Control and Prevention
National Center for Health Statistics

PATIENT RECORD NO.:

PATIENT'S NAME:

NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY
2009 EMERGENCY DEPARTMENT PATIENT RECORD

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 NCHS staff, contractors, and agents only when required and with necessary controls, and will not be disclosed or released to other persons without the consent of the individual or establishment in accordance with section 308(d) of the Public Health Service Act (42 USC 242m) and the Confidential Information Protection and Statistical Efficiency Act (PL-107-347).

(Provider: Detach and keep)

Please keep (X) marks inside of boxes → ☒ Correct ☒ Incorrect

1. PATIENT INFORMATION

a. Date and time of visit — Month / Day / Year / Time / a.m. p.m. Military

(1) Arrival

Seen by (2) MD/DO/PA/NP

(3) ED discharge

b. ZIP Code

c. Date of birth — Month / Day / Year

d. Patient residence
1 ☐ Private residence
2 ☐ Nursing home
3 ☐ Homeless
4 ☐ Other
5 ☐ Unknown

e. Sex
1 ☐ Female
2 ☐ Male

f. Ethnicity
1 ☐ Hispanic or Latino
2 ☐ Not Hispanic or Latino

g. Race – *Mark (X) one or more.*
1 ☐ White
2 ☐ Black or African American
3 ☐ Asian
4 ☐ Native Hawaiian or Other Pacific Islander
5 ☐ American Indian or Alaska Native

h. Arrival by ambulance
1 ☐ Yes
2 ☐ No
3 ☐ Unknown

i. Expected source(s) of payment for this visit – *Mark (X) all that apply.*
1 ☐ Private insurance
2 ☐ Medicare
3 ☐ Medicaid/SCHIP
4 ☐ Worker's compensation
5 ☐ Self-pay
6 ☐ No charge/Charity
7 ☐ Other
8 ☐ Unknown

2. TRIAGE

a. Initial vital signs

(1) Temperature ☐ °C ☐ °F

(2) Heart rate per minute

(3) Respiratory rate per minute

(4) Blood pressure Systolic / Diastolic

(5) Pulse oximetry %

(6) On oxygen
1 ☐ Yes 3 ☐ Unknown
2 ☐ No

(7) Glasgow Coma Scale (3–15)

b. Triage level (1–5)
1 ☐ No triage
2 ☐ Unknown

c. Pain scale (0–10)
1 ☐ Unknown

3. PREVIOUS CARE

a. Has patient been –	Yes	No	Unknown
(1) seen in this ED within the last 72 hours?	1 ☐	2 ☐	3 ☐
(2) discharged from any hospital within the last 7 days?	1 ☐	2 ☐	3 ☐

b. How many times has patient been seen in this ED within the last 12 months? 3 ☐

4. REASON FOR VISIT

a. Patient's complaint(s), symptom(s), or other reason(s) for this visit *Use patient's own words.*
(1) Most important:
(2) Other:
(3) Other:

b. Episode of care
1 ☐ Initial visit for problem
2 ☐ Follow-up visit for problem
3 ☐ Unknown

5. INJURY/POISONING/ADVERSE EFFECT

a. Is this visit related to an injury, poisoning, or adverse effect of medical treatment?
1 ☐ Yes
2 ☐ No – *SKIP to item 6.*

b. Is this injury/poisoning intentional?
1 ☐ Yes, self inflicted
2 ☐ Yes, assault
3 ☐ No, unintentional
4 ☐ Unknown

c. Cause of injury, poisoning, or adverse effect – *Describe the place and events that preceded the injury, poisoning, or adverse effect (e.g., allergy to penicillin, bee sting, pedestrian hit by car driven by drunk driver, spouse beaten with fists by spouse, heroin overdose, infected shunt, etc.).*

6. PROVIDER'S DIAGNOSIS FOR THIS VISIT

a. *As specifically as possible, list diagnoses related to this visit including chronic conditions.*
(1) Primary diagnosis:
(2) Other:
(3) Other:

b. Does patient have – *Mark (X) all that apply.*
1 ☐ Cerebrovascular disease/ History of stroke
2 ☐ Congestive heart failure
3 ☐ Condition requiring dialysis
4 ☐ HIV
5 ☐ Diabetes
6 ☐ None of the above

7. DIAGNOSTIC/SCREENING SERVICES

Mark (X) all ***ordered*** *or* ***provided*** *at this visit.*

1 ☐ NONE

Blood tests:
2 ☐ CBC
3 ☐ BUN/Creatinine
4 ☐ Cardiac enzymes
5 ☐ Electrolytes
6 ☐ Glucose
7 ☐ Liver function tests
8 ☐ Arterial blood gases
9 ☐ Prothrombin time/INR
10 ☐ Blood culture
11 ☐ BAC (blood alcohol)
12 ☐ Other blood test

Other tests:
13 ☐ Cardiac monitor
14 ☐ EKG/ECG
15 ☐ HIV test
16 ☐ Influenza test
17 ☐ Pregnancy test
18 ☐ Toxicology screen
19 ☐ Urinalysis (UA)
20 ☐ Wound culture
21 ☐ Other test/service

Imaging:
22 ☐ X-ray
23 ☐ CT scan
☐ Head
☐ Other than head
24 ☐ MRI
25 ☐ Ultrasound
26 ☐ Other imaging

8. PROCEDURES

Mark (X) all ***provided*** *at this visit. Exclude medications.*

1 ☐ NONE
2 ☐ IV fluids
3 ☐ Cast
4 ☐ Splint or wrap
5 ☐ Suturing/Staples
6 ☐ Incision & drainage (I&D)
7 ☐ Foreign body removal
8 ☐ Nebulizer therapy
9 ☐ Bladder catheter
10 ☐ Pelvic exam
11 ☐ Central line
12 ☐ CPR
13 ☐ Endotracheal intubation
14 ☐ Other

9. MEDICATIONS & IMMUNIZATIONS

List up to 8 drugs given at this visit or prescribed at ED discharge. Include Rx and OTC drugs, immunizations, and anesthetics.

☐ NONE

	Given in ED	Rx at discharge
(1)	1 ☐	2 ☐
(2)	1 ☐	2 ☐
(3)	1 ☐	2 ☐
(4)	1 ☐	2 ☐
(5)	1 ☐	2 ☐
(6)	1 ☐	2 ☐
(7)	1 ☐	2 ☐
(8)	1 ☐	2 ☐

10. PROVIDERS

Mark (X) all providers seen at this visit.

1 ☐ ED attending physician
2 ☐ ED resident/Intern
3 ☐ Consulting physician
4 ☐ PN/LPN
5 ☐ Nurse practitioner
6 ☐ Physician assistant
7 ☐ EMT
8 ☐ Mental health provider
9 ☐ Other

11. SERVICE LEVEL

Mark (X) all that apply.

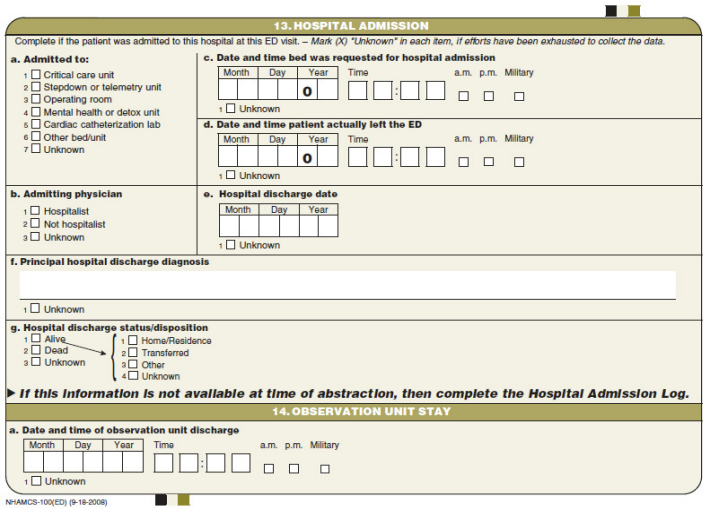
(CPT code)
1 ☐ 1 (99281)
2 ☐ 2 (99282)
3 ☐ 3 (99283)
4 ☐ 4 (99284)
5 ☐ 5 (99285)
6 ☐ Critical care (99291)
7 ☐ Unknown

12. VISIT DISPOSITION

Mark (X) all that apply.

1 ☐ No follow-up planned
2 ☐ Return if needed, PRN/appointment
3 ☐ Return/Refer to physician/clinic for FU
4 ☐ Left before medical screening exam
5 ☐ Left after medical screening exam
6 ☐ Left AMA
7 ☐ DOA
8 ☐ Died in ED
9 ☐ Transfer to psychiatric hospital
10 ☐ Transfer to other hospital
11 ☐ Admit to this hospital
12 ☐ Admit to observation unit then hospitalized
Continue with ***Item 13*** *on reverse side.*
13 ☐ Admit to observation unit, then discharged – *Continue with* ***Item 14*** *on reverse side.*
14 ☐ Other

NHAMCS-100(ED) (9-18-2008) **2009 ED**



13. HOSPITAL ADMISSION

Complete if the patient was admitted to this hospital at this ED visit. – *Mark (X) "Unknown" in each item, if efforts have been exhausted to collect the data.*

a. Admitted to:

1 ☐ Critical care unit
2 ☐ Stepdown or telemetry unit
3 ☐ Operating room
4 ☐ Mental health or detox unit
5 ☐ Cardiac catheterization lab
6 ☐ Other bed/unit
7 ☐ Unknown

b. Admitting physician

1 ☐ Hospitalist
2 ☐ Not hospitalist
3 ☐ Unknown

c. Date and time bed was requested for hospital admission

Month | Day | Year (0) | Time | a.m. p.m. Military

1 ☐ Unknown

d. Date and time patient actually left the ED

Month | Day | Year (0) | Time | a.m. p.m. Military

1 ☐ Unknown

e. Hospital discharge date

Month | Day | Year

1 ☐ Unknown

f. Principal hospital discharge diagnosis

1 ☐ Unknown

g. Hospital discharge status/disposition

1 ☐ Alive
2 ☐ Dead
3 ☐ Unknown

→ 1 ☐ Home/Residence
2 ☐ Transferred
3 ☐ Other
4 ☐ Unknown

▶ ***If this information is not available at time of abstraction, then complete the Hospital Admission Log.***

14. OBSERVATION UNIT STAY

a. Date and time of observation unit discharge

Month | Day | Year | Time | a.m. p.m. Military

1 ☐ Unknown

NHAMCS-100(ED) (9-18-2008)

EXHIBIT J

NHAMCS PARTICIPANT WEB PAGE