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Hospital Field Manual for the National Hospital Discharge Survey Redesign Pilot Study

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Prepared for the Centers for Disease Control and Prevention, National Center for Health Statistics
Foreword

The Centers for Disease Control and Prevention (CDC) through the National Center for Health Statistics (NCHS) and the RAND Corporation (RAND) very much appreciate your participation in this feasibility study of a proposed redesign to the National Hospital Discharge Survey (NHDS). The survey has served our nation well for more than 40 years during a time when we have all seen increased complexity in health care. The upcoming decades are likely to be at least as challenging as we address issues of quality, access, and costs of care. The new NHDS will be an invaluable tool to help understand the care provided in our hospitals and healthcare systems. Robust data will help providers, policymakers and researchers make better decisions about directions to take as they plan for our future.

This Field Manual is designed to assist hospital staff in organizing and collecting data necessary to pilot the redesigned NHDS. Chapter 1 provides background and general information. Subsequent chapters address specific phases of the project. For example, the chapter on record abstraction (Chapter 3) provides detail to the data abstractor based in the participating hospital.

We are here to support you as you work with us on this project. We invite you to contact us if you have any questions, require additional information or have suggestions for improving the process. We can be reached at the following numbers:

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Thank you again for your dedication and commitment to excellence in health care!
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Chapter 1
Background

About the National Center for Health Statistics
The National Center for Health Statistics (NCHS) is an agency of the Centers for Disease Control and Prevention (CDC). As the federal government’s principal health statistics agency, the NCHS compiles designs, develops, and maintains a number of surveys that produce data related to demographic and health concerns. These include data on registered births and deaths, the National Health Interview Survey (NHIS), the National Health and Nutrition Examination Survey (NHANES), the National Health Care Survey (NHCS), and the National Survey of Family Growth (NSFG), among others.

The National Health Care Survey (NHCS) is a suite of surveys designed to measure utilization of the health care delivery system including inpatient care, outpatient care, emergency room care, nursing home care, home health and hospice care, and ambulatory surgery center care. An important component of the NHCS is the National Hospital Discharge Survey (NHDS).

About the Current National Hospital Discharge Survey

Purpose of the NHDS
First conducted in 1965, the NHDS has been an important source of information on inpatient utilization in short-stay non-federal hospitals in the United States. The current survey collects health care claims data through the Uniform Bill (UB92). Data collected by the current NHDS are used by government, professional, scientific, academic, and commercial institutions, as well as by private citizens. The wide variety of uses of NHDS data are best exemplified by the diversity of its users. These include: federal agencies, such as the Centers for Medicare & Medicaid Services (CMS), the National Institutes of Health (NIH), the Food and Drug Administration (FDA), various centers within the Centers for Disease Control and Prevention (CDC), the Department of Defense (DoD), and the Department of Veterans’ Affairs (VA); international organizations, such as the Organization for Economic Cooperation and Development (OECD); universities and medical schools; professional organizations, such as the American College of Surgeons and the American Heart Association; state health planning agencies; hospitals; pharmaceutical and medical supply manufacturers; publishing houses; market research groups; and insurance companies.

Of particular importance, NHDS data are used by the Department of Health and Human Services (DHHS) in the development and monitoring of health objectives for the nation for the years 2000 and 2010 as well as the National Reports on Quality and Disparities. In addition, NHDS data provide annual updates for numerous tables in the Congressionally-mandated NCHS report, Health, United States.

Information about the NHDS can be found at:

Legal Authority
The initial basis for NCHS surveys is the National Health Survey Act (Public Law 84-652), which
was enacted by Congress on July 3, 1956. This Act calls for a continuing health survey and special studies on the nation’s health. Public Law 84-652 was codified later as Title 42, United States Code, Section 242k.

**About the National Hospital Discharge Survey Redesign Project**

Although the NHDS has served the country well for over 40 years, it was formulated in the context of a health care delivery system and hospital and patient universe of previous decades. The CDC’s National Center for Health Statistics (NCHS) is therefore undertaking a redesign of the NHDS so that it better reflects the current health care context and continues to provide a valuable source of information for current and future policymaking, health care research, academic education, and various other applications within the hospital industry. The redesigned NHDS will continue to produce a nationally-representative general purpose sample of hospital utilization while closing gaps in available information about care delivered within a hospital (e.g., use of resources, more clinical depth, demographic depth, outcomes) and also permitting ad hoc or focused modules as needed for policy and research demands (e.g., disease-specific studies, workforce issues).

RAND has been asked to assist the CDC in redesigning the NHDS (through the light blue arrows). The entire process is charted in Figure 1 below, beginning with a conceptual framework for the redesign, which involved the first two steps on the upper left.

**Figure 1. Process for Redesigning the NHDS**
Through interviews we sought input from economists, clinicians, researchers, insurers, policymakers, and others— in government, academic institutions, and private business—regarding issues that our health care system will face over the foreseeable future (e.g., 20 years). The group included people who have used the NHDS or other sources of hospital data in their research or need it to inform policy or strategic choices. The results of these interviews and the ideas they generated were consolidated and discussed by a working group that provided input on recommended redesign options for the CDC to consider. Based on the input, RAND and the CDC determined the data elements to be included in this feasibility study for the redesigned NHDS and created the survey instruments that are being tested in your hospital. The goal is to field test the survey and understand the challenges that the survey presents to hospitals and solicit input regarding strategies to improve the survey questions and data collection process in anticipation of a larger pilot test to be conducted in 2008. CDC plans to have the redesigned NHDS in the field by 2010.

Confidentiality

This study will collect protected health information (PHI). In the future, the PHI will be used to link the NHDS data to other data sources such as the National Death Index and Medicare claims data, thus permitting more robust analysis of process and outcomes. All PHI will remain confidential and will not be disclosed to anyone outside the RAND project team and the CDC - NCHS staff. However, because this study is intended to test feasibility, our focus will be on issues such as whether the data elements can be abstracted and how long abstraction takes. The data will be used only for these purposes.

The Guarantee of Confidentiality

In the future, information on patients and facilities will be used only for statistical purposes as required by Section 308(d) of the Public Health Service Act [42 United States Code 242m (d) and Section 513 of the Confidential Information Protection and Statistical Efficiency Act (PL-107-347)]. Published documents resulting from this feasibility test will not include any hospital, patient, or clinical data, but will focus only on the feasibility of collecting the data. All published summaries will be presented in such a way that no individual facility or patient can be identified.

Health Insurance Portability and Accountability Act Issues

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its Privacy Rule recognizes: 1) the legitimate need for public health authorities and others responsible for ensuring the public's health and safety to have access to protected health information to conduct their missions; and 2) the importance of public health reporting by covered entities to identify threats to the public and individuals. The rule: 1) permits protected health information disclosures without a written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes, such as the CDC (Appendix A); and 2) permits disclosures that are required by state and local public health or other laws. Thus, HIPAA permits hospitals to participate in studies of this nature for public health purposes. Because RAND is serving as an authorized agent of the CDC for this project, it is permissible to disclose data to RAND for the purposes of this project. HIPAA Regulations (45 CFR§164.501) do not require the hospital to obtain patient authorization prior to disclosing protected health information to the CDC or RAND, as an authorized agent of the CDC. HIPAA also permits covered entities to obtain the documentation and rely on the approval of one Institutional Review Board (IRB) or privacy board (see next section).
Institutional Review Board (Human Subjects Protection)

This study has been approved by the CDC – NCHS’s Institutional Review Board (IRB), which serves the same function that a Human Subjects Protection Committee (HSPC) would serve for hospitals or health care systems. For this study, the hospital may rely on the approval of the CDC IRB. A copy of the CDC IRB approval to conduct this study is included as Appendix B. If the hospital requires a copy of CDC’s IRB submission, please contact the CDC-NCHS (contact information shown below).

Role of the Feasibility Study

The CDC is conducting this feasibility study to ensure that the redesigned NHDS can continue to be completed efficiently and without significant disruption of hospital work flow. In particular, the study will allow the CDC to identify any problems and issues created by the new NHDS that need to be addressed or corrected before a more formal pilot is conducted. The procedures and abstraction tools employed during this initial feasibility study are designed to be as close as possible to what will be required to carry out the redesigned NHDS and were determined through the development of a conceptual framework, as discussed above. RAND staff and the CDC-NCHS will use the findings from this study to identify possible modifications of the data collection procedures and data items. The redesigned survey will be further tested in a full-scale pilot in 2008. Hospitals that participate in this feasibility study will not be asked to participate in the pilot in 2008.

Components of Hospital Participation

Involvement in this feasibility study includes activities such as the following:

- Meet with RAND staff (and possibly CDC-NCHS staff) to identify the facility personnel who would be involved in the feasibility study and the location and means of access to the data of interest.
- Complete the facility questionnaire. (Appendix C)
- Identify a hospital contact to facilitate the project within the hospital and be available to RAND abstractor(s) during their site visit to facilitate interaction with the hospitals records, systems and personnel as required.
- Identify a list of 20 sample patients as prescribed by a RAND-provided sampling plan (Chapter 3)
- Identify medical record abstractor(s) to pilot the abstraction tool. Using RAND-provided guideline materials (Chapter 4), abstractors will collect the requested data elements for the patient sample in anticipation of a RAND-abstractor visit date.
- Provide RAND-abstractors access to the same sample patient records (and/or electronic data, as applicable) for a RAND-conducted, on-site abstraction.
- Debrief with RAND and CDC-NCHS staff at the conclusion of the process.
- Participate if needed in a limited number of follow-up telephone calls to clarify findings and provide input to the redesign process.

We anticipate that different hospital staff will contribute to different components of this effort. We are very interested in learning about the titles and skills of individuals that hospitals involve in the process, the reasons why these individuals were necessary for the project, and the challenges each institution encountered when trying to complete this feasibility study.

All activities involved in the feasibility study will be conducted either at participating hospitals or via electronic means, such as telephone and e-mail. No travel will be required on the part of hospital personnel.
The chapters that follow provide detailed information regarding the four major activities involving hospital participation:

- Selection and induction of the hospital
- Sample selection of cases to be abstracted
- Abstraction
- Evaluation of the processes, procedures and forms

**Whom to Contact for Assistance with the Feasibility Study**

We welcome your questions, concerns and feedback. During your participation in this feasibility study, please feel free to write or call either of RAND’s lead investigators for this study.

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Hospitals participating in this feasibility test have been selected to be representative of non-federal acute care hospitals in the United States. Prior to our initial meeting, the hospital will agree by telephone to consider participation, identify a principal point of contact, and receive a packet of materials, including a letter addressed to the hospital’s principal point of contact with a copy to the hospital CEO. The letter will confirm the hospital’s willingness to consider participation, the date and time of the introductory visit, an agenda for the visit by RAND Principal Investigators and potentially CDC-NCHS employees, and suggested hospital meeting participants. The letter will accompany a packet of materials for the hospital to review in advance. The packet will include:

- Introductory letter from Dr. Sondik (Appendix D)
- Meeting agenda (Appendix E)
- Description of study (Appendix F)
- Frequently Asked Questions (Appendix G)
- CDC IRB approval letter (Appendix B)
- MMWR paper on participating in surveys with the CDC (Appendix A)
- Facility questionnaire (Appendix C)
- Patient abstraction form (Appendix H)
- Sampling plan (Chapter 3)

**Facility Questionnaire**

Immediately following the telephone solicitation and agreement, RAND will send a facility questionnaire (Appendix C) to the individual designated to receive it. RAND requests that the facility questionnaire be completed in advance of the meeting with RAND and the CDC-NCHS. However, if that is not possible, RAND and CDC-NCHS will be able to answer questions while on site for the interview and discussions.

The questionnaire is derived in part from the AHA database. The person responsible for completing the AHA survey may be a good resource for completing portions of this questionnaire. In addition, the questionnaire asks some questions regarding how medical records are managed and the extent to which patient and administrative records are stored electronically. The questionnaire also includes requests for additional structural information about the facility to help RAND and the CDC-NCHS understand differences among organizations.

**Meeting**

During RAND’s introductory meeting with the hospital, RAND staff will meet in person with senior leaders, including individuals selected by the primary contact person based on a description of the survey and his or her understanding of the types of individuals needed to successfully participate in the feasibility study. Key individuals may include, as appropriate, medical records and medical coding directors, the chief information officer, the chief financial officer, the privacy officer, the person designated to abstract the records, etc. The meeting should take about 1-2 hours. The agenda for this meeting will include a briefing on the study purposes and plans for the feasibility study. It will be important for RAND staff to identify key contacts with whom we will work on a day to day basis during the study. A draft agenda is included in Appendix E.
CHAPTER 3
CASE SELECTION

Introduction
This chapter provides guidance to hospital medical records and data management staff regarding how to select medical records for inclusion in the NHDS Feasibility Pilot. For this feasibility study it is important to abstract a diverse set of records. Therefore, the sampling strategy has a number of steps.

General Guidelines

1. Identify eligible discharges beginning with the most recent month for which your hospital can generate a list of patients with discharge diagnoses (ICD-9-CM) for which the month end statistics and financials are stable (e.g., 98% complete).
   For your hospital this month is__________, 2006
2. Eligible discharges exclude patients with lengths of stay greater than 10 days.
3. Study records selected should include the patient name, date of birth, admitting and discharge dates, medical record number, and visit number (if applicable) for confirmation that the correct record is abstracted. Data elements in the selected sample should include all identifiers required to link billing, medication, and clinical data, and to facilitate information retrieval and record collection. Below is a suggested format for the pull list:

   Figure 2  Suggested Pull List Format

<table>
<thead>
<tr>
<th>Group (A-G)</th>
<th>Medical Record Number</th>
<th>Patient Name</th>
<th>Date of Birth</th>
<th>Visit or Encounter Number</th>
<th>Admit Date</th>
<th>Discharge Date</th>
</tr>
</thead>
</table>

If during the survey you identify additional or different information that will be necessary to complete the survey, please note this in the abstractor assessment form which is detailed in Chapter 5

4. Twenty medical records will need to be abstracted. These will be drawn from seven categories (Groups A-G), as shown in the table below. If a record is unavailable, abstractors should go to the next record on the list for that category. We recommend that you select twice as many records for each group as will need to be abstracted so that if some records are missing, another case can be easily retrieved.

5. Identify all patients within a group from the eligible date range (item 1) and then randomly select the required number of cases within that group (a “simple random sample” within each group), considering the need for excess records to account for missing cases, as discussed above (item 4).

The random sample can be performed in one of three ways:

   a. On site using a computer algorithm available from the hospital’s business systems (e.g., medical records, decision support). The program should generate a list for each category, A through G below, and then select records randomly from each category specific list. During a debriefing session, RAND will ask how the hospital selected the sample and what issues or problems, if any, arose during the sample selection process.
b. Follow the instructions on each of the Sample Listing Sheets (Appendix I) under item #8 for each group A-G.

c. Manually with randomization assistance from RAND. Print a list for each of the seven categories in ascending terminal digit order. Use the form included in Appendix J to fax to RAND the number of cases in each category. (DO NOT INCLUDE PATIENT-SPECIFIC INFORMATION, ONLY THE TOTAL NUMBER OF CASES ON THE LIST.) RAND will return the fax to the hospital with the specific cases from the list that should be selected for abstraction.

6. If the facility does not have any patients in a particular identified group, add the number of records allocated for the “empty” group to the allocation for Group G ("all other patients"). For example, if the hospital does not have psychiatric admissions (Group F below), then include these 2 records with the 6 records that fall into Group G (”all other patients”) making a total of 8 “all other patient” cases.

7. For each group (A-G) complete a Sampling Listing Sheet (SLS) for all cases that have been selected for abstraction. The SLS will contain your hospital identifier, month of data collection, and the number of records in each group from which the sample for that group was drawn. The SLS form is included as Appendix I.

8. RAND will provide your facility a Roman numeral that you will use to identify your facility in lieu of your facility name. Assign cases consecutively with the identification letter followed by consecutive numbers. For example, for Facility “II”, assign numbers to records as follows: II-1, II-2, II-3, etc. This is called the “RAND ID #” on the SLS.

9. Identify and organize by group (A-G) each record and all additional documentation from other systems (e.g., lab, pharmacy, billing) to facilitate the hospital and RAND abstractor review.

10. Group A asks for patients on observation status. Observation status is an administrative classification of patients seen, often in hospital emergency rooms or outpatient clinics, who have unstable or uncertain conditions that are potentially serious enough to warrant close observation, but usually not so serious to warrant admission to the hospital. These patients may be placed in beds usually for less than 24 hours without formal admission to the hospital. (Adapted from Coffee RM, Barrett ML, Steiner S. Final report – observation status related to hospital records 2002. HCUP Methods Series Report #2002-4, Agency for Healthcare Research and Quality, www.hcup-us.ahrq.gov)

Patient Record Selection

Records should exclude any patient with a length of stay greater than 10 days and be sampled from one of seven groups according to the following rules:

Group A: Observation or 24 hour short stay patients
   1. Primary payer may be Medicare or any other payer that reimburses for patients in this status
   2. Exclude “extended recovery” patients from outpatient or ambulatory surgery.

Group B: Normal newborns
   1. Primary ICD-9-CM Diagnosis codes V27.0, V27.2, V27.5 or DRG 391

Group C: Eligible pediatric discharges
   2. Patient age less than or equal to 15 years
   3. Exclude normal newborns: Primary ICD-9-CM Diagnosis codes V27.0, V27.2, V27.5 or DRG 391
4. Exclude Asthma Patients: Primary ICD-9-CM Diagnosis codes 493.0 – 439.9

Group D: AMI/Acute coronary syndrome discharges
   1. ICD-9-CM Primary Diagnosis codes 410.x0, 410.x1 or 411.1

Group E: Asthma discharges
   1. ICD-9-CM Primary Diagnosis code 493.0 – 493.9

Group F: Psychiatric discharges
   1. Exclude patients age less than or equal to 15 years
   2. ICD-9-CM Primary Diagnosis codes 290.0 – 299.0

Group G: All other patients (discharges)
   1. Exclude patients age less than or equal to 15 years
   2. Exclude Asthma Patients: Primary ICD-9-CM Diagnosis codes 493.0 – 439.9
   3. Exclude ICD-9-CM Primary Diagnosis codes 410.x0, 410.x1 or 411.1
   4. Exclude ICD-9-CM Primary Diagnosis codes 290.0 – 299.0

Draw a simple random sample of cases within each group according to the allocation shown in the table below. A random sample may be drawn in one of three ways, as described in item 4 above.

<table>
<thead>
<tr>
<th>allocations</th>
<th>allocations</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Observation Cases</td>
<td>5</td>
</tr>
<tr>
<td>B. Normal Newborns</td>
<td>1</td>
</tr>
<tr>
<td>C. Pediatrics</td>
<td>2</td>
</tr>
<tr>
<td>D. AMI/Acute Coronary Syndrome</td>
<td>2</td>
</tr>
<tr>
<td>E. Asthma</td>
<td>2</td>
</tr>
<tr>
<td>F. Psychiatric</td>
<td>2</td>
</tr>
<tr>
<td>G. All Other Patients</td>
<td>6</td>
</tr>
<tr>
<td>Total</td>
<td>20</td>
</tr>
</tbody>
</table>
CHAPTER 4
RECORD ABSTRACTION

Introduction
A data abstraction form (Appendix H) has been constructed to facilitate data collection. This chapter provides guidance for the record abstractor regarding individual data elements to be collected. Each data element is described in more detail in this section. Please make sure to refer to the data definitions to ensure consistency in data abstraction.

Data Collection Instructions

General
Abstract medical records in the order they are listed. Before abstracting, confirm that the medical record number is the correct one by confirming medical record number, visit or encounter number, patient name, patient birth date, and admission and discharge dates.

Sources of Data
Data may come from the patient’s medical record, electronic data provided in printed hard copy form, or data abstracted from online sources within the facility. Incorporate all requested data elements from electronic data (whether hard copy or online) into the survey unless otherwise instructed. For example, incorporate required billing information about duration of care into the survey form. For medications received during admission, however, fill in the requested information only if an electronic system printout is not available. Otherwise, attach to the survey the printout of medications administered without entering the relevant data.

Sources of data are listed hierarchically in the order of preference. It is not necessary to review all listed sources of information. Use your judgment in selecting the best source from this list based on the documentation found. In the Evaluation section (Chapter 5, Appendix K) you will have the opportunity to tell us if there are better sources from which to obtain the requested information than what has been suggested in these instructions.

Conflicting Data
If conflicting data are encountered (e.g., the Face Sheet and Physician’s Notes disagree with respect to patient age), choose the data value from the information source listed first in the Sources list for each survey item. For example, if the Face Sheet indicates that a patient is separated but a Physician’s Note indicates the patient is married, choose the data from the Face Sheet because the order of preference for marital status (Item 21) is Face Sheet, the Admitting History and Physical, and finally Discharge Planning Note.
### Detailed Data Element Descriptions

#### A. PATIENT PROTECTED HEALTH INFORMATION

<table>
<thead>
<tr>
<th>Data Element Number</th>
<th>Data Element Name</th>
<th>Definition</th>
<th>Guidelines</th>
<th>Sources</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>AHA Hospital Number</td>
<td>Identification number assigned to the hospital by the American Hospital Association</td>
<td>--</td>
<td>Provided by the NCHS</td>
</tr>
<tr>
<td>2</td>
<td>HDS Number</td>
<td>Number assigned to the sampled record for processing</td>
<td>--</td>
<td>Provided by the NCHS</td>
</tr>
<tr>
<td>3</td>
<td>HIC Number</td>
<td>Patient’s Medicare number</td>
<td>Applies only to patients with a primary or secondary payer of Medicare</td>
<td>Face sheet, Billing record</td>
</tr>
<tr>
<td>4</td>
<td>Patient Name</td>
<td>Patient’s full name: last, first, middle</td>
<td>If the patient’s middle name is noted, enter that. If only a middle initial is noted, enter that.</td>
<td>Face Sheet</td>
</tr>
</tbody>
</table>
Data Element Numbers: 5 and 5a

Data Element Name: Medical Record Number
Definition: Patient identification number assigned by the hospital for this particular hospitalization
Guidelines: If patient is a newborn, enter 5a the medical record number of the mother.
Sources: Face Sheet

Data Element Number: 6

Data Element Name: Billing Number
Definition: Patient billing number assigned by the facility for this hospitalization
Guidelines: --
Sources: Billing Record

Data Element Number: 7

Data Element Name: Visit or Encounter Number
Definition: Internal facility number associated with this encounter.
Guidelines: Use the number (visit or encounter) that has the best information for tracking services that span financial and clinical data. The better number to use will vary by institution.
Sources: Billing record
ADT system

Data Element Number: 8

Data Element Name: Birth Date
Definition: Patient’s date of birth
Guidelines: Enter the month, day, and year the patient was born.
Sources: Face sheet
Patient record label

Data Element Number: 9

Data Element Name: Social Security Number (SSN)
Definition: Patient’s 9-digit social security number
Guidelines: --
Sources: Face sheet
Admission, discharge and transfer system
Billing system

Data Element Number: 10
Data Element Name: Patient Street Address
Definition: Patient’s street address at the time of presentation to the hospital
Guidelines: If different home and mailing addresses are listed, enter the home address.
Sources: Face sheet
Billing record

Data Element Number: 11
Data Element Name: Zip Code
Definition: Postal zip code of patient at the time of hospital presentation
Guidelines: If different home and mailing addresses are listed, enter the home address.
Sources: Face sheet
Billing record

---

B. PATIENT RECORD IDENTIFICATION

Data Element Number: 12
Data Element Name: Emergency Department (ED) Admission Date and Time
Definition: Date and time patient first presented at the ED. If patient was not seen in the ED during this admission, check the appropriate box to indicate this
Guidelines: Do not enter date or time from care given during transportation to the ED by emergency medical staff. Enter time in military time. For example, enter 0200 for 2:00 am and 1400 for 2:00 pm.
Sources: ED record

Data Element Number: 13
Data Element Name: Observation Admission Date and Time
**Definition:** Date and time patient first started observation status. If the patient was never in observation status during this admission, check the appropriate box to indicate this.

**Guidelines:** Use the time the patient was admitted to the hospital on observation status. If the patient was admitted to observation from the ED, use the date and time of the physician order to "admit to observation". Enter time in military time. For example, enter 0200 for 2:00 am and 1400 for 2:00 pm.

**Sources:**
- MD order
- Nursing admission note (if no physician note)

---

**Data Element Number:** 14

**Data Element Name:** Acute Hospitalization Admission Date and Time

**Definition:** Date and time patient started the acute inpatient hospitalization. If the patient was never an acute inpatient during this admission, check the appropriate box to indicate this.

**Guidelines:** If the patient was admitted from observation, use the date and time of the order in the chart for "admit to acute inpatient," "change status from observation to admission," or an analogous phrase. If the patient was directly admitted from outside or from the ED, use the admit time. Enter time in military time. For example, enter 0200 for 2:00 am and 1400 for 2:00 pm.

**Sources:**
- Face sheet
- MD admission order (particularly for status change from observation)
- Nursing admission note

---

**Data Element Number:** 15

**Data Element Name:** Acute Admission Type

**Definition:** Degree of urgency related to this admission

**Guidelines:** Indicate the type of inpatient admission. This information may be coded on the Face Sheet of the chart. If so, use this information. If not, determine the type of admission based on medical record documentation.

- **Emergency** = Patient requires immediate medical intervention as a result of severe, life threatening or potentially disabling conditions. Generally, the patient is admitted through the emergency room.

- **Urgent** = Patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally, the patient is admitted to the first available and suitable accommodation.

- **Elective** = Patient's condition permits adequate time to schedule the availability of a suitable accommodation. An elective admission can be delayed without substantial risk to the health of the individual.

- **Newborn** = Child is just born. Generally, the child is born within the facility.

If unable to tell the type of admission, indicate this by checking the relevant box. For non-admissions (i.e., observation only), check the "Not Applicable" box.
Data Element Number: 16

Data Element Name: Critical Care

Definition: Admission and discharge dates and times related to the first admission to critical care, and the total number (count, not days) of critical care admissions during this hospitalization.

Guidelines: Determine these data based on the timing of the MD order written for the change to critical care. If this information is not available or unclear, use the first critical care nursing note entry. If the patient was directly admitted to critical care, use the hospital admission time. Enter time in military time. For example, enter 0200 for 2:00 am or 1400 for 2:00 pm.

Critical care = Admission to any critical care unit (e.g., ICU, CCU, NICU, etc.)

Sources: MD orders
          Nursing notes
          MD progress notes

Data Element Number: 17

Data Element Name: Observation/Acute Hospitalization Discharge Date and Time

Definition: Date and time patient left the hospital or died

Guidelines: Enter time in military time. For example, enter 0200 for 2:00 am or 1400 for 2:00 pm.

Sources: Nursing discharge note

C. PATIENT IDENTIFICATION and DEMOGRAPHICS

Data Element Number: 18

Data Element Name: City

Definition: City in which patient resided at the time of hospital presentation

Guidelines: If different home and mailing addresses are listed, enter the home address.

Sources: Face sheet
          Billing record
<table>
<thead>
<tr>
<th>Data Element Number:</th>
<th>19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element Name:</td>
<td>State</td>
</tr>
<tr>
<td>Definition:</td>
<td>State in which patient resided at the time of hospital presentation</td>
</tr>
<tr>
<td>Guidelines:</td>
<td>If different home and mailing addresses are listed, enter the home address.</td>
</tr>
</tbody>
</table>
| Sources:            | Face sheet  
|                     | Billing record |

<table>
<thead>
<tr>
<th>Data Element Number:</th>
<th>20</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element Name:</td>
<td>Age</td>
</tr>
<tr>
<td>Definition:</td>
<td>Patient’s age at the time of first presentation to the hospital</td>
</tr>
<tr>
<td>Guidelines:</td>
<td>Enter the patient’s age only if the date of birth is NOT available. Otherwise leave this item blank. Enter the age and indicate the units of age (years, months, or days).</td>
</tr>
</tbody>
</table>
| Sources:            | Face sheet  
|                     | Patient record label  
|                     | Admitting history and physical |

<table>
<thead>
<tr>
<th>Data Element Number:</th>
<th>21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element Name:</td>
<td>Sex</td>
</tr>
<tr>
<td>Definition:</td>
<td>Patient’s sex (male / female)</td>
</tr>
<tr>
<td>Guidelines:</td>
<td>--</td>
</tr>
</tbody>
</table>
| Sources:            | Face sheet  
|                     | Patient record label  
|                     | Admitting history and physical |

<table>
<thead>
<tr>
<th>Data Element Number:</th>
<th>22</th>
</tr>
</thead>
<tbody>
<tr>
<td>Data Element Name:</td>
<td>Marital Status</td>
</tr>
<tr>
<td>Definition:</td>
<td>Patient’s marital status at the time of hospital presentation</td>
</tr>
<tr>
<td>Guidelines:</td>
<td>Limit this classification to legal marital status at the time of hospital presentation. Do not reference notations about living relationships that are not legally recognized (e.g. roommate, companion, significant other). Code “single “ unless married.</td>
</tr>
</tbody>
</table>
| Sources:            | Face sheet  
|                     | Admitting history and physical  
|                     | Discharge planning note |
Data Element Number: 23

Data Element Name: Living Situation at Admission

Definition: Patient's living situation at the time of hospital presentation

Alone, private residence = Patient lives alone in any non-institutional setting, including a house, rented home or apartment, residential hotel, etc. If it is not clear from the documentation whether the patient lives with someone, assume that he/she lives alone.

Share private reference = Patient lives with at least 1 other individual in any non-institutional setting. This individual may be a relative or roommate.

Psychiatric facility = Includes any residential psychiatric, mental health, or substance abuse facility.

Skilled nursing facility = This is a nursing home that provides skilled nursing and/or skilled rehabilitation services to patients who need skilled medical care that cannot be provided in a custodial level nursing home or in the patient's home. A skilled nursing bed may be housed in a facility with non-skilled beds. The difference between the 2 bed types is the degree of nursing care required (i.e., skilled vs. non-skilled).

Long-term care = Includes any nursing home that is not providing skilled nursing care to the patient and is a level of care above assisted living.

Assisted living = This includes living situations with limited support such as assisted living (not long-term care), board and care, group homes, adult care homes, etc.

Homeless = Patient is noted to be homeless or staying in a shelter of any kind.

Incarcerated = Patient came from a prison, jail, or any other type of detention facility.

Other/Not stated = Any living arrangement not included above

Guidelines: Do not use the Face Sheet as a source for this item.

Sources: Admitting history and physical
         Nursing admission note
         Discharge planning note

Data Element Number: 24

Data Element Name: Race

Definition: Patient’s race

Guidelines: If patient is noted to be of mixed race, check all categories that apply

Sources: Face sheet
         Admitting history and physical
Data Element Number: 25
Data Element Name: Ethnicity
Definition: Whether or not the patient is Hispanic or Latino

Hispanic = Includes individuals of Spanish descent and from countries in Latin America where the primary language is Spanish. Also includes persons from Mexico, Puerto Rico, Cuba, Central or South America, or of some other Hispanic origin. Persons of Hispanic origin may be of any race.

Guidelines: Do not make this determination based solely on a Spanish surname.

Sources: Face sheet
Admitting history and physical
Discharge planning note

Data Element Number: 26
Data Element Name: Mode of Arrival
Definition: Mode by which patient arrived at hospital location for this admission

Guidelines:
Ambulance (air/ground) = Any emergency transport
Public service (non-ambulance) = Any mode of public transportation such as bus, taxi, etc.
Personal transportation = Patient arrived via personal auto either by driving or by transportation provided by a family member or acquaintance or patient walked to the hospital.

Sources: ED record
EMT/Ambulance transport record
Nurse admission note
Admitting history and physical

Data Element Number: 27
Data Element Name: Source of Admission
Definition: Source of acute care received just prior to hospital arrival for this admission

Guidelines:
Physician referral = Patient was sent to the hospital on the advice of his/her personal physician. This may be an elective (i.e., planned) admission or may be an urgent admission directly from the physician’s office.

Acute ➔ acute transfer = Patient was transferred from another acute care facility to the current facility at the start of this admission.
Other ED ➔ acute transfer = Patient was transferred from an emergency department (ED) of another acute hospital to the current facility at the start of this admission.

Court/law enforcement = Patient was brought to the hospital by order of a court or request of a law enforcement officer.

Other transfer = Any other transfer not included above.

**Sources:**
- ED record
- Admitting history and physical
- Nurse admission note

---

**Data Element Number:** 28

**Data Element Name:** Education

**Definition:** Patient’s highest level of education, or, if the patient is less than 18 years old, the education of the patient’s parent/caregiver

Not HS grad = Includes patients who are currently in high school, dropped out of high school without graduating and have not passed the General Educational Development (GED) test, and patients who never attended high school.

HS grad/GED = Includes patients whose highest level of educational preparation is high school graduation or the successful completion of the General Educational Development (GED) test.

Some college = Includes patients who have attended some college courses, but have not met the requirements for completion of a 4-year college degree.

College grad = Includes patients who have completed the requirements for a 4-year college degree.

Post grad = Includes patients who have completed some postgraduate courses after completion of 4-year college degree.

**Guidelines:** Only enter information that is documented. For example, do not guess at the patient’s education based on occupation. If the educational level of both parents is given, note the highest level. If a minor patient [less than 18 years old] is under the care of someone other than a parent (e.g., grandparent) as his/her primary caregiver/guardian, note the educational level of the caregiver.

**Sources:**
- Admitting history and physical (e.g., social history)
- Nursing admission note
- First social work note
- Discharge planning note

---

**Data Element Number:** 29

**Data Element Name:** Occupation

**Definition:** Patient’s occupation at the time of hospital presentation for this admission, or, if patient is less than 18 years old, occupations of the patient’s parents/caregivers

**Guidelines:** Enter the occupation of the patient (if 18 years of age or older) or the occupation(s) of the parent(s)/caregiver(s), if the patient less than 18 years old. Enter only occupations reflecting current
employment. Therefore, if a patient is noted to be an “unemployed teacher,” check “unemployed.” If a patient is noted to be a “retired attorney,” check “retired.” If the patient is less than 18 years of age and attending school OR 18 years of age or older and whose current primary activity is attending school, enter “student.”

Sources:  
Face sheet  
Admitting history and physical  
First social work note  
Discharge planning note

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**Data Element Number:** 30  
**Data Element Name:** English Proficiency  
**Definition:**  
English proficiency of patient (if at least 8 years old) and/or parent/caregiver (if patient is less than 18 years old)

**Guidelines:**

Proficient = Able to interact with healthcare providers in English and understand instructions provided and convey his/her own needs to healthcare providers.

Consider a patient/parent/caregiver to be NOT proficient in English if s/he:

- Required an interpreter or there is documentation of the need for an interpreter
- Required a family member to act as an interpreter
- Signed any consent form in a language other than English or the consent was cosigned by an interpreter
- Required physician to conduct the history with the patient in a language other than English
- Received printed materials in a language other than English

If not proficient, enter the primary language, if stated. Do not make assumptions about the primary language based on surname. Enter only what is documented in the record.

**Sources:**  
Admitting history and physical  
Admission nursing note  
Admission/surgical/procedure consents  
First social work note  
Discharge planning note

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**D. PATIENT CLINICAL VARIABLES (Obtained from Medical Record)**

**Data Element Number:** 31  
**Data Element Name:** Vital Signs on First Presentation: Blood Pressure  
**Definition:**  
Patient’s first systolic and diastolic blood pressure on hospital presentation, as measured within the first 24 hours
Guidelines: Use the first value noted after hospital arrival if within first 24 hours. Do NOT use values measured prior to arrival (e.g., physician’s office, emergency transport). If there is no blood pressure value noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources: ED record
Nursing admission form
Nursing notes
Vital signs flow sheet/graphic
Admitting history and physical

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Heart Rate

Definition: Patient’s first documented heart rate on hospital presentation, as measured within the first 24 hours.

Guidelines: Use the first value noted after hospital arrival if within first 24 hours. Do NOT use values measured prior to arrival (e.g., physician’s office, emergency transport). If there is no heart rate measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources: ED record
Nursing admission form
Nursing notes
Vital signs flow sheet/graphic
Admitting history and physical

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Respiratory Rate

Definition: Patient’s first documented respiratory rate on hospital presentation, as noted within the first 24 hours.

Guidelines: Use the first value noted after hospital arrival and within the first 24 hours. Do NOT use values measured prior to arrival (e.g., physician’s office, emergency transport). If there is no respiratory rate measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources: ED record
Nursing admission form
Nursing notes
Vital signs flow sheet/graphic
Admitting history and physical

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Temperature

Definition: Patient’s first documented temperature on hospital presentation, as noted within the first 24 hours.
Guidelines: Use the first value noted after hospital arrival. Accept all sources of temperature measurement (e.g., oral, rectal, axillary, aural). Do NOT use values measured prior to arrival (e.g., physician’s office, emergency transport). Enter the value and indicate whether the units are centigrade or Fahrenheit and the source of the first temperature measurement. If there is no temperature measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources: ED record
Nursing admission form
Nursing notes
Vital signs flow sheet/graphic
Admitting history and physical

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Oxygen Saturation

Definition: Oxygen saturation is the measure of the percent of oxygen in the blood. It can be determined either through pulse oximetry or arterial blood gas (ABG) measurement. Alternative names that can be used to define oxygen saturation are:
  - Pulse oximetry
  - Pulse ox
  - SaO₂
  - Oxygen saturation
  - O₂ sat

Guidelines: Take the first value documented after hospital arrival and within the first 24 hours. Indicate whether the patient was on room air (RA) or was receiving oxygen at the time the oxygen saturation was measured. Include supplemental oxygen regardless of rate (liters/minute) and delivery system (e.g., nasal prongs, mask). If there is no oxygen saturation measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources: ED record
Nursing notes
MD progress notes
Respiratory therapy notes

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Height

Definition: Measurement of patient height

Guidelines: Take the first value documented after hospital arrival and within the first 24 hours. If during the first 24 hours height is documented both by patient estimate and actual measurement, take the measured height over the estimated height. If only an estimated height is available, take this value. Check whether the units of measurement are inches or centimeters (cm).

If the height is noted in meters (e.g., 1.85), convert this to centimeters by multiplying by 100 or moving the decimal point 2 digits to the right (e.g., 1.85 meters = 185 centimeters).

If the height is given in feet and inches (e.g., 6 feet 2 inches), convert this to inches by multiplying the feet by 12 and adding the inches to that number (e.g., 6 feet 2 inches = 6 x 12 = 72 + 2 = 74 inches).
If there is no height measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources:  
Nursing admission note  
Nursing notes  
Anesthesia assessment  
MD progress notes

Data Element Number: 31 (continued)

Data Element Name: Vital Signs on First Presentation: Weight

Definition:  
Measurement of patient weight

Guidelines:  
Take the first value documented after hospital arrival and within the first 24 hours. If during the first 24 hours weights are documented both by patient estimate and actual measurement, take the measured weight over the estimated weight. If only an estimated weight is available, take this value. Check whether the units of measurement are pounds or kilograms (kg). Enter the value to the nearest 10\(^{0}\) of a pound or kilogram (e.g., enter 151\(\frac{1}{2}\) pounds as 151.5).

If the weight is noted in grams (e.g., 750 grams), convert this to kilograms by dividing by 1000 or moving the decimal point 3 digits to the left (e.g., 750 grams = 0.75 or 0.8 kilograms).

If there is no weight measurement noted in the first 24 hours of this hospitalization, check the box to indicate this.

Sources:  
Nursing admission note  
Nursing notes  
Anesthesia assessment  
MD progress notes

Data Element Number: 32

Data Element Name: Clinical Laboratory Results: Hematocrit

Definition:  
Percent of blood that is red blood cells.  Synonyms: Hct, crit

Guidelines:  
Enter the value to 1 decimal point. Use the first value measured after hospital arrival if within first 24 hours. Do NOT use any preadmission values. If there is no hematocrit value noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources:  
Laboratory results  
Admitting history and physical  
MD progress notes
Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: White Blood Count

Definition: White blood cell concentration in blood. Synonyms: WBC, white count, total WBC, leukocyte count

Guidelines: Enter the value to 1 decimal point in units of 1000. For example, enter 158,300 as 158.3. Use the first value measured after hospital arrival. Do NOT use any preadmission values. If there is no white blood cell count noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory results
Admitting history and physical
MD progress notes

Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: Platelet Count

Definition: Platelet concentration in blood. Synonyms: Thrombocyte count, plt

Guidelines: Enter the value to 1 decimal point in units of 1000. For example, enter 350,000 as 350.0. Use the first value measured after hospital arrival and within first 24 hours. Do NOT use any preadmission values. If there is no platelet count noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory Results
Admitting history and physical
MD progress notes

Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: Creatinine

Definition: Concentration of creatinine in the blood or serum. Synonyms: Serum creat, Cr

Guidelines: Enter the value to 1 decimal point. Do NOT enter creatinine clearance. Be sure that the source of the specimen is blood. Use the first value measured after hospital arrival and within first 24 hours. Do NOT use any preadmission values. If there is no creatinine value noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory results
Admitting history and physical
MD progress notes
Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: Urea Nitrogen

Definition: Concentration of urea nitrogen in the blood or serum. Synonyms: BUN

Guidelines: Do NOT enter urea clearance. Be sure that the source of the specimen is blood. Use the first value measured after hospital arrival and within first 24 hours. Do NOT use any preadmission values. If there is no urea nitrogen value noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory results
Admitting history and physical
MD progress notes

Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: Potassium

Definition: Concentration of potassium in the blood or serum. Synonyms: Serum K, K+.

Guidelines: Enter the value to 1 decimal point. Use the first value measured after hospital arrival and within first 24 hours. Do NOT use any preadmission values. If there is no potassium value noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory results
Admitting history and physical
MD progress notes

Data Element Number: 32 (continued)

Data Element Name: Clinical Laboratory Results: Sodium

Definition: Concentration of sodium in the blood or serum. Synonyms: Serum Na.

Guidelines: Enter the value to 1 decimal point. Use the first value measured after hospital arrival and within first 24 hours. Do NOT use any preadmission values. If there is no sodium value noted in the first 24 hours of this hospitalization, check the box to indicate this. Include a value only if the time sent to lab, time received in lab, or time recorded is within the first 24 hours of admission.

Sources: Laboratory results
Admitting history and physical
MD progress notes
Data Element Number: 33

Data Element Name: Activities of Daily Living

Definition: Activities of daily living (ADLs) are self-care activities that people must accomplish to survive without help. Patients unable to perform these activities usually require caregiver support for a significant part of the day.

Guidelines: Note if the patient had difficulty with regard to ADLs at the time of admission (i.e., patient’s usual functioning prior to admission) and at the time of discharge. “Has difficulty with” is defined as:

- Bathing: Requires assistance with bathing more than 1 part of the body
- Dressing: Requires assistance that is more than for just tying shoes
- Toileting: Requires more assistance than just a cane or walker and/or requires a bedpan or urinal during the day
- Transfer: Requires more assistance than just a cane or walker
- Continence: Lack of bowel or bladder control that is more than just an occasional accident.
- Feeding: Requires more assistance than just help with cutting meat or buttering bread.

ADLs may be given as a Katz score of 0-6 (poor to good). The Katz Index of Independence in Activities of Daily Living, commonly referred to as the Katz ADL, is a measurement of the patient’s ability to perform activities of daily living independently. Clinicians typically use the tool to detect problems in performing activities of daily living and to plan care accordingly. The index ranks adequacy of performance in the 6 listed functions with a scored yes/no for independence in each of the functions. A score of 6 indicates full function, 4 indicates moderate impairment, and 2 or less indicates severe functional impairment. The ADLs are listed hierarchically; that is, as a patient loses function, s/he is likely to lose the functions listed at the top first.

If there are no listed ADLs but the patient has a computed Katz score, enter the data as follows:

<table>
<thead>
<tr>
<th>Katz score</th>
<th>Box(es) to check:</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Independent</td>
</tr>
<tr>
<td>5</td>
<td>Bathing</td>
</tr>
<tr>
<td>4</td>
<td>Bathing, Dressing</td>
</tr>
<tr>
<td>3</td>
<td>Bathing, Dressing, Toileting</td>
</tr>
<tr>
<td>2</td>
<td>Bathing, Dressing, Toileting, Transfer</td>
</tr>
<tr>
<td>1</td>
<td>Bathing, Dressing, Toileting, Transfer, Continence</td>
</tr>
<tr>
<td>0</td>
<td>Bathing, Dressing, Toileting, Transfer, Continence, Feeding</td>
</tr>
</tbody>
</table>
If an alternative scoring mechanism is used, please translate to the ADL terminology as listed above.

**Sources:**
- Nursing admission note
- Admitting history and physical
- MD progress notes
- Discharge planning note
- Nursing discharge note

---

**Data Element Number:** 34  
**Data Element Name:** Pain Assessment  
**Definition:** Assessment of the patient’s level of pain on presentation.

**Guidelines:** This may either be documented as a rating on a 10-point or 5-point scale or noted with a severity descriptor (e.g., moderate). Take the first value documented after hospital arrival and within the first 24 hours. If pain severity is given as a range (e.g., mild to moderate, 5-6/10), note the more severe level of pain (e.g., mild to moderate = moderate, 5-6/10 = 6). If an alternative scale is used, please translate the score to Severe, Moderate, Mild, Unknown.

**Sources:**
- Nursing admission note
- Nursing notes
- MD progress notes

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**Data Element Number:** 35  
**Data Element Name:** ASA Classification for Surgical Patients  
**Definition:** Assessment of patient surgical risk based on a system created by the American Society of Anesthesiologists (ASA):

- **Class 1:** Generally healthy, localized pathologic process
- **Class 2:** Stable mild to moderate systemic condition (e.g., smoker, history of hypertension, obesity, diabetes, asthma, age >70 years)
- **Class 3:** Moderately severe systemic disorder (e.g., poorly controlled disorders, history of coronary artery disease, cardiac arrhythmia)
- **Class 4:** Severe and clearly life-threatening disorder (e.g., recent myocardial infarction, acute coronary syndrome, severe congestive heart failure or COPD, hepatic or renal failure)
- **Class 5:** Little chance of survival; not expected to survive without the surgery
- **Class 6:** A declared brain-dead patient whose organs are being removed for donor purposes

**Guidelines:** This must be noted in the chart by a physician and specifically described by patient Class (or ASA). Do not try to determine ASA class based solely on patient medical history. Check “Not applicable” if the patient did not have surgery or another interventional procedure requiring an anesthesia assessment during the admission.

**Sources:**
- Anesthesiology preoperative note
- Anesthesia record
- MD progress notes
**Data Element Number:** 36

**Data Element Name:** Drug Allergies

**Definition:** Allergy to any prescription or over-the-counter medication.

**Guidelines:** Do NOT include reference to herbal preparations (e.g., St. John’s Wort). Include any drug to which the patient is known/suspected to have an allergy or past untoward side effect. This includes references to specific drugs as well as drug categories (e.g., beta-blockers). Include any medication that a provider has noted that the patient is not a candidate to take or for which the patient has a contraindication (absolute or relative). Do not include allergies to other types of allergens (e.g., environmental, food, etc.).

**Sources:** Nursing admission note
Admitting history and physical
MD progress notes
Medication administration record
Medical record allergy alert sticker

---

**Data Element Number:** 37

**Data Element Name:** Tobacco Use

**Definition:** Assessment of patient’s tobacco use. This information includes smoking cigarettes and any use of cigars, pipes, and/or chewing tobacco.

**Guidelines:** Consider the patient a cigarette smoker if s/he smokes any amount of cigarettes and of any frequency. If a patient is currently in a smoking cessation program and/or is using prescription nicotine aids to stop, base your answer on whether or not smoking has completely stopped at the time of this admission. If a patient is noted to be a “non-smoker” and there is no documentation of past use, check “Never.” If a patient is noted to be a “non-smoker” and there IS evidence of use, check the appropriate box regarding timing of stopping. Include in “Other” any current or past use of tobacco other than cigarettes and use the rules noted above to describe the use.

If two providers note conflicting data from the same medical record source (e.g., MD notes include a statement by an MD that the patient is a smoker, but another MD notes that the patient does not smoke), note the more "positive" value (e.g., patient is a smoker).

**Sources:** Admitting history and physical
MD progress notes
Nursing admission note
Nursing notes

---

**Data Element Number:** 38

**Data Element Name:** Pack Years

**Definition:** Number resulting from multiplying the number of packs of cigarettes smoked per day times the years smoked.
Guidelines: If the patient has never smoked cigarettes, check “not applicable.” For other patients, document pack-years smoked. If pack-years are not given but the quantity of daily smoking and years of smoking are known, calculate the pack-years. One pack of cigarettes = 20 cigarettes. Pack years = number of packs of cigarettes smoked per day multiplied by the number of years the patient has smoked. For example, if a patient smoked 10 cigarettes per day for 10 years, that would equal 5 pack years (0.5 packs/day x 10 years). If a patient smoked 2 packs per day for 6 months, that would equal 1 pack year (2 packs/day x 0.5 year). If complete information about pack years is not available (e.g., only years smoked but not amount, amount given in non-specific terms such as “heavy smoker.”), check “Not available/applicable.”

If 2 providers note conflicting data from the same source (e.g., MD notes include a statement by an MD that the patient has smoked 2 packs of cigarettes a day for 10 years, but another MD notes that the patient has smoked 2 packs of cigarettes a day for 15 years), document the more “positive” value (e.g., patient smoked 2 packs of cigarettes for 15 years).

Sources: Admitting history and physical
Nursing admission note
Nursing notes

Data Element Number: 39
Data Element Name: DNR Order
Definition: Indication of whether the patient had a Do Not Resuscitate (DNR) order at any point during this hospital episode. Patients who have DNR orders will not have a resuscitation (chest compressions, mechanical ventilation, defibrillation) initiated in the event of cardiac/respiratory arrest other than possibly pharmacologic intervention.

Guidelines: A DNR order from a physician must be in the record. Do not count any other documentation regarding patient preferences for care. Give the date (or first date, if more than one) of the DNR order for this admission.

Sources: MD orders
DNR form signed by patient/patient representative and physician

Data Element Number: 40
Data Element Name: Stability at Discharge
Definition: Signs/symptoms of instability on the day of or day before discharge in a patient who was discharged to home.

Guidelines: Indicate if any physiologic measure in the specified range listed below was documented any time on the day before or day of discharge:

- Temperature > 37.8 °C or > 100 °F
- Heart rate > 100/minute
- Respiratory rate > 24/minute
- Systolic blood pressure < 90 mm Hg
- O₂ saturation < 90% on room air (RA) OR < 95% on supplemental oxygen by any means (e.g., mask, nasal prongs) and of any concentration
Note the occurrence of any of the above regardless of the frequency and/or duration of its occurrence. Only count measurements above the listed level (e.g., include a temperature of 37.9°C, but not 37.8°C).

Sources: Vital signs flow sheet/graphic
Nursing notes
MD progress notes
Respiratory therapy notes

Data Element Number: 41
Data Element Name: Status/Disposition of the patient at discharge
Definition: Patient’s status at the time of hospital discharge
Guidelines: Select only one disposition among those listed. If a patient left against medical advice (AMA), it is not necessary to enter any more disposition information.

Left against medical advice (AMA) = This will be specifically noted in the record and includes a form signed by the patient acknowledging that he/she is leaving against medical advice and releases the hospital from any liability from the outcome of such a decision.

If the patient was discharged home, indicate whether the patient was ordered to have/had any of the following:

Home health care = Any referral for visiting nurse care or other home ancillary care (e.g., physical therapy) after discharge to home. This refers to physician prescribed home care and does NOT include arranging for paid help in the home.

Intravenous (IV) medication = Patients who leave the hospital with an IV or who are scheduled to continue IV treatment (e.g., antibiotic, morphine) or parenteral nutrition (TPN, IPN) at home.

MD follow-up instructions = Notation that the patient was instructed to any degree about following up post-hospitalization. This includes being advised to make an appointment with the MD or another consulting MD.

MD follow-up appointment = Specific appointment date given to the patient at the time of discharge for seeing his/her MD.

Test/treatment = Specific appointment for a test or treatment noted as part of the discharge plan.

If the patient was not discharged to home, note where the patient went directly from this hospitalization.

Acute hospital = Inpatient facility that administers acute care.

Acute rehabilitation = Rehabilitation that is part of patient’s acute care. This may be a facility that is part of the acute hospital facility or may be a freestanding facility. This is NOT the same as a skilled nursing facility, which provides skilled but non-acute nursing care.

Psychiatric facility = Any residential psychiatric, mental health, or substance abuse facility.

Skilled nursing facility = Nursing home that provides skilled nursing and/or skilled rehabilitation services to patients who need skilled medical care that cannot be provided in a custodial level nursing home or in the patient's home. A skilled nursing bed may be housed in a facility with non-skilled beds. The difference between the 2 bed types is the degree of nursing care required (i.e., skilled vs. non-skilled).
Other long-term care = Any assisted living facility or nursing home that is not providing skilled nursing care to the patient.

If the patient died during this hospitalization, note the place in the hospital where the death occurred. If a patient died in the hospital and changed locations during a cardiac arrest, for example, note the place in the hospital where the patient was pronounced dead.

**Sources:**
- Discharge planning note
- Nursing discharge note
- MD discharge order
- MD progress notes
- Nursing notes

### Data Element Number: 42

**Data Element Name:** Hospice/Palliative Care

**Definition:** Indication that patient was deemed to be a hospice patient or to receive only palliative care at the time of discharge

**Guidelines:** Documentation should clearly indicate that the patient’s classification at discharge is hospice or strictly palliative care.

Hospice care = Care for patients who are no longer seeking medical management that is aggressive and aimed toward seeking cure. Hospice care is palliative and emphasizes comfort measures and counseling to provide social, spiritual and physical support to the dying patient and his or her family. It may be administered in an inpatient or home setting. There will be an order for this classification of care as it directs the payer to fund palliative measures and not curative-seeking medical care.

Palliative care = Care for patients that concentrates on reducing the severity of the symptoms of a disease or slows its progress rather than providing a cure. It aims at improving quality of life, by reducing or eliminating pain and other physical symptoms, enabling the patient to ease or resolve psychological and spiritual problems, and at the same time, supporting the partner and family.

**Sources:**
- MD orders
- Discharge planning note
- Nursing discharge note

### E. MEDICAL RECORD CODED DATA

### Data Element Number: 43

**Data Element Name:** Attending Physician UPIN/NPI

**Definition:** Physician identification number of attending physician

**Guidelines:** Currently, the UPIN *Unique Physician Identification Number) is used. In 2007 providers will be required to have a national provider identifier (NPI).
**Data Element Number: 44**

**Data Element Name:** DRG Assigned to this Admission

**Definition:** Diagnosis-Related Group (DRG) is a system to classify hospital cases into one of approximately 500 groups, also referred to as DRGs, expected to have similar hospital resource use, developed for Medicare as part of the prospective payment system.

**Guidelines:** DRGs are assigned by a "grouper" program based on ICD diagnoses, procedures, age, sex, and the presence of complications or comorbidities. To meet those evolving needs, the objective of the DRG system had to expand in scope. Today, there are several different DRG systems that have been developed in the US.

**Sources:** Coding sheet/Discharge abstract, Billing record

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**Data Element Number: 45**

**Data Element Name:** Admitting Diagnosis

**Definition:** The admitting diagnosis listed for this patient admission.

**Guidelines:** Enter the ICD-9-CM code that is listed for the admitting diagnosis as well as the description.

**Sources:** Coding sheet/Discharge abstract, Billing record

---

**Data Element Number: 46**

**Data Element Name:** Final Diagnoses

**Definition:** List of diagnoses (up to 20) relating to this admission, including ICD-9-CM codes, principal diagnosis, whether the diagnoses existed on admission, and E-codes, if applicable.

**Guidelines:** Examine the discharge abstract to determine whether the diagnoses were coded as to presence at the time of admission. If not, check the medical record documentation for the first 24 hours of admission to determine whether stated diagnoses were present at that time.

**Sources:** Coding sheet/Discharge abstract, Admitting history and physical, Consults within the first 24 hours
Data Element Number: 46

Data Element Name: Final Diagnoses Present on Admission (POA)

Definition: Evidence that a diagnosis is present at the time the order for admission (acute inpatient, observation) occurs. Includes conditions that occur in the emergency department or hospital outpatient facilities (excluding observation facilities).

Guidelines: For each diagnosis, check the box to indicate whether there is evidence that this diagnosis was present on admission or acquired during the hospitalization. Identify one of these options for each primary and secondary diagnosis:

Y – Yes, condition present on admission
N – No, condition not present on admission
U – No information in the record to determine whether the condition was preexisting (for California until UB-04 is implemented, follow current California coding rules)

The POA indicator is based not only on the conditions known to be present at the time of admission, but also includes those conditions that were clearly present, but not diagnosed, until after the time of admission. For example, in the situation where a patient presents with an unknown cause of weight loss and infection that 3 days later is found to be secondary to a malignancy, the malignancy would be coded as present on admission even though it was identified during the course of care.

Sources: Coding sheet/Discharge abstract (for California, all states when UB04 is implemented) Admitting history and physical MD Progress notes

Data Element Number: 47

Data Element Name: Surgical and Diagnostic Procedures

Definition: List of surgical and diagnostic procedures relating to this admission, including codes, principal procedure, and dates of occurrence. Includes CPT-4 codes for hospital observation admissions.

Guidelines: List procedure descriptions for all relevant codes.

Sources: Coding sheet/Discharge abstract Billing record

Data Element Number: 47 (continued)

Data Element Name: Procedure Date

Definition: Date procedure was performed or started.

Guidelines: --

Sources: Coding sheet/Discharge abstract Billing record MD progress notes Procedure notes Operative reports
Data Element Number: 47 (continued)

Data Element Name: Procedure Physician UPIN/NPI

Definition: Physician identification number

Guidelines: Enter identification number of physician performing listed surgical or diagnostic procedure. See element 43 for more detailed description.

Sources: Coding sheet/Discharge abstract
Billing record

Data Element Number: 47 (continued)

Data Element Name: Anesthesia Type

Definition: Type of anesthesia given for each surgical or diagnostic procedure. Anesthesia does NOT include conscious sedation (e.g., Versed).

Loc = Local anesthesia. Involves infiltration by injection of a local anesthetic agent (e.g., lidocaine) into the area of the body involved in the procedure and likely to experience localized pain in the process. The physician or health care provider performing the procedure most often administers local anesthesia.

Reg = Regional anesthesia. Administered by injecting a local anesthetic agent to interrupt nerve impulses on large nerves or nerve roots serving relatively large segments of the body. Included under the term regional anesthesia are the following: spinal anesthesia, epidural anesthesia, caudal anesthesia, brachial plexus anesthesia (including axillary block, interscalene block, supraclavicular block), sacral nerve block, femoral nerve block, and ankle block, etc. Usually administered by an anesthesiologist or nurse anesthetist.

Gen = General anesthesia. Administered by the intravenous injection of anesthetic agents, the inhalation of anesthetic agents, or (more often) a combination of the two. General anesthesia involves loss of consciousness and loss of protective reflexes. It is administered by an anesthesiologist or nurse anesthetist.

Guidelines: If the patient had no anesthesia, leave this item blank. If you cannot determine the type of anesthesia given, check “Unk.” If more than one type of anesthesia was used, code the highest level (e.g., general, over regional, over local).

Sources: Anesthesia record
Intra-operative note
Operative report
Procedure report
F. FINANCIAL AND BILLING RECORD DATA ELEMENTS

Data Element Number: 48

Data Element Name: Expected Source of Payment

Definition: Patient’s source(s) of payment for hospital care.

Guidelines: Indicate both primary and other sources.

Sources: Face sheet
          Billing record

Data Element Number: 49

Data Element Name: Payment Type

Definition: Type of primary insurance plan held by the patient.

Guidelines: Enter the payment type only for the primary insurance.

Sources: Face sheet
         Billing record

Data Element Number: 50

Data Element Name: Billing Data Elements

Definition: Breakdown of types of care provided, duration of care, expected and actual reimbursement.

Guidelines: Enter, as applicable, the duration of care for inpatient intensive care (days), inpatient general acute care (days), rehabilitation/step down care (days). Enter as applicable and available the related amounts for total charges for care, expected reimbursement, and actual payment received.

Sources: Billing record

Data Element Number: 51

Data Element Name: Billing Data Printout

Definition: Printout of all charges for this admission allocated by revenue center ID.

Guidelines: Attach printout to the abstraction form.

Sources: Billing record
G. INFORMATION FROM HOSPITAL CARE WITHIN 30 DAYS

Data Element Number: 52
Data Element Name: Acute Admission/Observation in 30 Days Prior to/After this Admission
Definition: Any acute admissions/observations of this patient in the 30 days prior to this admission date (up to 3) or in the 30 days after this discharge date that occurred in this same facility (up to 3).
Guidelines: This data element requires examination of the patient’s entire medical record for any encounters (acute inpatient, observation, emergency department) for the 30 days prior to admission and 30 days after discharge. If the medical record is not complete, it will be necessary to ask for the complete record or access to the patient’s electronic record. This information may be produced from the hospital’s administrative records of admissions.
Include for all relevant admissions the admission and discharge dates, the principal diagnosis (ICD-9-CM), principal procedure (ICD-9-CM or most significant CPT-4), and the DRG (if an inpatient admission).
For reference, please also record the dates of the current admission (i.e., index admission) that you are abstracting.
Sources: Complete patient record
Hospital information system

H. MEDICATIONS

Data Element Number: 53
Data Element Name: Medications at Admission and Discharge
Definition: Summary of all medications (up to 20) that the patient was taking immediately preceding admission to the hospital and at the time of discharge
Guidelines: If there are more than 20 medications listed at either admission or discharge, list drugs in the following order of priority until 20 are listed:
Medications (Allopathic)
  Route: Oral, sublingual, patch, inhaled, IV
  Regular
  Prescription
  Over the counter
  PRN
Data Element Number: 54
Data Element Name: Medications Received During Admission
Definition: Summary of all medications administered to the patient during this admission
Guidelines: If a printout of medications administered is available from the Medication Administration Record, attach it to the survey form, and check the appropriate box under “Source.” Do not include medications given in the OR and/or procedural areas. There is no need to enter any other medication data onto the form for this item. If no such printout is available, enter the requested data (medication name, date, time/start time, and route).

If NO printout of medications administered is available, enter the data requested. Do not include medications administered during surgery and procedures. Enter only the first administration of a drug. Enter each drug only once. Do not enter multiple doses of the same drug. Enter time in military time. For example, enter 0200 for 2:00 am or 1400 for 2:00 pm. Do NOT include IV solutions without additional medications or electrolytes (e.g., D5W).

For date and time, list the time the medication dose was administered, or if a continuous infusion, the date and time it started. Routes may be noted as follows:

PO = Oral (pill, tablet, capsule, liquid, lozenge)
IV = Intravenous
IM = Intramuscular
SQ = Subcutaneous
PR = Rectal (liquid, suppository)
Vag = Vaginally (suppository)
SL = Sublingual (liquid, tablet, spray)
TD = Transdermal (patch)
Top = Topical (cream, ointment, paste)
Inh = Inhaled (mist, inhaler, aerosol)
NS = Nasal spray
IT = Intrathecal
ID = Intradermal
IP = Intraperitoneal

Sources: Medication administration record
Billing record
Pharmacy information system
**CLINICAL MODULE: PATIENTS PRESENTING WITH ACUTE MYOCARDIAL INFARCTION OR ACUTE CORONARY SYNDROME**

**NOTE:** This section applies only to patients with a principal diagnosis of acute myocardial infarction or acute coronary syndrome (ICD-9-CM codes 410.x0, 410.x1, or 411.1)

---

**Data Element Number:** C1

**Data Element Name:** First ECG on Admission

**Definition:** Indicate the date and time of the first electrocardiogram (ECG, EKG) performed on or after hospital arrival. If an ECG was performed within 1 hour prior to arrival (e.g., ECG done by emergency response personnel or MD’s office), consider it to be the first ECG.

**Guidelines:** Enter the date and time of the first 12-lead ECG performed, whether prior to or after hospital arrival. The first ECG may be that performed in the ambulance, the Emergency Department (ED) or while the patient was under observation. Do not include any ECG’s that were obtained more than 60 minutes prior to hospital arrival. Enter time in military time. For example, 2:00 am would be entered as 0200 and 2:00 pm as 1400.

**Sources:**
- ECG report
- ED notes
- Admitting history and physical
- MD progress notes

---

**Data Element Number:** C2

**Data Element Name:** ST-segment Elevation

**Definition:** Documentation in the first ECG at admission that shows ST-segment elevation of a left bundle branch block (LBBB). If using the ECG report, the initial automated report should have been reviewed to confirm the findings or an official signed ECG report is present in the record. An MD’s (or physician extender’s) progress note describing the ECG findings is also acceptable.

**Guidelines:** If the location of an MI is documented and it is described as acute/evolving, or an acute/evolving MI is described as “transmural” or “Q wave”, the presumption is being made that it is an ST elevation MI. Do not consider “subendocardial” an MI “location” (e.g., “acute subendocardial MI” should be excluded).

Consider “infarct” synonymous with myocardial infarction (e.g., “acute inferior infarct”) and include these. MIs MUST be described as acute or evolving (in addition to documentation of location or description of MI as “transmural” or “Q wave”). Do NOT include MIs specified as old or previously seen, where the age is documented as undetermined (e.g., “inferior MI age undetermined,” “extensive anterior infarct, age indeterminant,” “anterolateral MI on or before 09-01-2004”), or where age is not addressed in any manner (e.g., “Q wave MI”).
“New,” “recent” and “subacute” should not be considered synonymous with “acute.” “Evolving” should be considered synonymous with “acute.”

When both an inclusion and exclusion are documented in reference to the same ECG, or documentation is otherwise conflicting, select “No.”

Sources: ECG report
          ED notes
          Admitting history and physical
          MD progress notes

Data Element Number: C3
Data Element Name: Troponin Levels
Definition: Test for contractile proteins of the myofibril used to diagnose acute myocardial infarction (AMI) and minor myocardial cell damage from a few hours after onset of symptoms to as long as 5-7 days. Either a troponin I or a troponin T can be performed; usually a laboratory will offer one test or the other. Synonyms: Cardiac troponin, troponin I, cTnI, troponin T, cTnT.

Guidelines: Enter date, time, and results of the first 3 troponin tests to 1 decimal point. Enter the reference range listed on the laboratory report as well.

Sources: Laboratory results
          ED record
          Admitting history and physical
          MD progress notes

Data Element Number: C4
Data Element Name: Beta-blocker Within 24 Hours
Definition: Whether patient received a beta-blocker within 24 hours of hospital arrival. Beta blockers are agents which block beta-adrenergic receptors, thereby decreasing the rate and force of heart contractions, and reducing blood pressure. Over time, beta-blockers improve the heart’s pumping ability.

Guidelines: Include any beta-blocker given, at any dose, by any route. Consider a beta-blocker “given” if a beta-blocker is included in the patient’s medical regimen just prior to acute care treatment. Include medications given en-route to the hospital. Beta-blockers include:

<table>
<thead>
<tr>
<th>Beta-blocker</th>
<th>Trade Name</th>
<th>Other Trade Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acebutolol</td>
<td>Inderide</td>
<td>Sorine</td>
</tr>
<tr>
<td>Atenolol</td>
<td>Inderide LA</td>
<td>Sotalol</td>
</tr>
<tr>
<td>Atenolol/chlorothalidone</td>
<td>Kerlone</td>
<td>Sotalol HC1</td>
</tr>
<tr>
<td>Betapace</td>
<td>Labetalol</td>
<td>Tenoretic</td>
</tr>
<tr>
<td>Betapace AF</td>
<td>Levatol</td>
<td>Tenormin</td>
</tr>
<tr>
<td>Betaxolol</td>
<td>Lopressor</td>
<td>Tenormin I.V.</td>
</tr>
<tr>
<td>Bisoprol</td>
<td>Lopressor HCT</td>
<td>Timolide</td>
</tr>
<tr>
<td>Bisoprol/fumarate</td>
<td>Lopressor/hydrochlorothiazide</td>
<td>Timolol</td>
</tr>
<tr>
<td>Bisoprol/hydrochlorothiazide</td>
<td>Metoprolol</td>
<td>Timolol maleate/hydrochlorothiazide</td>
</tr>
<tr>
<td>Blocaadren</td>
<td>Metoprolol/hydrochlorothiazide</td>
<td>Timolol/hydrochlorothiazide</td>
</tr>
<tr>
<td>Brevibloc</td>
<td>Metoprolol Tartrate/hydrochlorothiazide</td>
<td>Toprol</td>
</tr>
<tr>
<td>Carteolol</td>
<td>Nadolol</td>
<td>Toprol-XL</td>
</tr>
<tr>
<td>Carotrol</td>
<td>Nadolol/bendroflumethiazide</td>
<td>Trandate</td>
</tr>
<tr>
<td>Carvedilol</td>
<td>Normodyne</td>
<td>Trandate HCl</td>
</tr>
<tr>
<td>Coreg</td>
<td>Penbutolol</td>
<td>Visken</td>
</tr>
<tr>
<td>-----------</td>
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<td>----------</td>
</tr>
<tr>
<td>Corgard</td>
<td>Pindolol</td>
<td>Zebeta</td>
</tr>
<tr>
<td>Corzide 40/5</td>
<td>Propranolol</td>
<td>Ziac</td>
</tr>
<tr>
<td>Corzide 80/5</td>
<td>Propranolol HCl</td>
<td></td>
</tr>
<tr>
<td>Esmolol</td>
<td>Propranolol hydrochloride</td>
<td></td>
</tr>
<tr>
<td>Inderal</td>
<td>Propranolol/hydrochlorothiazide</td>
<td></td>
</tr>
<tr>
<td>Inderal LA</td>
<td>Sectral</td>
<td></td>
</tr>
</tbody>
</table>

Sources: ED record
Medication administration record
Admitting history and physical
MD progress notes
Nursing admission note

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**Data Element Number: C5**

**Data Element Name:** Beta-blocker Contraindication at Arrival

**Definition:** Indication in the record at the time of admission that the patient had a beta-blocker contraindication or was otherwise not a candidate for receiving the drug.

**Guidelines:** If the patient did not get a beta-blocker within 24 hours of hospital arrival, indicate whether there was an indication in the record at the time of admission that the patient had a beta-blocker contraindication or was otherwise not a candidate for receiving the drug.

Contraindications include:
- Beta-blocker allergy of any kind. Do not try to distinguish between true allergies/sensitivities and intolerances and side effects. Allergy documentation does NOT need to refer to the entire class of beta-blockers.
- Bradycardia (heart rate less than 60 beats per minute [bpm]) on arrival or within 24 hours after arrival while not on a beta blocker
- Heart failure on arrival or within 24 hours after arrival
- Second- or third-degree heart block on ECG on arrival or within 24 hours after arrival and does not have a pacemaker
- Shock on arrival or within 24 hours after arrival
- Other reason documented by physician, nurse practitioner, or physician assistant for not prescribing or for holding a beta blocker on arrival

Sources: Medication administration record
Chart allergy sticker
Admitting history and physical
MD progress notes
Nursing admission note

---

**Data Element Number: C6**

**Data Element Name:** Beta-blocker at Discharge

**Definition:** Whether the patient’s discharge medications included a beta-blocker
Guidelines: This data element should be answered independently and irrespective of whether the patient was prescribed a beta-blocker on arrival. Include any beta-blocker, of any dose and frequency. Beta-blockers include all drug names listed in C4 above.

Sources: Discharge plan
Nursing discharge notes
MD progress notes

Data Element Number: C7

Data Element Name: Beta-blocker Contraindication at Discharge

Definition: Indication in the record that the patient had a beta-blocker contraindication or was otherwise not a candidate for receiving the drug.

Guidelines: If the patient’s discharge medications did not include a beta-blocker, indicate whether there was an indication in the record that the patient had a beta-blocker contraindication or was otherwise not a candidate for receiving the drug.

Contraindications include documentation in the record of any of the following:
- Beta-blocker allergy of any kind. Do not try to distinguish between true allergies/sensitivities and intolerances and side effects. Allergy documentation does NOT need to refer to the entire class of beta-blockers.
- Bradycardia (heart rate less than 60 beats per minute [bpm]) while not on a beta blocker
- Heart failure
- Second- or third-degree heart block on ECG and does not have a pacemaker
- Shock
- Other reason documented by physician, nurse practitioner, or physician assistant for not prescribing or for holding a beta blocker

Sources: Medication administration record
Chart allergy sticker
Admitting History and Physical
MD progress notes
Nursing notes
NOTE: This section applies only to patients with a principal diagnosis psychiatric disorder (ICD-9-CM codes 290.0 – 299.9).

Data Element Number: P1
Data Element Name: Bed Type
Definition: Type of facility bed to which the patient is admitted
Guidelines: Indicate whether the patient’s bed on admission was to a dedicated psychiatric unit. If the patient was first in the ER and/or on observation before admission, indicate whether the bed immediately after inpatient admission was a dedicated psychiatric bed. If only the location of the bed is known (e.g., 1-North), it may be necessary to query the facility about the bed status.
Sources: MD orders
Admitting history and physical
Nursing admission note
MD progress notes

Data Element Number: P2
Data Element Name: Global Assessment of Function at Admission
Definition: Patient’s overall functional assessment at the time of admission
Guidelines: Include the first score noted on the day of or day after admission. If a range is given (e.g., 61-70), enter the midpoint (e.g., 65)
Sources: Admitting history and physical
MD progress notes

Data Element Number: P3
Data Element Name: Global Assessment of Function at Discharge

The Global Assessment of Functioning (GAF) scale GAF Score is an estimate of a patient’s level of functioning independent of physical/environmental factors. It reflects symptom severity and level of functioning on a hypothetical continuum of health-illness at a particular point in time. The scoring is broken down in 10-point ranges with a higher score indicating a higher level of functioning. A score of 1-30 indicates a patient is a candidate for inpatient care. A GAF score of 31-70 suggests a patient is a candidate for outpatient care. A score of 70 and above indicates mild/transient symptoms to no symptoms and superior functioning. A similar 1-100 scale is applied to assess the global functioning of children.

Guidelines: Include the final score noted on the day of or day prior to discharge. If a range is given (e.g., 61-70), enter the midpoint (e.g., 65)

Sources: MD progress notes
Discharge planning note

Data Element Number: P4

Data Element Name: Type of Admission

Definition: Whether or not patient’s admission was voluntary

Guidelines: Involuntary psychiatric treatment is used only in unusual circumstances, such as when patients are likely to kill or harm themselves or someone else, and hospitalization is necessary to keep them safe. Involuntary treatment is always subject to review, which helps protect the patient’s rights. Involuntary treatment can be conducted on either an inpatient or outpatient basis. Involuntary treatment procedures vary from state to state. Most states allow a physician to prescribe that a person be admitted involuntarily to a hospital for a brief evaluation period. During the evaluation period, a team of psychiatrists and mental health professionals assess the person’s illness, the likelihood of danger to self or others, and the appropriate course of treatment. If involuntary admission is recommended, a court issues an order for a specific period of time. At the end of that period, the question of hospitalization must again go to a court hearing.

Sources: Court document/legal form ordering involuntary admission
Admitting history and physical
MD progress notes

Data Element Number: P5

Data Element Name: Suicidality on Admission

Definition: Whether the patient had suicidal ideation on the day of or day after admission

Guidelines: The presence of suicidality includes any reference in the notes to statements about not wanting to live anymore, comments about killing oneself or doing oneself serious harm, overwhelming hopelessness, thoughts of death as a “solution,” or indications that patient was entertaining any similar thoughts.

Sources: Admitting history and physical
MD progress notes
Nursing admission note
Nursing notes
**CLINICAL MODULE: PATIENTS PRESENTING WITH ASTHMA**

**NOTE:** This section applies only to patients with a principal diagnosis of asthma (ICD-9-CM codes 493.x).

<table>
<thead>
<tr>
<th>Data Element Number: A1</th>
<th>Data Element Name: Oxygen Assistance on Admission</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition:</strong></td>
<td>Level of oxygen or respiratory assistance first given to the patient up to 8 hours after hospital presentation</td>
</tr>
<tr>
<td><strong>Guidelines:</strong></td>
<td>Indicate the FIRST oxygen/respiratory assistance given in the first 8 hours. Do NOT enter later assistance even if that assistance was more intensive. For example, if patient was given oxygen by nasal cannula on arrival and was intubated 2 hours later, enter “oxygen given by nasal cannula.”</td>
</tr>
<tr>
<td></td>
<td>If oxygen was given, indicate the concentration of oxygen and the oxygen flow rate in liters per minute of the first oxygen administration. Do NOT enter later flow rates even if the rate was higher/changed later. Enter the flow rate to 1 decimal point. For example, if the flow rate was 0.25 liters per minute, enter 0.3.</td>
</tr>
<tr>
<td><strong>Sources:</strong></td>
<td>ED record&lt;br&gt;Nursing admission note&lt;br&gt;Nursing notes&lt;br&gt;Respiratory therapy notes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Data Element Number: A2</th>
<th>Data Element Name: Frequency of Albuterol or Levalbuterol</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Definition:</strong></td>
<td>Frequency of the FIRST order for albuterol (AccuNeb, Proventil, Ventolin, Volmax) or levalbuterol HCl (Xopenex) after admission</td>
</tr>
<tr>
<td><strong>Guidelines:</strong></td>
<td>Do NOT include orders from the emergency room, but do include the first order after admission (either to observation or acute hospitalization). Do not enter any subsequent albuterol/levalbuterol frequency even if it increased/changed later.</td>
</tr>
<tr>
<td><strong>Sources:</strong></td>
<td>MD orders</td>
</tr>
</tbody>
</table>

| Data Element Number: A3 | Data Element Name: Intubation |
Definition: Intubation at any time during this hospitalization, including ER and/or observation status, if applicable

Guidelines: Intubation involves the passage of a tube (endotracheal tube, ET) through the nose or mouth into the trachea for maintenance of the airway.

Sources: MD orders
MD progress notes

Data Element Number: A4

Data Element Name: Asthma Medications

Definition: Asthma medications patient was taking just prior to admission

Guidelines: Indicate all the asthma medications the patient was taking at the time of admission. Include all daily medications as well as prn (“as necessary”) medications. Include all routes of administration. If a medication for asthma is noted in the record that is not included on the checklist, check “other” and write in the name of the medication.

Sources: Admitting history and physical
Nursing admission note
MD progress notes

Data Element Number: A5

Data Element Name: Home Management Care Plan

Definition: Indication that home management of asthma was addressed with the patient and/or family prior to discharge

Guidelines: Include any reference to discussing with the patient and/or the parents how to manage asthma at home, including measures to prevent/decrease the likelihood of an asthma exacerbation as or to deal with an exacerbation that occurs. This could include environmental changes, lifestyle changes, diet, medication use, etc. This could be a formal home care plan, educational materials about self-management, education by the health care provider, or any note that indicated that self-management of the patient’s asthma was addressed.

Sources: Discharge planning note
Nursing discharge note
Nursing notes
MD progress notes
CHAPTER 5
EVALUATION

Introduction
RAND will work closely with participating hospitals to understand the challenges and concerns experienced during the feasibility study. Hospital staff, abstractors, CDC-NCHS and RAND project leaders will collectively participate in the evaluation process. There are four components associated with the evaluation process:

- Completion of the feasibility assessment forms
- Debriefing on-site following abstraction
- Reconciliation of abstraction records (facility and RAND abstractors)
- Joint hospital debrief

Completion of Feasibility Assessment Forms
During the course of record identification and abstraction, participants are asked to complete the feasibility assessment forms included in Appendix K. There are three specific forms for completion: 1) a record retrieval assessment, 2) a general assessment of record abstraction, and 3) a record specific abstraction reporting form.

Record Retrieval Assessment Form
This form is used to describe overall issues associated with retrieving the required records. One form should be completed by the individual most responsible for identifying the records required for abstraction. There are five specific questions and a general question associated with this form.

1. **Background:** We are interested in understanding whether you had sufficient background to be able to complete the tasks necessary to identify and pull the records needed to complete this study. Sources of information include discussions with RAND and NCHS project staff, the Field Manual, and discussions with others locally that are working on the project. If you feel you did not receive sufficient background information, please describe what was lacking and how and to whom that information could best be communicated.

2. **Instruction:** If instructions for completing record retrieval were unclear or could be stated in a clearer manner, please let RAND know. Further, if steps were missing or ambiguous, specifics related to those steps should be recorded.

3. **Personal Background:** If the record retrieval process was of a nature that is outside your normal job duties, please describe the areas that were difficult based on your normal day to day work experience.

4. **Job title:** Indicate your job title

5. **Other individuals assisting in retrieving information:** We are interested in knowing the types of individuals who assisted in retrieving records. The purpose of this request is to understand which other individuals, by job title, in addition to you, were required to identify and retrieve records.

6. **Blank space:** Use this space to provide any suggestions or recommendations so that we may incorporate guidance for future professionals that will be involved in the redesigned National Hospital Discharge Survey. Use additional paper if necessary.
Record Abstractor General Assessment Form

Please use this form to describe overall issues associated with abstraction of records. Each abstractor should complete this form only once following completion of the abstraction process. There are five specific questions and a general question associated with this form.

1. **Background:** We are interested in understanding whether you had sufficient background to be able to complete the tasks necessary to abstract all the information requested as part of the abstraction form. Sources of information include discussions with RAND and NCHS project staff, the Field Manual, and discussions with others locally that are working on the project. If you feel you did not receive sufficient background information, please describe what was lacking and how and to whom that information could best be communicated.

2. **Instruction:** If instructions for completing abstraction were unclear or could be stated in a clearer manner, please let RAND know. Further, if steps were missing or ambiguous, specifics related to those steps should be recorded.

3. **Personal Background:** If the record abstraction process was of a nature that is outside your normal job duties, please describe the areas that were difficult based on your normal day to day work experience.

4. **Job title:** Indicate your job title

5. **Other individuals assisting in retrieving information:** We are interested in knowing the types of individuals, by job title, who assisted in performing the abstraction. The purpose of this request is to understand which other types of individuals, in addition to you, were involved in the abstraction process.

6. **Blank space:** Use this space to provide any suggestions or recommendations so that we may incorporate guidance for future professionals that will be involved in the redesigned National Hospital Discharge Survey. Use additional paper if necessary.

Record Abstractor Record Assessment Form

Please use this form to describe challenges associated with obtaining required information from individual records. One form should be used for each record abstracted. Record the RAND ID # assigned to the case to which the individual assessment form applies. This form is divided into two sections.

**Process Questions**

1. Indicate whether you completed this record all at once before going on to the next record or whether you “batched” certain sections (e.g., clinical, administrative, financial). If you did not abstract the record in its entirety at one time, indicate how you approached completing the record. Use additional space as needed.

2. Record the total amount of time you took to complete this form. If you completed the abstract over multiple sittings, or in sections, note the time that each sitting took and then report the collective amount of time to complete the record on the abstraction form.

**Specific Questions**

Use this section to describe any challenges you encountered with respect to completion of individual questions or groups of questions. The assessment form is grouped by types of variables to facilitate reporting of challenges related to groups or types of questions. Use additional space as needed. Note that the numbers on the form correspond to the question numbers on the abstraction form.
Questions are divided into two parts, the general form and the specific clinical modules. Complete the specific clinical module section only for those records identified as falling into those specific groups (i.e., Groups D, E and F described in Chapter 3).

Debriefing On-Site Following Abstraction
At the end of the two days that RAND abstractors spend at the facility, a one hour on-site session will be conducted by the RAND abstractors and/or Principal Investigators. While the hospital’s principal point of contact should identify the appropriate parties for the debriefing session, RAND will recommend that those present include at least the same individuals who were present at the training session. The purpose of the debriefing session is to review the process, problems, issues, concerns and suggestions for improvement by the hospital staff. Because RAND staff will not have had the opportunity to compare their abstraction forms to those completed by hospital staff, some questions may need to be deferred to follow-up phone calls or e-mail correspondence.

Reconciliation of Abstraction Records (Facility and RAND Abstractors)
RAND abstractors and study leaders, possibly with NCHS staff, will review the feasibility assessment forms. In particular they will compare the RAND record abstraction forms to those completed by the hospital to assess differences in the data gathered and the location from which the data were obtained. This information will be used to simplify and clarify abstraction forms. If issues are difficult to resolve, RAND may discuss differences with hospital abstraction staff, either by telephone or e-mail.

Joint Hospital Debrief
Once RAND staff have had a chance to review and abstract records and debrief at all participating sites, RAND will aggregate the findings and identify major issues and concerns. The abstraction and documentation field materials will be revised based on the collective input. RAND will schedule a conference call and invite all hospital sites to participate anonymously. Only the findings related to the survey process will be discussed. No patient level data will be the subject of the discussion. RAND will share their proposed solutions with the group for their feedback. This feedback will be used to refine the final field materials.
APPENDIX A

HIPAA PRIVACY RULE AND PUBLIC HEALTH

MMWR Report
(Note particularly page 6, column 2)
HIPAA Privacy Rule and Public Health

Guidance from CDC and the U.S. Department of Health and Human Services*

Summary

New national health information privacy standards have been issued by the U.S. Department of Health and Human Services (DHHS), pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The new regulations provide protection for the privacy of certain individually identifiable health data, referred to as protected health information (PHI). Balancing the protection of individual health information with the need to protect public health, the Privacy Rule expressly permits disclosures without individual authorization to public health authorities authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, including but not limited to public health surveillance, investigation, and intervention.

Public health practice often requires the acquisition, use, and exchange of PHI to perform public health activities (e.g., public health surveillance, program evaluation, terrorism preparedness, outbreak investigations, direct health services, and public health research). Such information enables public health authorities to implement mandated activities (e.g., identifying, monitoring, and responding to death, disease, and disability among populations) and accomplish public health objectives. Public health authorities have a long history of respecting the confidentiality of PHI, and the majority of states as well as the federal government have laws that govern the use of, and serve to protect, identifiable information collected by public health authorities.

The purpose of this report is to help public health agencies and others understand and interpret their responsibilities under the Privacy Rule. Elsewhere, comprehensive DHHS guidance is located at the HIPAA website of the Office for Civil Rights (http://www.hhs.gov/ocr/hipaa/).

Introduction

The shift of medical records from paper to electronic formats has increased the potential for individuals to access, use, and disclose sensitive personal health data. Although protecting individual privacy is a long-standing tradition among health-care providers and public health practitioners in the United States, previous legal protections at the federal, tribal, state, and local levels were inconsistent and inadequate. A patchwork of laws provided narrow privacy protections for selected health data and certain keepers of that data (1).

The U.S. Department of Health and Human Services (DHHS) has addressed these concerns with new privacy standards that set a national minimum of basic protections, while balancing individual needs with those of society. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) was adopted to ensure health insurance coverage after leaving an employer and also to provide standards for facilitating health-care–related electronic transactions. To improve the efficiency and effectiveness of the health-care system, HIPAA included administrative simplification provisions that required DHHS to adopt national standards for electronic health-care transactions (2). At the same time, Congress recognized that advances in electronic technology could erode the privacy of health information. Consequently, Congress incorporated into HIPAA provisions that mandated adoption of federal privacy protections for certain individually identifiable health information.

The HIPAA Privacy Rule (Standards for Privacy of Individually Identifiable Health Information) (3) provides the first national standards for protecting the privacy of health information. The Privacy Rule regulates how certain entities, called covered entities, use and disclose certain individually identifiable health information, called protected health information (PHI). PHI is individually identifiable health information that is transmitted or maintained in any form or medium (e.g., electronic, paper, or oral), but excludes certain educational records and employment records. Among other provisions, the Privacy Rule

• gives patients more control over their health information;
• sets boundaries on the use and release of health records;
• establishes appropriate safeguards that the majority of health-care providers and others must achieve to protect the privacy of health information;

* Prepared by CDC staff, in consultation with the Office of the General Counsel, the Office for Civil Rights, other offices and agencies within the U.S. Department of Health and Human Services, Washington, D.C., and health privacy specialists.
• holds violators accountable with civil and criminal penalties that can be imposed if they violate patients’ privacy rights;
• strikes a balance when public health responsibilities support disclosure of certain forms of data;
• enables patients to make informed choices based on how individual health information may be used;
• enables patients to find out how their information may be used and what disclosures of their information have been made;
• generally limits release of information to the minimum reasonably needed for the purpose of the disclosure;
• generally gives patients the right to obtain a copy of their own health records and request corrections; and
• empowers individuals to control certain uses and disclosures of their health information.

The deadline to comply with the Privacy Rule is April 14, 2003, for the majority of the three types of covered entities specified by the rule [45 CFR § 160.102]. The covered entities are

• health plans,
• health-care clearinghouses, and
• health-care providers who transmit health information in electronic form in connection with certain transactions.

At DHHS, the Office for Civil Rights (OCR) has oversight and enforcement responsibilities for the Privacy Rule. Comprehensive guidance and OCR answers to hundreds of questions are available at http://www.hhs.gov/ocr/hipaa (4).

Impact on Public Health

Public health practice and research, including such traditional public health activities as program operations, public health surveillance, program evaluation, terrorism preparedness, outbreak investigations, direct health services, and public health research, use PHI to identify, monitor, and respond to disease, death, and disability among populations. Public health agencies have a long history of protecting and preserving the confidentiality of individually identifiable health information. They also recognize the importance of protecting individual privacy and respecting individual dignity to maintaining the quality and integrity of health data. CDC and others have worked to consistently strengthen federal and state public health information privacy practices and legal protections (5).

DHHS recognized the importance of sharing PHI to accomplish essential public health objectives and to meet certain other societal needs (e.g., administration of justice and law enforcement). Therefore, the Privacy Rule expressly permits PHI to be shared for specified public health purposes.

For example, covered entities may disclose PHI, without individual authorization, to a public health authority legally authorized to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability [45 CFR § 164.512(b)] (Box 1). Further, the Privacy Rule permits covered entities to make disclosures that are required by other laws, including laws that require disclosures for public health purposes.

Thus, the Privacy Rule provides for the continued functioning of the U.S. public health system. Covered entities should become fully aware of the scope of permissible disclosures for public health activities as well as state and local reporting laws and regulations. Moreover, a public health authority may also

BOX 1. Protected health information (PHI) disclosures by covered entities for public health activities requiring no authorization under the Privacy Rule

Without individual authorization, a covered entity may disclose PHI to a public health authority* that is legally authorized to collect or receive the information for the purposes of preventing or controlling disease, injury, or disability including, but not limited to

• reporting of disease, injury, and vital events (e.g., birth or death); and
• conducting public health surveillance, investigations, and interventions.

PHI may also be disclosed without individual authorization to

• report child abuse or neglect to a public health or other government authority legally authorized to receive such reports;
• a person subject to jurisdiction of the Food and Drug Administration (FDA) concerning the quality, safety, or effectiveness of an FDA-related product or activity for which that person has responsibility;
• a person who may have been exposed to a communicable disease or may be at risk for contracting or spreading a disease or condition, when legally authorized to notify the person as necessary to conduct a public health intervention or investigation; and
• an individual’s employer, under certain circumstances and conditions, as needed for the employer to meet the requirements of the Occupational Safety and Health Administration, Mine Safety and Health Administration, or a similar state law.

Source: Adapted from [45 CFR § 164.512(b)].
* Or to an entity working under a grant of authority from a public health authority, or when directed by a public health authority, to a foreign government agency that is acting in collaboration with a public health authority.
be a covered entity. For example, a public health agency that operates a health clinic, providing essential health-care services and performing covered transactions electronically, is a covered entity.

This report provides guidance to public health authorities and their authorized agents, researchers, and health-care providers in interpreting the Privacy Rule as it affects public health. CDC recommends that public health authorities share the information in this report with covered health-care providers and other covered entities and work closely with those entities to ensure implementation of the rule consistent with its intent to protect privacy while permitting authorized public health activities to continue.

Overview of the Privacy Rule

Who Is Covered

The authority of DHHS to issue health-information privacy regulations was limited by Congress in HIPAA to a defined set of covered entities. More complete definitions of these, and other terms, are located elsewhere in this report (Appendix A). Covered entities are as follows:

- **Health plans.** An individual or group plan that provides, or pays the cost of, medical care that includes the diagnosis, cure, mitigation, treatment, or prevention of disease. Health plans include private entities (e.g., health insurers and managed care organizations) and government organizations (e.g., Medicaid, Medicare, and the Veterans Health Administration).

- **Health-care clearinghouses.** A public or private entity, including a billing service, repricing company, or community health information system, that processes non-standard data or transactions received from another entity into standard transactions or data elements, or vice versa.

- **Health-care providers.** A provider of health-care services and any other person or organization that furnishes, bills, or is paid for health care in the normal course of business. Health-care providers (e.g., physicians, hospitals, and clinics) are covered entities if they transmit health information in electronic form in connection with a transaction for which a HIPAA standard has been adopted by DHHS.

The Privacy Rule also establishes requirements for covered entities with regard to their nonemployee business associates (e.g., lawyers, accountants, billing companies, and other contractors) whose relationship with covered entities requires sharing of PHI. The Privacy Rule allows a covered provider or health plan to disclose PHI to a business associate if satisfactory written assurance is obtained that the business associate will use the information only for the purposes for which it was engaged, will safeguard the information from misuse, and will help the covered entity comply with certain of its duties under the Privacy Rule.

The Privacy Rule does not apply to all persons or entities that regularly use, disclose, or store individually identifiable health information. For example, the Privacy Rule does not cover employers, certain insurers (e.g., auto, life, and worker compensation), or those public agencies that deliver social security or welfare benefits, when functioning solely in these capacities.

Types of Health Information

**Protected Health Information**

The Privacy Rule protects certain information that covered entities use and disclose. This information is called protected health information (PHI), which is generally individually identifiable health information that is transmitted by, or maintained in, electronic media or any other form or medium. This information must relate to 1) the past, present, or future physical or mental health, or condition of an individual; 2) provision of health care to an individual; or 3) payment for the provision of health care to an individual. If the information identifies or provides a reasonable basis to believe it can be used to identify an individual, it is considered individually identifiable health information.

**De-Identified Information**

De-identified data (e.g., aggregate statistical data or data stripped of individual identifiers) require no individual privacy protections and are not covered by the Privacy Rule. De-identifying can be conducted through

- statistical de-identification — a properly qualified statistician using accepted analytic techniques concludes the risk is substantially limited that the information might be used, alone or in combination with other reasonably available information, to identify the subject of the information [45 CFR § 164.514(b)]; or the
- safe-harbor method — a covered entity or its business associate de-identifies information by removing 18 identifiers (Box 2) and the covered entity does not have actual knowledge that the remaining information can be used alone or in combination with other data to identify the subject [45 CFR § 164.514(b)].

In certain instances, working with de-identified data may have limited value to clinical research and other activities. When that is the case, a limited data set may be useful.
The following protected health information (PHI) can be included, without authorization, in a limited data set for public health, research, or health-care operations:

- town or city, state, and zip code; and
- elements of dates related to a person (e.g., years, birth dates, admission dates, discharge dates, and dates of death).

To disclose a limited data set, a covered entity must enter into a data-use agreement with the recipient, which agrees to use or disclose the PHI for limited purposes. Disclosure of a limited data set is not subject to the accounting requirement, but must meet the minimum necessary standards of the Privacy Rule.

BOX 3. Use of limited data sets under the Privacy Rule

The following protected health information (PHI) can be included, without authorization, in a limited data set for public health, research, or health-care operations:

- town or city, state, and zip code; and
- elements of dates related to a person (e.g., years, birth dates, admission dates, discharge dates, and dates of death).

To disclose a limited data set, a covered entity must enter into a data-use agreement with the recipient, which agrees to use or disclose the PHI for limited purposes. Disclosure of a limited data set is not subject to the accounting requirement, but must meet the minimum necessary standards of the Privacy Rule.

BOX 2. Individual identifiers under the Privacy Rule

The following 18 identifiers of a person, or of relatives, employers, or household members of a person must be removed, and the covered entity must not have actual knowledge that the information could be used alone or in combination with other information to identify the individual, for the information to be considered de-identified and not protected health information (PHI):

- names;
- all geographic subdivisions smaller than a state, including county, city, street address, precinct, zip code,* and their equivalent geocodes;
- all elements of dates (except year) directly related to an individual; all ages >89 and all elements of dates (including year) indicative of such age (except for an aggregate into a single category of age >90);
- telephone numbers;
- fax numbers;
- electronic mail addresses;
- Social Security numbers;
- medical record numbers;
- health-plan beneficiary numbers;
- account numbers;
- certificate and license numbers;
- vehicle identifiers and serial numbers, including license plate numbers;
- medical device identifiers and serial numbers;
- Internet universal resource locators (URLs);
- Internet protocol (IP) addresses;
- biometric identifiers including fingerprints and voice prints;
- full-face photographic images and any comparable images; and
- any other unique identifying number, characteristic, or code, except that covered identities may, under certain circumstances, assign a code or other means of record identification that allows de-identified information to be re-identified.

* The first three digits of a zip code are excluded from the PHI list if the geographic unit formed by combining all zip codes with the same first three digits contains >20,000 persons.

Limited Data Sets

Health information in a limited data set is not directly identifiable, but may contain more identifiers than de-identified data that has been stripped of the 18 identifiers [45 CFR § 164.514] (Box 3). A data-use agreement must establish who is permitted to use or receive the limited data set, and provide that the recipient will:

- not use or disclose the information other than as permitted by the agreement or as otherwise required by law;
- use appropriate safeguards to prevent uses or disclosures of the information that are inconsistent with the data-use agreement;
- report to the covered entity any use or disclosure of the information, in violation of the agreement, of which it becomes aware;
- ensure that any agents to whom it provides the limited data set agree to the same restrictions and conditions that apply to the limited data set recipient with respect to such information; and
- not attempt to re-identify the information or contact the individual.

What is Required

For covered entities using or disclosing PHI, the Privacy Rule establishes a range of health-information privacy requirements and standards that attempt to balance individual privacy interests with the community need to use such data [45 CFR § 164.504]. Among its provisions, the Privacy Rule requires covered entities to:

- notify individuals regarding their privacy rights and how their PHI is used or disclosed;
- adopt and implement internal privacy policies and procedures;
- train employees to understand these privacy policies and procedures as appropriate for their functions within the covered entity;
• designate individuals who are responsible for implementing privacy policies and procedures, and who will receive privacy-related complaints;
• establish privacy requirements in contracts with business associates that perform covered functions;
• have in place appropriate administrative, technical, and physical safeguards to protect the privacy of health information; and
• meet obligations with respect to health consumers exercising their rights under the Privacy Rule.

With respect to individuals, they are vested with the following rights:

• Receive access to PHI. Individual rights include inspections of records and the provision for copies of PHI about the individual in a designated record set, for as long as the PHI is maintained in the designated record set, except for psychotherapy notes, information compiled for use in civil, criminal, or administrative actions, and PHI maintained by a covered entity subject to the Clinical Laboratory Improvement Amendments of 1988 [42 CFR § 263(a)]. In the majority of cases, covered entities must accommodate a request or provide a process of denial, subject to review [45 CFR § 164.524].
• Request amendments to PHI. Individuals can request that covered entities amend PHI about the individual in a designated record set for as long as the PHI is maintained in a designated record set. If the covered entity agrees to the amendment, it must 1) identify the records affected; 2) append or provide a link to the amendment; 3) inform the individual the amendment has been made; and 4) work with other covered entities or business associates who possess or receive the data to make the amendments [45 CFR § 164.526]. If the covered entity denies this request, the Privacy Rule provides a process for contesting the denial [45 CFR § 164.524].
• Receive adequate notice. With limited exceptions, individuals have the right to receive a notice of the uses and disclosures the covered entity will make of their PHI, their rights under the Privacy Rule, and the covered entity’s obligations with respect to that information. In certain cases, notice may be provided electronically. The notice must be in plain language (e.g., “your health information may be shared with public health authorities for public health purposes . . .”) and posted where it is likely to be seen by patients [45 CFR § 164.520].
• Receive an accounting of disclosures. Upon request, covered entities are required to provide individuals with an accounting for certain types of disclosures of PHI, although the rule contains certain exceptions, including disclosures with individual authorization, disclosures related to providers’ treatment, payment and health-care operations (TPO), and other exceptions. A typical a accounting includes the name of the person or entity who received the information, date of the disclosure, a brief description of the information disclosed, and a brief explanation of the reasons for disclosure or copy of the request [45 CFR § 164.528]. However, requirements for accounting of public health disclosures may vary (see Accounting for Public Health Disclosures).

• Request restrictions. Individuals have the right to request a restriction on certain uses or disclosures of their PHI; however, the covered entity is not obligated to agree to such a request. If the covered entity does agree to a restriction, it must generally abide by the agreement, except for emergency treatment situations. But such an agreement is not effective to prevent certain permitted uses or disclosures [CFR 45 § 164.512].

**Required PHI Disclosures**

A covered entity is required by the Privacy Rule to disclose PHI in only two instances: 1) when an individual has a right to access an accounting of his or her PHI (see previous paragraph); and 2) when DHHS needs PHI to determine compliance with the Privacy Rule [45 CFR § 164.502(a)(2)]. Certain other uses and disclosures of PHI may be permitted without authorization, but are not required by the Privacy Rule. However, other federal, tribal, state, or local laws may compel disclosure.

**Permitted PHI Disclosures Without Authorization**

The Privacy Rule permits a covered entity to use and disclose PHI, with certain limits and protections, for TPO activities [45 CFR § 164.506]. Certain other permitted uses and disclosures for which authorization is not required follow. Additional requirements and conditions apply to these disclosures. The Privacy Rule text and OCR guidance should be consulted for a full understanding of the following:

• Required by law. Disclosures of PHI are permitted when required by other laws, whether federal, tribal, state, or local.
• Public health. PHI can be disclosed to public health authorities and their authorized agents for public health purposes including but not limited to public health surveillance, investigations, and interventions.
• Health research. A covered entity can use or disclose PHI for research without authorization under certain conditions, including 1) if it obtains documentation of a waiver from an institutional review board (IRB) or a privacy board, according to a series of considerations; 2) for
activities preparatory to research; and 3) for research on a decedent’s information.

- Abuse, neglect, or domestic violence. PHI may be disclosed to report abuse, neglect, or domestic violence under specified circumstances.
- Law enforcement. Covered entities may, under specified conditions, disclose PHI to law enforcement officials pursuant to a court order, subpoena, or other legal order, to help identify and locate a suspect, fugitive, or missing person; to provide information related to a victim of a crime or a death that may have resulted from a crime, or to report a crime.
- Judicial and administrative proceedings. A covered entity may disclose PHI in the course of a judicial or administrative proceeding under specified circumstances.
- Cadaveric organ, eye, or tissue donation purposes. Organ-procurement agencies may use PHI for the purposes of facilitating transplant.
- Oversight. Covered entities may usually disclose PHI to a health oversight agency for oversight activities authorized by law.
- Worker’s compensation. The Privacy Rule permits disclosure of work-related health information as authorized by, and to the extent necessary to comply with, workers’ compensation programs.

**Other Authorized Disclosures**

A valid authorization is required for any use or disclosure of PHI that is not required or otherwise permitted without authorization by the Privacy Rule. In general, these authorizations must

- specifically identify the PHI to be used or disclosed;
- provide the names of persons or organizations, or classes of persons or organizations, who will receive, use, or disclose the PHI;
- state the purpose for each request;
- notify individuals of their right to refuse to sign the authorization without negative consequences to treatment, payment, or health plan enrollment or benefit eligibility, except under specific circumstances;
- be signed and dated by the individual or the individual’s personal representative;
- be written in plain language;
- include an expiration date or event;
- notify the individual of the right to revoke authorization at any time in writing, and how to exercise that right, and any applicable exceptions to that right under the Privacy Rule; and
- explain the potential for the information to be subject to redisclosure by recipient and no longer protected by the Privacy Rule.

**The Privacy Rule and Public Health**

The Privacy Rule recognizes 1) the legitimate need for public health authorities and others responsible for ensuring the public’s health and safety to have access to PHI to conduct their missions; and 2) the importance of public health reporting by covered entities to identify threats to the public and individuals. Accordingly, the rule 1) permits PHI disclosures without a written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes, and 2) permits disclosures that are required by state and local public health or other laws. However, because the Privacy Rule affects the traditional ways PHI is used and exchanged among covered entities (e.g., doctors, hospitals, and health insurers), it can affect public health practice and research in multiple ways. To prevent misconceptions, understanding the Privacy Rule is important for public health practice. Some illustrative examples are presented in this report (Box 4). Also provided are sample letters that might prove useful in clarifying relationships involving public health and the Privacy Rule (Appendix B).

A public health authority is broadly defined as including agencies or authorities of the United States, states, territories, political subdivisions of states or territories, American Indian tribes, or an individual or entity acting under a grant of authority from such agencies and responsible for public health matters as part of an official mandate. Public health authorities include federal public health agencies (e.g., CDC, National Institutes of Health [NIH], Health Resources and Services Administration [HRSA], Substance Abuse and Mental Health Services Administration [SAMHSA], Food and Drug Administration [FDA], or Occupational Safety and Health Administration [OSHA]); tribal health agencies; state public health agencies (e.g., public health departments or divisions, state cancer registries, and vital statistics departments); local public health agencies; and anyone performing public health functions under a grant of authority from a public health agency [45 CFR § 164.501].

Public health agencies often conduct their authorized public health activities with other entities by using different mechanisms (e.g., contracts and memoranda or letters of agreement). These other entities are public health authorities under the Privacy Rule with respect to the activities they conduct under a grant of authority from such a public health agency. A covered entity may disclose PHI to public health authorities.
BOX 4. Examples of situations related to the Privacy Rule and public health

**State cancer registry.** Under a state law, health-care providers are required to report cancer cases to a state’s cancer registry. Names are included to prevent duplicate reporting and counting. State law protects the confidentiality of the data. Can covered entities disclose the information under the Privacy Rule?

**Privacy Rule effect.** Covered entities may disclose PHI to a public health agency, or any other entity, when the disclosure is required by law. However, as covered entities, the providers must give an accounting to the persons whose PHI has been shared. The state agency may use and further disclose the PHI consistent with applicable state law.

**State university-maintained cancer registry.** Under a state law, health-care providers are mandated to report cancer cases to a state health department’s cancer registry. The state health department contracts with a state university to receive the reports and maintain its registry. As covered entities, can health-care providers disclose PHI to the state university under the Privacy Rule?

**Privacy Rule effect.** As noted in the previous example, covered entities may disclose, without authorization, PHI to the cancer registry under the Privacy Rule, which expressly permits disclosure of PHI as required by law and sharing of PHI with public health authorities for public health purposes. The state university is acting under a grant of authority from a public health authority, the state health department. The university can use and disclose the information, without authorization, consistent with its agreement with the state health department and applicable state law.

**Early hearing detection and intervention.** An early hearing detection and intervention program in a state needs data from two large hospitals. The state does not have a law requiring reporting of hearing loss. Under the Privacy Rule, can covered entities release results of newborn hearing-screening tests to the state program?

**Privacy Rule effect.** The Privacy Rule expressly permits release of PHI, without authorization, from a covered entity to a public health authority (e.g., the state health department), which is authorized by law to receive PHI for the purpose of controlling disease, injury, or disability. The rule does not require a state law mandating such disclosures for PHI to be released to a public health authority. Finally, the covered entities may rely upon the state’s representation that the information requested is the minimum necessary for the purposes of the registry.

**Disease registry maintained by private foundation.** A private foundation maintains a disease registry as a way to support research and service for those with the disease. Can health-care providers release PHI to the foundation under the Privacy Rule?

**Privacy Rule effect.** Nongovernment disease registries (e.g., those maintained by foundations and other private organizations) are not considered public health authorities unless they have a grant of authority from a public health authority. With such a grant, covered entities may disclose PHI to the foundations. But without a grant of authority, PHI may be released only under one of the following situations:

- Release is authorized by the patient.
- The PHI is de-identified.
- The PHI is contained in a limited data set governed by a data-use agreement.
- Release of PHI is in accord with the rule’s provisions for disclosure for research without authorization.
- Release is otherwise permitted by the rule (e.g., to entities subject to the jurisdiction of the Food and Drug Administration (FDA) [45 CFR § 164.512(b)(1)(iii)].

**Surveillance project.** A state health department that is not a covered entity conducts a surveillance project on human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS). The HIV/AIDS surveillance project is an interview study. It asks for self-reported information from participants, including dates of diagnosis and visits for care. Is this PHI covered by the Privacy Rule?

**Privacy Rule effect.** Information collected directly from persons by a person, agency, or institution that is not a covered entity, including individually identifiable information, is not covered by the Privacy Rule.

and to these designated entities pursuant to the public health provisions of the Privacy Rule.

The Privacy Rule permits covered entities to disclose PHI, without authorization, to public health authorities or other entities who are legally authorized to receive such reports for the purpose of preventing or controlling disease, injury, or disability. This includes the reporting of disease or injury; reporting vital events (e.g., births or deaths); conducting public health surveillance, investigations, or interventions; reporting child abuse and neglect; and monitoring adverse outcomes related to food (including dietary supplements), drugs, biological products, and medical devices [45 CFR 164.512(b)]. Covered entities may report adverse events related to FDA-regulated products or activities to public agencies and private entities that are subject to FDA jurisdiction [45 CFR 164.512(b)(1)(iii)]. To protect the health of the public, public health authorities might need to obtain information related to the individuals affected by a disease. In certain cases, they might need to contact those affected to determine the cause of the disease to allow for actions to prevent further...
illness. Also, covered entities may, at the direction of a public health authority, disclose protected health information to a foreign government agency that is acting in collaboration with a public health authority [45 CFR 164.512(b)(1)(i)].

To receive PHI for public health purposes, public health authorities should be prepared to verify their status and identity as public health authorities under the Privacy Rule. To verify its identity, an agency could provide any one of the following:

- if the request is made in person, presentation of an agency identification badge, other official credentials, or other proof of government status;
- if the request is in writing, the request is on the appropriate government letterhead;
- if the disclosure is to a person acting on behalf of a public health authority, a written statement on appropriate government letterhead that the person is acting under the government’s authority [45 CFR § 164.514(h)(2)].

Public health authorities receiving information from covered entities as required or authorized by law [45 CFR 164.512(a)] [45 CFR 164.512(b)] are not business associates of the covered entities and therefore are not required to enter into business associate agreements. Public health authorities that are not covered entities also are not required to enter into business associate agreements with their public health partners and contractors. Also, after PHI is disclosed to a public health authority, a written statement on appropriate government letterhead that the person is acting under the government’s authority [45 CFR § 164.514(h)(2)].

Public health authorities receiving information from covered entities as required or authorized by law [45 CFR 164.512(a)] [45 CFR 164.512(b)] are not business associates of the covered entities and therefore are not required to enter into business associate agreements. Public health authorities that are not covered entities also are not required to enter into business associate agreements with their public health partners and contractors. Also, after PHI is disclosed to a public health authority, a written statement on appropriate government letterhead that the person is acting under the government’s authority [45 CFR § 164.514(h)(2)].

Public health authorities operating under broad mandates to protect the health of their constituent populations.

Disclosures for Public Health Purposes

The Privacy Rule allows covered entities to disclose PHI to public health authorities when required by federal, tribal, state, or local laws [45 CFR 164.512(a)]. This includes state laws (or state procedures established under such law) that provide for receiving reporting of disease or injury, child abuse, birth, or death, or conducting public health surveillance, investigation, or intervention.

For disclosures not required by law, covered entities may still disclose, without authorization, to a public health authority authorized by law to collect or receive the information for the purpose of preventing or controlling disease, injury, or disability, the minimum necessary information to accomplish the intended public health purpose of the disclosure [45 CFR 164.512(b)] (Box 1).

For example, to protect the health of the public, public health officials might need to obtain information related to persons affected by a disease. In certain cases, they might need to contact those affected to determine the cause of the disease to allow for actions to prevent further illness. The Privacy Rule continues to allow for the existing practice of sharing PHI with public health authorities who are authorized by law to collect or receive such information to aid them in their mission of protecting the health of the public. Examples of such activities include those directed at the reporting of disease or injury, reporting adverse events, reporting births and deaths, and investigating the occurrence and cause of injury and disease (I).

Although it is not a defined term, DHHS interpreted the phrase “authorized by law” to mean that a legal basis exists for the activity. Further, DHHS called the phrase “a term of art,” including both actions that are permitted and actions that are required by law [64 FR 59929, November 3, 1999]. This does not mean a public health authority at the federal, tribal, state, or local level must have multiple disease or condition-specific laws that authorize each collection of information. Public health authorities operate under broad mandates to protect the health of their constituent populations.

Requirements for Covered Entities

Accounting for Public Health Disclosures

Although the Privacy Rule permits disclosures of PHI to public health authorities, covered entities must comply with certain requirements related to these disclosures. One such requirement is that a covered entity must be able to provide an individual, upon request, with an accounting of certain disclosures of PHI. The covered entity is not required to account for all disclosures of PHI. For example, an accounting is not required for disclosures made

- prior to the covered entity’s compliance date;
- for TPO purposes;
- to the individual or pursuant to the individual’s written authorization; or
- as part of a limited data set.

However, usually an accounting is required for disclosures made without authorization, including public health purposes.

The required accounting for disclosures may be accomplished in different ways. Typically, the covered entity must provide the individual with an accounting of each disclosure by date, the PHI disclosed, the identity of the recipient of the PHI, and the purpose of the disclosure. However, where the covered entity has, during the accounting period, made multiple disclosures to the same recipient for the same purpose, the Privacy Rule provides for a simplified means of accounting. In such cases, the covered entity need only identify the recipient of such repetitive disclosures, the
purpose of the disclosure, and describe the PHI routinely disclosed. The date of each disclosure need not be tracked. Rather, the accounting may include the date of the first and last such disclosure during the accounting period, and a description of the frequency or periodicity of such disclosures. For example, the vast amount of data exchanged between covered entities and public health authorities is made through ongoing, regular reporting or inspection requirements. A covered health-care provider may routinely report all cases of measles it diagnoses to the local public health authority. An accounting of such disclosures to a requesting individual would need to identify the local public health authority receiving the PHI, the PHI disclosed, the purpose of the disclosure (required for communicable disease surveillance), the periodicity (weekly), and the first and last dates of such disclosures during the accounting period (May 1, 2003 to June 1, 2003). Thus, the covered entity would not need to annotate each patient’s medical record whenever a routine public health disclosure was made.

**Notice of Privacy Practices**

With certain exceptions, under the Privacy Rule, individuals have the right to adequate notice of the uses and disclosures of PHI that may be made by the covered entity, as well as their rights and the covered entity’s legal obligations. Notices must be in plain language and clearly posted. Certain covered entities must make a good faith effort to obtain an individual’s acknowledgment of receipt of this notice. In certain cases, notice may be provided electronically.

**Minimum Necessary Standard**

The Privacy Rule usually directs covered entities to limit the amount of information disclosed to the minimum necessary to achieve the specified goal [45 CFR § 164.514(d)(1)]. This requirement usually applies to disclosures to a public health agency. It would not apply, however, if the disclosure were required by law, authorized by the individual, or for treatment purposes. A covered entity may also reasonably rely on a public official’s determination that the information requested is the minimum necessary for the public health purpose.

**Public Health Authorities Performing Covered Functions**

Public health authorities at the federal, tribal, state, or local levels that perform covered functions (e.g., providing health care or insuring individuals for health-care costs), may be subject to the Privacy Rule’s provisions as covered entities. For example, a local public health authority that operates a health clinic providing essential health-care services to low-income persons and performs certain electronic transactions might be defined under the Privacy Rule as a covered health-care provider and therefore a covered entity. Flow charts and interactive tools designed to help determine covered entity status are provided online by the Centers for Medicare and Medicaid Services, available at http://www.cms.gov/hipaa/hipaa2/support/tools/decisionsupport/default.asp.

The following are examples of public health authority functions that make them covered entities:

- **Public health authorities as covered health-care providers.** A public health authority that conducts health care as part of its activities is a covered health-care provider if it also performs electronic transactions covered by the HIPAA Transactions Rule as part of these activities. The fact that these activities are conducted in pursuit of a public health goal (e.g., vaccinating children or screening a targeted population for sexually transmitted diseases) does not preclude the public health authority from being a covered entity.

- **Public health authorities as health plans.** Under the Privacy Rule, a health plan is an individual or group plan that provides, or pays the cost of, medical care. This specifically includes government health plans (e.g., Medicare, Medicaid, or Veterans Health Administration). However, the Privacy Rule defines health plan to exclude government-funded programs whose principal activity is the direct provision of health care to persons or the making of grants to fund the direct provision of health care to persons [45 CFR § 160.103]. Examples include the Ryan White Comprehensive AIDS Resources Emergency Act. Although certain government programs that fund providers directly may not be health plans, government programs that reimburse providers or otherwise fund providers to perform direct health-care services should carefully analyze the details of their programs to determine if they are performing covered functions.

- **Public health authorities as health-care clearinghouses.** Although unlikely, a public health authority might be a health-care clearinghouse if it receives health information from another entity and translates that information from a nonstandard format into a standard transaction or standard data elements (or vice versa). Operators of community health information systems should carefully consider whether they meet the definition for a health-care clearinghouse.

- **Public health agencies as hybrid entities.** A public health agency that is a covered entity, and has both covered and noncovered functions may become a hybrid entity by designating its health-care components. By designating itself as a hybrid entity, a public health authority can carve out its noncovered functions, so that the majority of Privacy
Rule provisions apply only to its health-care component, which is required to comply with the Privacy Rule requirements, including using and disclosing PHI only as authorized, meeting the administrative requirements, accounting for disclosure of PHI, and providing a notice of practices. However, such a designation does not preclude the public health authority from continuing to conduct authorized public health functions. A covered entity that is also a public health authority may use, as well as disclose, PHI for public health purposes to the same extent it would be permitted to disclose the PHI as a public health authority.

**The Privacy Rule and Public Health Research**

The topic of research under the Privacy Rule is covered in depth in the DHHS report, Protecting Personal Health Information in Research — Understanding the HIPAA Privacy Rule (6). The Privacy Rule provides separate provisions for disclosure without individual authorization for public health purposes and for certain research [45 CFR § 164.512(b)] [45 CFR § 164.512(i)]. Other federal law pertaining to research stresses the importance of distinguishing between research and practice to ensure that human subjects are appropriately protected [45 CFR Part 46]. For certain activities, this distinction is not always clear. A full discussion of the distinctions between public health practice and research is beyond the scope of this document. However, CDC and others provide guidance in this area (7–9).

**Research Versus Practice**

The definition of research is the same for the Privacy Rule and the Common Rule (10) — systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge. Research is designed to test a hypothesis, permit conclusions to be drawn, and thereby to develop or contribute to generalizable knowledge. The majority of public health activities (e.g., public health surveillance, and disease prevention and control projects) are based on scientific evidence and data collection or analytic methods similar to those used in research. However, they are not designed to contribute to generalizable knowledge. Their primary purpose is to protect the health of the population through such activities as disease surveillance, prevention, or control.

The Belmont Report (11) defines practice as interventions designed solely to enhance the well-being of a person, patient, or client, and which have reasonable expectation of success. The report further states that the purpose of medical or behavioral practice is to provide diagnosis, preventive treatment, or therapy to particular patients. For public health agencies, the patient is the community. Public health practice activities (e.g., public health surveillance, disease control, or program evaluation) are undertaken with the intent to benefit a specific community, although occasionally they may provide unintended generalizable benefits to others.

Some public health activities that are initially public health practice may subsequently evolve into a research activity (e.g., an investigation to determine the cause of an outbreak that incorporates a research study evaluating the efficacy of a new drug to treat the illness). When that is the case, the disclosures may be made initially under the public health provisions of the Privacy Rule. But when the activity becomes an ongoing research activity, the entity should consider application of the relevant research disclosures provisions to continue to obtain information for this purpose. Moreover, there may be cases where the activity is both research and public health practice (e.g., an ongoing survey to monitor health conditions in the population, data from which can also be analyzed for research purposes). In those cases, disclosures may be made either under the research provisions or the public health provisions, as appropriate — the covered entity need not comply with both sets of requirements.

**The Privacy Rule and Other Laws**

- **Federal laws.** Covered entities subject to the Privacy Rule are also subject to other federal statutes and regulations. The specific relationship of the Privacy Rule and certain federal laws is discussed in the preamble to the December 2000 Final Rule [65 Fed.Reg. 82481]. In certain instances, the Privacy Rule imposes requirements in direct conflict with other federal laws or regulations. In those instances, an analysis will be necessary to determine whether the later provision was intended to overrule the prior law or regulation.

- **State laws.** As a federal regulatory standard, the Privacy Rule preempts only those contrary state laws relating to the privacy of individually identifiable health information that have less stringent requirements or standards than the Privacy Rule (i.e., more stringent laws remain in effect). In addition, DHHS may, upon specific request from a state or other entity or person, determine that a provision of state law that is contrary to the federal requirements and that meets certain additional criteria, will not be preempted by the federal requirements. Thus,
preemption of a contrary state law will not occur if the Secretary or designated DHHS official determines, in response to a request, that the state law 1) is necessary to prevent fraud and abuse related to the provision of or payment for health care; 2) is necessary to ensure appropriate state regulation of insurance and health plans to the extent expressly authorized by statute or regulation; 3) is necessary for state reporting on health-care delivery or costs; 4) is necessary to serve a compelling public health, safety, or welfare need, and, if a Privacy Rule provision is at issue, if the Secretary determines that the intrusion into privacy is warranted when balanced against the need to be served; or 5) has as its principal purpose the regulation of the manufacture, registration, distribution, dispensing, or other control of any controlled substances. The Privacy Rule specifically does not preempt contrary state public health laws that provide for the reporting of disease or injury, child abuse, birth or death, or for the conduct of public health surveillance, investigation, or intervention [45 CFR § 160.202].

Online Resources

References to non-DHHS sites on the Internet are provided as a service to MMWR readers and do not constitute or imply endorsement of these organizations or their programs by CDC or the U.S. Department of Health and Human Services. CDC is not responsible for the content of these sites. URL addresses listed in MMWR were current as of the date of publication.

Federal Government Resources

DHHS Office for Civil Rights — HIPAA guidelines
http://www.hhs.gov/ocr/hipaa

CDC — Privacy Rule guidelines
http://www.cdc.gov/privacyrule

Centers for Medicare and Medicaid Services
http://www.cms.gov/hipaa/

Health Resources and Services Administration — HIPAA
http://www.hrsa.gov/website.htm

National Center for Health Statistics
http://www.cdc.gov/nchs/otheract/phdsc/phdsc.htm

National Committee on Vital and Health Statistics
http://www.nvhs.hhs.gov/

National Health Information Infrastructure
http://www.health.gov/ncvhs-nhii/

Indian Health Service — HIPAA
http://www.ihs.gov/AdminMngrResources/HIPAA/index.cfm

National Institutes of Health
http://privacyruleandresearch.nih.gov

Substance Abuse and Mental Health Services Administration — HIPAA
http://www.samhsa.gov/hipaa/

State Government Resources

California
http://www.dhs.ca.gov/hipaa/
http://www.ohi.ca.gov/state/calohi/ohiHome.jsp
http://www.dmh.ca.gov/hipaa/

Colorado
http://www.cdphe.state.co.us/HIPAA/

Florida
http://www.myflorida.com/myflorida/sto/hipaa/

Illinois
http://www.state.il.us/dpa/hipaa.html

Kentucky
http://chs.state.ky.us/dms/HIPAA/default.htm
http://dmhmrs.chr.state.ky.us/hipaa.asp

Maryland
http://www.mhcc.state.md.us/edi/hipaa/_hipaa.htm
http://dhmh.state.md.us/HIPAA/

Minnesota
http://www.dhs.state.mn.us/hipaa/

Missouri
http://www.health.state.mo.us/HIPAA/

New York
http://www.ofr.state.ny.us/hipaa/index.htm

North Carolina
http://dirm.state.nc.us/hipaa/

Ohio
http://www.state.oh.us/hipaa/

Pennsylvania
http://www.dpw.state.pa.us/omap/hipaa/omaphipaa.asp
http://www.insurance.state.pa.us/html/hipaa.html

South Carolina
http://www.hipaa.state.sc.us/

Texas
http://www.hhsc.state.tx.us/NDIS/NDISTaskForce.html

Virginia
http://www.dmas.state.va.us/hpa-home.htm

Wisconsin
http://www.dhfs.state.wi.us/HIPAA/
Associations, Nonprofit Organizations, and Academic Resources

American Hospital Association — HIPAA
http://www.hospitalconnect.com/aha/key_issues/hipaa/resources/resources.html

American Medical Association — HIPAA
http://www.ama-assn.org/ama/pub/category/4234.html

Association of State and Territorial Health Officials — HIPAA
http://www.astho.org/?template=hipaa.html

Georgetown University Health Privacy Project
http://www.healthprivacy.org/

Joint Healthcare Information Technology Alliance
http://www.jhita.org/

National Association of Health Data Organizations
http://www.nahdo.org/

National Association of Insurance Commissioners
http://www.naic.org/1privacy/initiatives/health_privacy.htm

National Governors Association — HIPAA
http://www.nga.org/center/topics/1,1188,C_CENTER_ISSUE^D_4324,00.html

North Carolina Healthcare Information and Communications Alliance
http://www.nchica.org/

Public Health Grand Rounds HIPAA Privacy Rule: Enhancing or Harming Public Health?
http://www.publichealthgrandrounds.unc.edu/

Stanford University Medical School — HIPAA
http://www.med.stanford.edu/HIPAA/

Workgroup for Electronic Data Interchange — Strategic National Implementation Process
http://www.wedi.org/snip/

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References

Appendix A

Selected Privacy Rule Concepts and Definitions

The following concepts and definitions are adapted from the regulatory language. For further information, see the citations to the Privacy Rule.

**Accounting.** An individual has a right to receive an accounting of disclosures of protected health information made by a covered entity in the six years prior to the date on which the accounting is requested, except for disclosures (a) to carry out treatment, payment and health care operations [45 CFR § 164.506]; (b) to individuals of protected health information about them [45 CFR § 164.502]; (c) incident to a use or disclosure otherwise permitted or required by this subpart, as provided in 45 CFR §164.502; (d) pursuant to an authorization as provided in 45 CFR §164.508; (e) for the facility’s directory or to persons involved in the individual’s care or other notification purposes, as provided in 45 CFR §164.510; (f) for national security or intelligence purposes as provided in 45 CFR §164.512(k)(2), (g) to correctional institutions or law enforcement officials as provided in 45 CFR §164.512(k)(5); or (h) as part of a limited data set in accordance with 45 CFR §164.514(e); or (i) that occurred prior to the compliance date for the covered entity. Such an accounting must meet the following requirements: (1) except as otherwise provided by paragraph (a) of this section, the accounting must include disclosures of protected health information that occurred during the six years (or such shorter time period at the request of the individual as provided in paragraph (a)(3) of this section) prior to the date of the request for an accounting, including disclosures to or by business associates of the covered entity; (2) except as otherwise provided by paragraphs (b)(3) or (b)(4) of this section, the accounting must include for each disclosure: the date of the disclosure, the name of the entity or person who received the protected health information, and if known, the address of such entity or person; a brief description of the protected health information disclosed; and, a brief statement of the purpose of the disclosure that reasonably informs the individual of the basis for the disclosure, or in lieu of such a statement, a copy of the individual’s written authorization pursuant to 45 CFR §164.508, or a copy of a written request for a disclosure under 45 CFR § 164.502(a)(2)(ii) or 45 CFR § 164.512, if any.

If, during the period covered by the accounting, the covered entity has made multiple disclosures of protected health information to the same person or entity for a single purpose under 45 CFR § 164.502(a)(2)(ii) or 45 CFR § 164.512, the accounting may, with respect to such multiple disclosures, provide the information required by paragraph (b)(2) of 45 CFR § 164.528 for the first disclosure during the accounting period, the frequency, periodicity, or number of the disclosures made during the accounting period, and the date of the last such disclosure during the accounting period [45 CFR § 164.528].

Modified accounting procedures are also provided for covered entities making research disclosures involving >50 persons [45 CFR § 164.528(b)(4)].

**Business associate.** A person who, on behalf of a covered entity or of an organized health care arrangement [45 CFR § 154.501] in which the covered entity participates, but other than in the capacity of a member of the workforce of such covered entity or arrangement, performs, or assists in the performance of . . . a function or activity involving the use or disclosure of individually identifiable health information, including claims processing or administration, data analysis, processing or administration, utilization review, quality assurance, billing, benefit management, practice management, and repricing; or any other function or activity regulated by this subchapter; or provides, other than in the capacity of a member of the workforce of such covered entity, legal, actuarial, accounting, consulting, data aggregation [45 CFR § 164.501], management, administrative, accreditation, or financial services to or for such covered entity, or to or for an organized health-care arrangement in which the covered entity participates, where the provision of the service involves the disclosure of individually identifiable health information from such covered entity or arrangement, or from another business associate of such covered entity or arrangement, to the individual [45 CFR § 160.103].

**Covered entity.** 1) a health plan; 2) a health-care clearinghouse; 3) a health-care provider who transmits any health information in electronic form in connection with a transaction [45 CFR § 160.103].

**Covered functions.** Those functions of a covered entity the performance of which makes the entity a health plan, health-care provider, or health-care clearinghouse [45 CFR § 164.103].

**Data aggregation.** With respect to protected health information created or received by a business associate in its capacity as the business associate of a covered entity, the combining of such protected health information by the business associate with the protected health information received by the business associate in its capacity as a business associate of another
covered entity, to permit data analyses that relate to the healthcare operations of the respective covered entities [45 CFR §164.501].

**De-identified health information.** Health information that does not identify an individual and with respect to which no reasonable basis exists to believe that the information can be used to identify an individual is not individually identifiable information. [45 CFR § 164.514(a)].

**Disclosure.** The release, transfer, provision of access to, or divulging in any other manner of information outside the entity holding the information [45 CFR § 160.103].

**Electronic media.** 1) Electronic storage media including memory devices in computers (hard drives) and any removable/transportable digital memory medium, such as magnetic tape or disk, optical disk, or digital memory card; or 2) transmission media used to exchange information already in electronic storage media. Transmission media include, for example, the Internet (wide open), extranet (using Internet technology to link a business with information accessible only to collaborating parties), leased lines, dial-up lines, private networks, and the physical movement of removable/transportable electronic storage media. Certain transmissions, including of paper, via facsimile, and of voice, via telephone, are not considered to be transmissions via electronic media, because the information being exchanged did not exist in electronic form before the transmission [45 CFR § 160.103].

**Health care.** Care, services, or supplies related to the health of an individual. It includes but is not limited to 1) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care, and counseling, service, assessment, or procedure with respect to the physical or mental condition, or functional status, of an individual or that affects the structure or function of the body; and, 2) sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription [45 CFR § 160.103].

**Health-care clearinghouse.** A public or private entity, including a billing service, repricing company, community health management information system, community health information system, or value-added network or switch that processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction or 2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity [45 CFR § 160.103].

**Health-care operations.** Any of the following activities of the covered entity to the extent that the activities are related to covered functions: 1) conducting quality assessment and improvement activities, population-based activities, and related functions that do not include treatment; 2) reviewing the competence or qualifications of health care professionals, evaluating practitioner, provider, and health plan performance, conducting training programs where students learn to practice or improve their skills as health-care providers, training of nonhealth-care professionals, accreditation, certification, licensing, or credentialing activities; 3) underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or benefits; 4) conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs; 5) business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and 6) business management and general administrative activities of the entity [45 CFR § 164.501].

**Health-care provider.** A provider of services, (as defined in section 1861(u) of the Act, 42 U.S.C. 1395x(u)), a provider of medical or health-care services, (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)), and any other individual or organization that furnishes, bills, or is paid for health care in the normal course of business [45 CFR § 160.103].

**Health information.** Any information, whether oral or recorded in any form or medium, that 1) is created or received by a health-care provider, health plan, public health authority, employer, life insurer, school or university, or health-care clearinghouse; and 2) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual [45 CFR § 160.103].

**Health plan.** An individual or group plan that provides, or pays the cost of, medical care (as defined in section 2791(a)(2) of the PHS Act, 42 U.S.C. 300gg-91(a)(2)). Health plan includes the following, singly or in combination: (i) a group health plan as defined in 45 CFR § 160.103 of the Privacy Rule; (ii) a health insurance issuer, as defined in 45 CFR § 160.103 of the Privacy Rule; (iii) an HMO, as defined in 45 CFR § 160.103 of the Privacy Rule; (iv) Part A or B of the Medicare program under title XVIII of the Act; (v) the Medicaid program under title XIX of the Act; (vi) a provider of services, (as defined in section 1861(s) of the Act, 42 U.S.C. 1395x(s)); (vii) an issuer of a Medicare supplemental policy, (as defined in section 1882(g)(1) of the Act, 42 U.S.C. 1395ss(g)(1)); (viii) an issuer of a long-term care policy, excluding a nursing home fixed-indemnity policy; (ix) an employee welfare benefit plan or any other arrangement that is established or maintained for the purpose of offering or providing health benefits to the employees of two or more
Minimum necessary. For any type of disclosure that a covered entity makes on a routine and recurring basis, that the covered entity must implement policies and procedures (which may be standard protocols) that limit the protected health information disclosed to the amount reasonably necessary to achieve the purpose of the disclosure. For all other disclosures, covered entities must develop and implement criteria designed to limit the protected health information disclosed to the information reasonably necessary to accomplish the purpose for which disclosure is sought and review requests for disclosure on an individual basis in accordance with such criteria. A covered entity may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purpose when (a) making disclosures to public officials that are permitted under 45 CFR § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purpose, (b) if the information is requested by another covered entity (c) their business associates providing personal services, or (d) documentation or representations that comply with the applicable requirements of 45 CFR § 164.512(i) have been provided by an individual requesting the information for research purposes [45 CFR § 164.514(d)(3)].

The minimum necessary standard also applies to uses of protected health information [45 CFR § 164.514(d)(2)] and requests for protected health information [45 CFR § 164.514(d)(4)].

Notice. An individual, with certain exceptions, has a right to adequate notice of the uses and disclosures of protected health information that may be made by the covered entity and of the individual’s rights, and the covered entity’s legal duties, with respect to protected health information. The notice must be written in plain language and contain the following elements: (i) a header as specified in the rule; (ii) a description, including at least one example, of the types of uses and disclosures that the covered entity is permitted to make for treatment, payment, and health care operations, and a description of each of the other purposes for which the covered entity is permitted or required to use or disclose protected health information without the individual’s written consent or authorization. If a use or disclosure is prohibited or materially limited by other applicable law, the description of such use or disclosure must reflect the more stringent law (as defined in 45 CFR § 160.202). Each description must include sufficient detail to place the individual on notice of the uses and disclosures that are permitted or required by the Privacy Rule or other applicable law, and a statement that other uses and disclosures will be made only with the individual’s written authorization and that the individual may revoke such authorization as provided by 45 CFR § 164.508(b)(5).
A separate statement must be included in the notice if a covered entity intends to engage in any of the following activities. The statement should explain that 1) the covered entity may contact the individual to provide appointment reminders or information regarding treatment alternatives or other health-related benefits; 2) the covered entity may contact the individual to raise funds for the covered entity; or 3) a group health plan, health insurer, or HMO with respect to a group health plan may disclose protected health information to the sponsor of the plan.

The notice must contain a statement of the individual’s rights with respect to the protected health information and a brief description of how the individual may exercise these rights, a statement of the covered entity’s duties, a statement that individuals may complain to the covered entity or the Secretary if they believe their privacy rights have been violated, contact information, and the effective date of the notice [45 CFR § 164.520].

**Payment.** 1) The activities undertaken by (i) a health plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the health plan; or (ii) a health-care provider or health plan to obtain or provide reimbursement for the provision of health care; and 2) the activities relate to the individual to whom health care is provided and include, but are not limited to (i) determinations of eligibility or coverage and adjudication or subrogation of health benefit claims; (ii) risk adjusting amounts due based on enrollee health status and demographic characteristics; (iii) billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance) and related health-care data processing; (iv) review of health-care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges; (v) utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and (vi) disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: (a) name and address; (b) date of birth; (c) social security number; (d) payment history; (e) account number; and (f) name and address of the health-care provider or health plan [45 CFR § 164.501].

**Protected health information (PHI).** Individually identifiable health information that is transmitted by electronic media, maintained in electronic media, or transmitted or maintained in any other form or medium. PHI excludes individually identifiable health information in: (i) education records covered by the Family Education Rights and Privacy Act (20 U.S.C. 1232g); (ii) records described at 20 U.S.C. 1232g(a)(4)(B)(iv); and (iii) employment records held by a covered entity in its role as employer [45 CFR § 160.103].

**Public health authority.** An agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, or an individual or entity acting under a grant of authority from or contract with such public agency, including the employees or agents of such public agency or its contractors or individuals or entities to whom it has granted authority, that is responsible for public health matters as part of its official mandate [45 CFR § 164.501].

Examples of public health authorities include state and local health departments, CDC, National Institutes of Health (NIH), Food and Drug Administration (FDA), and Occupational Safety and Health Administration (OSHA).

**Required by law.** A mandate contained in law that compels an entity to make a use or disclosure of protected health information and that is enforceable in a court of law. This term includes, but is not limited to court orders and court-ordered warrants; subpoenas or summons issued by a court, grand jury, a governmental or tribal inspector general, or an administrative body authorized to require the production of information; a civil or an authorized investigative demand; Medicare conditions of participation with respect to health-care providers participating in the program; and statutes or regulations that require the production of information, including statutes or regulations that require such information if payment is sought under a government program providing public benefits [45 CFR § 164.103].

**Research.** A systematic investigation, including research development, testing, and evaluation, designed to develop or contribute to generalizable knowledge [45 CFR § 164.501].

**Statistical de-identification.** A properly qualified statistician using accepted analytical techniques concludes that the risk is limited that the information could be used, alone or in combination with other reasonably available information to identify the subject of the information [45 CFR § 164.514(b)].

**Safe harbor method.** A covered entity or its agent removes a comprehensive set of identifiers enumerated in the Privacy Rule, which includes but is not limited to, names, geographic subdivisions smaller than states, dates more specific than years, contact information, identification numbers and photographic images, and has no actual knowledge that the remaining information could be used alone or in combination with other information to identify the individual who is a subject of the information, or the individual’s relatives, employers, or household members. Eighteen specific identifiers will need to be removed to achieve de-identification [45 CFR § 164.514(b)].

**Transaction.** The transmission of information between two parties to carry out financial or administrative activities...
related to health care. It includes the following types of information transmissions: health care claims or equivalent encounter information; health care payment and remittance advice; coordination of benefits; health care claim status; enrollment and disenrollment in a health plan; eligibility for a health plan; health plan premium payments; referral certification and authorization; first report of injury; health claims attachments; and other transactions that the Secretary may prescribe by regulation [45 CFR § 164.103].

**Treatment.** The provision, coordination, or management of health care and related services by one or more health-care providers, including the coordination or management of health care by a health-care provider with a third party; consultation between health-care providers relating to a patient; or the referral of a patient for health care from one health-care provider to another [45 CFR § 164.501].

**Use.** With respect to individually identifiable health information, the sharing, employment, application, utilization, examination, or analysis of such information within an entity that maintains such information [45 CFR § 160.103].
Appendix B
Sample Text That Can Be Used To Clarify Public Health Issues Under the Privacy Rule

Following are sample letters that can be used to help clarify Privacy Rule issues among covered entities and public health authorities (e.g., CDC, National Institutes of Health, Food and Drug Administration, Substance Abuse and Mental Health Services Administration, Health Resources and Services Administration, state and local health departments). Public health authorities can use these letters as templates by inserting names of the appropriate individuals, projects, agreements, laws, activity types, covered entities, public health authorities, and authorized agencies.

From a public health authority to a covered entity, clarifying rules regarding disclosure
To Whom It May Concern:
[Public health authority] is an agency of [parent authority] and is conducting the activity described here in its capacity as a public health authority as defined by the Health Insurance Portability and Accountability Act (HIPAA), Standards for Privacy of Individually Identifiable Health Information; Final Rule (Privacy Rule)[45 CFR §164.501]. Pursuant to 45 CFR §164.512(b) of the Privacy Rule, covered entities such as your organization may disclose, without individual authorization, protected health information to public health authorities “. . . authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions . . .” The definition of a public health authority includes “. . . an individual or entity acting under a grant of authority from or contract with such public agency . . .”

[Authorized agency] is acting under [contract, grant, cooperative agreement] with [public health authority] to conduct [project], which is authorized by [law or regulation]. [Public health authority] grants this authority to [authorized agency] for purposes of this project. Further, [public health authority] considers this to be [activity type], for which disclosure of protected health information by covered entities is authorized by 45 CFR §164.512(b) of the Privacy Rule.

From a public health authority to an authorized agency, confirming grant of authority to an authorized agency
To Whom It May Concern:
[Public health authority] is an agency of [parent authority] and is conducting [project], a public health activity as described by 45 CFR §164.512(b), and is authorized by [law or regulation]. The information being requested represents the minimum necessary to carry out the public health purposes of this project pursuant to 45 CFR §164.514(d) of the Privacy Rule.

If you have questions or concerns please contact [project leader].

From a public health authority to an authorized agency, providing grant of authority
Dear [authorized agency]:
This letter serves as verification of a grant of authority from [public health authority] for you to conduct the public health activities described here, acting as a public health authority pursuant to the Standards for Privacy of Individually Identifiable Health Information promulgated under the Health Insurance Portability and Accountability Act (HIPAA)[45 CFR Parts 160 and 164]). Under this rule, covered entities may disclose, without individual authorization, protected health information to public health authorities “. . . authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, including, but not limited to, the reporting of disease, injury, vital events such as birth or death, and the conduct of public health surveillance, public health investigations, and public health interventions . . .” The definition of a public health authority includes “. . . an individual or entity acting under a grant of authority from or contract with such public agency . . .” [45 CFR § 164.501]. [Authorized agency] is acting under [contract, grant or cooperative agreement] with [public health authority] to carry out [project].
Through this grant of authority, [authorized agency] may function as a public health authority under the Privacy Rule for purposes of this project.

[Project] is a public health activity as described by 45 CFR § 164.512(b) referenced previously, and is authorized by [law or regulation]. The information being requested represents the minimum necessary to carry out the public health purposes of this project pursuant to 45 CFR § 164.514(d) of the Privacy Rule. The Privacy Rule provides that covered entities “... may rely, if such reliance is reasonable under the circumstances, on a requested disclosure as the minimum necessary for the stated purposes when making disclosures to public officials that are permitted under 45 CFR § 164.512, if the public official represents that the information requested is the minimum necessary for the stated purposes(s).”

If you have questions or concerns please contact [project leader for authorized agency; public health authority contact].
APPENDIX B

NOTICE OF APPROVAL BY CDC ERB

Institutional Review Board
Human Subjects Protection
September 27, 2006

From: Stephen Blumberg, Ph.D.
      Chair, NCHS Research ERB
      Anjani Chandra, Ph.D.
      Vice Chair, NCHS Research ERB

Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS)

To: Robert Pokras, MA

The NCHS Research Ethics Review Board reviewed the request for new Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS), using the review process, based on 45 CFR 46, on 09/20/2006.

Protocol #2006-10 is approved for the maximum allowable period of one year.

IRB approval of protocol #2006-10 will expire on 09/20/2007.

If it is necessary to continue the study beyond the expiration date, a request for continuation approval should be submitted about 6 weeks prior to 09/20/2007.

The Board also granted the following waivers:

The Board granted a Waiver of Authorization of Informed Consent for Release of Patient Medical Record Data by Hospitals (45 CFR 164.512). The Board found that use or disclosure of protected health information involves no more than a minimal risk to the privacy of individuals, based on the presence of an adequate plan to protect the identifiers from improper use and disclosure; an adequate plan to destroy the identifiers at the earliest opportunity consistent with the conduct of the research; adequate written assurances that the protected health information will not be reused or disclosed to any other person or entity are in place; the research could not be practically conducted without the waiver; the research could not be practically conducted without access to and use of the protected health information.

The Board granted a Waiver of Informed Consent from Patients under 45 CFR 46.116(c). The Board found that 1) the research involves no more than minimal risk to the subjects, 2) the waiver or alteration will not adversely affect the rights and welfare of the subjects, and 3) that the research could not be practically be carried out without the waiver or alteration. Criteria 4) was found not to apply.

Any problems of a serious nature resulting from implementation of this protocol should be brought to the attention of the Research ERB, and any proposed changes should be submitted for Research ERB approval before they are implemented.

Please submit "clean" copies of the revised protocol, consent forms, and any other revised materials to this office for the official protocol file.

Please call me or Dewey LaRochelle if you have any questions.

[Signatures]

Stephen Blumberg, Ph.D.
Chair, NCHS Research ERB

Anjani Chandra
Vice Chair, NCHS Research ERB
September 27, 2006

From: Stephen Blumberg, Ph.D.
Chair, NCHS IRB

Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS)

To: Robert Pokras, M.A.

The NCHS Institutional Review Board reviewed the request for new amendment of Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS), using the review process, based on 45 CFR 46, as allowed in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 164.512(1)(2)(iv)(C).

The NCHS IRB approved Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS) on September 20, 2006.

The Board granted the following waiver to Protocol #2006-10 Feasibility Study for a Redesign of the National Hospital Discharge Survey (NHDS) under NCHS Institutional Review Board procedures:

1) In accordance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy Regulation (45 CFR 164.512), the Board, using the IRB review process, approves a waiver of patient authorization for release of patient medical record data by health care providers. The Board determined that the disclosure of protected health information involves no more than a minimal risk to privacy of individuals. The Board determined that:
   a. There was an adequate plan to protect the identifiers from improper use and disclosure,
   b. There was an adequate plan to destroy the identifiers at the earliest opportunity consistent
      with conduct of the research, and that an adequate research justification was provided for
      retaining the following identifiers: exact dates of admission, discharge, birth, and procedures;
      Zip code.
   c. There were adequate written assurances that the protected health information will not be
      reused or disclosed to any other person or entity, except as required by law, for authorized
      oversight of the research project, or for other research for which the use or disclosure of
      protected health information would be permitted by this subpart.

2) The Board agreed that the research could not practically be conducted without the waiver.

3) The Board also agreed that the research could not practically be conducted without access to and use
   of the protected health information.

Any problems of a serious nature resulting from implementation of this amendment should be brought to the
attention of the IRB, and any proposed changes should be submitted for IRB approval before they are
implemented.

[Signature]
Stephen Blumberg
Chair, NCHS IRB

[Signature]
Anjani Chandra
Vice Chair, NCHS IRB
Thank you for participating in the pilot study for redesign of the National Hospital Discharge Survey. The information collected will be invaluable to policy makers, researchers and all who provide patient care in America’s hospitals and healthcare systems.

This survey collects information on the capabilities and capacity of your organization, which will be linked to the clinical data collected through the patient abstraction form. The first part of this questionnaire (questions 1 and 2) collects basic hospital and key contact information. The second part (questions 3 - 6) are the same as the American Hospital Association (AHA) annual survey and utilize AHA definitions. Please feel free to attach your response to the AHA survey. The third part is in the same format as the AHA survey. It requires the AHA answers and also asks for additional information (questions 7 and 8). You can complete only the additional information requested and utilize your AHA submission for the remainder. The last part (questions 9 – 19) asks for information that is not generally part of the AHA survey, for example more detailed information on reimbursement, staffing and health information technology.

If you have questions as you fill out this form, please feel free to contact RAND Research Staff:

Robin C. Meili, MBA
310-393-0411 x7190
meili@rand.org

Lee H. Hilborne, MD, MPH
310-393-0411 x6400
leeh@rand.org

I. HOSPITAL DEMOGRAPHIC AND KEY CONTACT INFORMATION

1) Hospital Information

<table>
<thead>
<tr>
<th>AHA Number</th>
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<table>
<thead>
<tr>
<th>Legal Name</th>
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<table>
<thead>
<tr>
<th>Address</th>
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<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip</th>
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<th>Phone</th>
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2) Person Completing This Form

<table>
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<tr>
<th>Name</th>
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<th>Phone</th>
<th>Fax</th>
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</table>
II. INFORMATION AVAILABLE FROM YOUR AHA SUBMISSION

You do not need to complete this section if you attach your 2005 AHA Survey.

3) Aggregate Hospital Utilization Statistics for Calendar Year 2005

<table>
<thead>
<tr>
<th>Total Acute Inpatient Admissions</th>
<th>Inpatient Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Length of Stay (all acute inpatients)</td>
<td>Median Length of Stay (all acute inpatients)</td>
</tr>
</tbody>
</table>

Live Births

<table>
<thead>
<tr>
<th>Surgeries: Inpatient</th>
<th>Surgeries: Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Department Visits</td>
<td>Outpatient Visits</td>
</tr>
</tbody>
</table>

Was the Facility Open as of January 1, 2005  □ Yes  □ No  Number of Days Open During Reporting Period

4) Accreditation and Certification

Is your hospital accredited/certified by the following agencies?
- CMS/Medicare Certified  □ No  □ Yes
- JCAHO Accredited  □ No  □ Yes (year of last accreditation: 200___)

5) Hospital Ownership and Affiliations

a) Ownership Type
- Government
- Proprietary
  - Percent of this hospital that is owned by physicians who work for or are affiliated with this hospital: ___ ___ ___%
- Non-Profit
- Church related or other religious order affiliated
- Other: specify ___________________________________________________

b) Is the hospital a subsidiary of a larger company?
- No
- Yes: Please indicate the name and contact information for the parent company
  - Corporation Name
  - Address
  - City: ________________________ State: ___ ___ Zip: ______
  - Total number of hospitals owned by this corporation: ______________________

c) Is the hospital affiliated with any organized physician practices?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Independent Practice Association</td>
<td>□ No  □</td>
</tr>
<tr>
<td>Group practice without walls</td>
<td>□ No  □</td>
</tr>
<tr>
<td>Open physician-hospital association</td>
<td>□ No  □</td>
</tr>
<tr>
<td>Closed physician-hospital association</td>
<td>□ No  □</td>
</tr>
</tbody>
</table>

6) Which one of the descriptions below best describes the services offered by your hospital?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Acute Care</td>
<td>□ Eye, ear, nose and throat</td>
</tr>
<tr>
<td>Children’s Hospital</td>
<td>□ Alcohol/drug dependency only</td>
</tr>
<tr>
<td>Osteopathic Hospital</td>
<td>□ Psychiatric only facility</td>
</tr>
<tr>
<td>Cancer</td>
<td>□ Rehabilitation only</td>
</tr>
<tr>
<td>Heart</td>
<td>□ Other:____________________</td>
</tr>
<tr>
<td>Maternity/Obstetrics</td>
<td></td>
</tr>
</tbody>
</table>
## III. QUESTIONS RELATED TO AHA SUBMISSION REQUIRING ADDITIONAL INFORMATION

7) Hospital / Bed Capacity

### a) Hospital Inpatient

If you attach your AHA submission, you do not need to fill in column (2) – # of staffed beds

<table>
<thead>
<tr>
<th>AHA 2005 survey question #</th>
<th>Hospital Service</th>
<th># of licensed beds (1)</th>
<th># of staffed beds (2)</th>
<th># of non-teaching beds (3)</th>
<th># of discharges per month (4)</th>
<th>Average Length of Stay (5)</th>
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<tbody>
<tr>
<td>1</td>
<td>General medical – surgical care</td>
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<td>2</td>
<td>Pediatric medical – surgical care</td>
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<td>3</td>
<td>Obstetrics (Please specify the level of unit provided by the hospital if applicable.)</td>
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<tr>
<td>4</td>
<td>Medical surgical intensive care</td>
<td></td>
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<td>5</td>
<td>Cardiac intensive care</td>
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<tr>
<td>6</td>
<td>Neonatal Intensive</td>
<td>Unit Level</td>
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<td></td>
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<td>□ I</td>
<td>□ II</td>
<td>□ III</td>
<td>□ IV</td>
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<td>Neonatal intensive care</td>
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<td>8</td>
<td>Pediatric intensive care</td>
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<td>9</td>
<td>Burn care</td>
<td></td>
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<tr>
<td>10</td>
<td>Other special care</td>
<td></td>
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<tr>
<td>11</td>
<td>Other intensive care (Please specify the type of other intensive care provided by the hospital if applicable.)</td>
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<tr>
<td>12</td>
<td>Physical rehabilitation</td>
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<td>13</td>
<td>Alcoholism – drug abuse or dependency care</td>
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<td>14</td>
<td>Psychiatric care</td>
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<td>Skilled nursing care</td>
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<td>Intermediate nursing care</td>
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<td>17</td>
<td>Acute long term care</td>
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<td>18</td>
<td>Other long term care</td>
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<td>19</td>
<td>Other care (Please specify the type of other care provided by the hospital if applicable.)</td>
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</table>
8) **Clinical Capabilities and Services**

If known, please provide the 2005 volume for each of the services that are blank. The categorizations of these capabilities and services and the definitions are those used by in the AHA 2005 survey. You do not need to fill out the “Services Provided in This Hospital” column if you attach your AHA 2005 survey.

<table>
<thead>
<tr>
<th>AHA 2005 survey question #</th>
<th>Clinical Capabilities and Services</th>
<th>Service Provided In This Hospital</th>
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<tr>
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<td>Adult day care program</td>
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<td>21</td>
<td>Airborne infection isolation room (specify # of rooms)</td>
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<td>22</td>
<td>Alcoholism – drug abuse or dependency outpatient services</td>
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<td>23</td>
<td>Alzheimer Center</td>
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<td>24</td>
<td>Ambulances services</td>
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<td>Arthritis treatment center</td>
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<td>28</td>
<td>Bariatric/weight control services</td>
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<td>29</td>
<td>Birthing room – LDR room – LDRP room</td>
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<td>Blood Donor Center</td>
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<td>31</td>
<td>Breast Cancer screening / mammograms</td>
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<tr>
<td>32</td>
<td>Cardiology and cardiac surgery services</td>
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<tr>
<td>32a</td>
<td>Adult diagnostic/invasive catheterization</td>
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<td>32b</td>
<td>Pediatric diagnostic/invasive catheterization</td>
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<td>32c</td>
<td>Adult interventional cardiac catheterization</td>
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<td>Cardiac rehabilitation</td>
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<td>Case management</td>
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<td>Chaplaincy/pastoral care services</td>
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<td>Chemotherapy</td>
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<td>Children wellness program</td>
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<td>Computer assisted orthopedic surgery (CAOS)</td>
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<td>Crisis prevention</td>
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<td>Dental services</td>
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<td>Emergency services</td>
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<td>Emergency department</td>
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<td>43b</td>
<td>Freestanding/Satellite emergency department</td>
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<tr>
<td>43c</td>
<td>Trauma center (certified)</td>
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<td>Enabling services</td>
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<td>Hospice program</td>
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<td>Palliative care program</td>
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<td>Enrollment assistance services</td>
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<td>Extracorporeal shock wave lithotripter (ESWL)</td>
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<td>Geriatric services</td>
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<td>Health fair</td>
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<td>Health screenings</td>
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<td>HIV – AIDS services</td>
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<td>Home health services (visits)</td>
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<td>Hospital – based outpatient care center – services</td>
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<td>Indigent care clinic</td>
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<td>Linguistic/translation services</td>
<td>Do Not Provide</td>
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<td>Meals on wheels</td>
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<td>61</td>
<td>Mobile health services</td>
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<td>Neurological services</td>
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<td>Nutrition programs</td>
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<td>Orthopedic services</td>
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<td>Outpatient surgery</td>
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<td>68</td>
<td>Patient Controlled Analgesia (PCA)</td>
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<td>69</td>
<td>Patient education center</td>
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<td>70</td>
<td>Patient representative services</td>
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<td>71</td>
<td>Physical rehabilitation outpatient services</td>
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<td>72</td>
<td>Primary care department</td>
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<td>Use 2005 Usage/Patient Volume, If Known</td>
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<td>Psychiatric child – adolescent services</td>
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<td>73b</td>
<td>Psychiatric consultation – liaison services</td>
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<td>73c</td>
<td>Psychiatric education services</td>
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<td>73d</td>
<td>Psychiatric emergency services</td>
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<td>73e</td>
<td>Psychiatric geriatric services</td>
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<td>73f</td>
<td>Psychiatric outpatient services</td>
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<td>73g</td>
<td>Psychiatric partial hospitalization program</td>
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<td>74</td>
<td>Radiology therapeutic</td>
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<tr>
<td>74a</td>
<td>Image-guided Radiation Therapy (IGRT)</td>
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<td>AHA 2005 survey question #</td>
<td>Clinical Capabilities and Services</td>
<td>Service Provided In This Hospital</td>
<td>Enter 2005 Usage / Patient Volume, If Known</td>
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<td></td>
<td>Provide</td>
<td>Do Not Provide</td>
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<td>74b</td>
<td>Intensity-Modulated Radiation Therapy (IMRT)</td>
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<td>74c</td>
<td>Shaped Beam Radiation System</td>
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<td>75</td>
<td>Radiology, diagnostic</td>
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<td>75a</td>
<td>CT scanner</td>
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<td>Diagnostic radioisotope facility</td>
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<td>75c</td>
<td>Electron beam computed tomography (EBCT)</td>
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<tr>
<td>75d</td>
<td>Full-field digital mammography (FFDM)</td>
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<tr>
<td>75e</td>
<td>Magnetic resonance imaging (MRI)</td>
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<tr>
<td>75f</td>
<td>Multi-slice spiral computer tomography (&lt;64 slice CT)</td>
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<tr>
<td>75g</td>
<td>Multi-slice spiral computer tomography (64+ slice)</td>
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<td>[ ]</td>
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<tr>
<td>75h</td>
<td>Positron emission tomography (PET)</td>
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<td>75i</td>
<td>Positron emission tomography/CT (PET/CT)</td>
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<td>75j</td>
<td>Single photon emission computerized tomography (SPECT)</td>
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<td>75k</td>
<td>Ultrasound</td>
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<td>76</td>
<td>Reproductive health</td>
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<tr>
<td>76a</td>
<td>Fertility Clinic</td>
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</tr>
<tr>
<td>76b</td>
<td>Genetic testing/counseling</td>
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<td>77</td>
<td>Retirement housing</td>
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<td>78</td>
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<td>Support groups</td>
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<td>Swing bed services</td>
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<td>Teen outreach services</td>
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<td>86</td>
<td>Tobacco treatment/cessation program</td>
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<td>87</td>
<td>Transplant services</td>
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<tr>
<td>87a</td>
<td>Bone marrow transplant services</td>
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<tr>
<td>87b</td>
<td>Heart</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>87c</td>
<td>Kidney</td>
<td>[ ]</td>
<td>[ ]</td>
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<td>87d</td>
<td>Liver</td>
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<tr>
<td>87e</td>
<td>Lung</td>
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<td>87f</td>
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<td>87g</td>
<td>Other</td>
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<td>Transportation to health facilities</td>
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<td>Virtual Colonoscopy</td>
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<td>92</td>
<td>Women’s health center/services</td>
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<td>93</td>
<td>Wound management services</td>
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IV. ADDITIONAL QUESTIONS

9) Financial information (2005)

a) Patient insurance: Please indicate the insurance mix among patients treated in your facility and the distribution from where your revenue comes.

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<tr>
<th></th>
<th>% with This Source of Primary Insurance Coverage</th>
<th>% of Facility’s Total Revenue</th>
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<td>Medicaid</td>
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<td>Private/Commerical</td>
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<td>Self-Pay</td>
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<td>• Uncovered Services</td>
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<tr>
<td>• No Insurance</td>
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<td>Charity Care</td>
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<td>No Charge</td>
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<td>TRICARE</td>
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<td>Workers’ Compensation</td>
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<td>Other Government</td>
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<td>Other:___________________</td>
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<td>Other:___________________</td>
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<td>Other:___________________</td>
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<tr>
<td>Other:___________________</td>
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</table>

b) Payment type: Of the revenue that this hospital receives from each of the different payer types, indicate the percent that comes from each payment type.

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<th>Medicare</th>
<th>Medicaid</th>
<th>Private/Commercial</th>
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<tr>
<td>Fee-for-service plan</td>
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<tr>
<td>HMO Plan</td>
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<td>PPO Plan</td>
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<tr>
<td>Other:___________________</td>
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<td></td>
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<tr>
<td>Other:___________________</td>
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</tbody>
</table>

10) Emergency Department

☐ Our emergency department is staffed 24 hours
☐ We have an emergency department, but it is not open 24 hours/day
☐ We do not have an emergency department (skip to 7b)
### a) Emergency Department Volume

<table>
<thead>
<tr>
<th>Service</th>
<th># of licensed beds/bays</th>
<th>Admitted from ED to this hospital</th>
<th>Transferred from ED to another facility</th>
<th>Patients seen and discharged</th>
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<tbody>
<tr>
<td>General/Overall</td>
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<tr>
<td>IF YOU HAVE DEDICATED BEDS AND CAN BREAK DOWN BY SERVICE, INDICATE BELOW</td>
<td></td>
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</tr>
<tr>
<td>Adult</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Pediatric</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Psychiatric</td>
<td></td>
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</tbody>
</table>

### b) What is the trauma level rating of the Emergency Department and hospital? (check appropriate boxes)

<table>
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<tr>
<th>Trauma Level</th>
<th>Adult</th>
<th>Pediatrics</th>
</tr>
</thead>
<tbody>
<tr>
<td>None</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Level I</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Level II</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Level III</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Level IV</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Level V</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Other/Unknown</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

### 11) Hospital Observation/Outpatient Accommodations

<table>
<thead>
<tr>
<th>Dedicated Observation Unit</th>
<th># of licensed beds</th>
<th>Average # of patients per month</th>
</tr>
</thead>
<tbody>
<tr>
<td>Other Outpatient</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Observation Stays (Medicare only)</th>
<th>TOTAL Observation Stays (Including Medicare)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### 12) Operating Rooms

Total
- Inpatient
- Outpatient


13) Facility Staffing

a) Medical Staff

i) Total Medical Staff
What is the total number of physicians, dentists, podiatrists and other licensed independent practitioners (LIPs) privileged at your facility (do not include residents or fellows unless they practice independently as full members of the medical staff for some services). Include physicians that practice in outpatient departments.

Total Physicians: __________________

ii) Medical Specialty Staffing
How many licensed independent practitioners (LIPs) of each type listed below practice within, or admit to, your hospital (i.e., they have privileges)? The practitioner type is based on self-designation of primary specialty. Do not include residents or fellows in any of these areas. Include LIPs that practice in outpatient departments. Identify only one specialty per provider.

<table>
<thead>
<tr>
<th>Discipline/Department/Division</th>
<th>Number of Privileged LIPs</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology (those who work in OR or pain clinic, but not as critical care intensivists)</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Emergency Medicine</td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td></td>
</tr>
<tr>
<td>Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>• Allergy</td>
<td></td>
</tr>
<tr>
<td>• Cardiology</td>
<td></td>
</tr>
<tr>
<td>• Endocrinology</td>
<td></td>
</tr>
<tr>
<td>• Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>• General Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>• Geriatrics</td>
<td></td>
</tr>
<tr>
<td>• Hematology/Oncology</td>
<td></td>
</tr>
<tr>
<td>• Infectious Disease</td>
<td></td>
</tr>
<tr>
<td>• Nephrology</td>
<td></td>
</tr>
<tr>
<td>• Rheumatology</td>
<td></td>
</tr>
<tr>
<td>• Other Internal Medicine</td>
<td></td>
</tr>
<tr>
<td>Hospitalists—See Question 9b</td>
<td></td>
</tr>
<tr>
<td>Intensive Care Medicine (Include those trained through any specialty—e.g., Internal Medicine, Anesthesia, Surgery)</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Intensive Care Medicine (specify)</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td></td>
</tr>
<tr>
<td>Discipline/Department/Division</td>
<td>Number of Privileged LIPs</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------</td>
</tr>
<tr>
<td>General Ob/Gyn</td>
<td></td>
</tr>
<tr>
<td>Gynecologic Oncology</td>
<td></td>
</tr>
<tr>
<td>Gynecology only</td>
<td></td>
</tr>
<tr>
<td>Maternal Fetal Medicine</td>
<td></td>
</tr>
<tr>
<td>Obstetrics Only</td>
<td></td>
</tr>
<tr>
<td>Reproductive Endocrinology</td>
<td></td>
</tr>
<tr>
<td>Other Ob/Gyn</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
</tr>
<tr>
<td>Adolescent Medicine</td>
<td></td>
</tr>
<tr>
<td>Allergy</td>
<td></td>
</tr>
<tr>
<td>Cardiology</td>
<td></td>
</tr>
<tr>
<td>Developmental/Behavioral Pediatrics</td>
<td></td>
</tr>
<tr>
<td>Endocrinology</td>
<td></td>
</tr>
<tr>
<td>Infectious Disease</td>
<td></td>
</tr>
<tr>
<td>Gastroenterology</td>
<td></td>
</tr>
<tr>
<td>General Pediatrics</td>
<td></td>
</tr>
<tr>
<td>Genetics</td>
<td></td>
</tr>
<tr>
<td>Hematology/Oncology</td>
<td></td>
</tr>
<tr>
<td>Neonatology</td>
<td></td>
</tr>
<tr>
<td>Nephrology</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td></td>
</tr>
<tr>
<td>Pulmonology</td>
<td></td>
</tr>
<tr>
<td>Rheumatology</td>
<td></td>
</tr>
<tr>
<td>Other pediatric</td>
<td></td>
</tr>
<tr>
<td>Physical Medicine and Rehabilitation</td>
<td></td>
</tr>
<tr>
<td>Podiatry</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
</tr>
<tr>
<td>Pediatric Psychiatry (specify)</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td></td>
</tr>
<tr>
<td>Nuclear Medicine</td>
<td></td>
</tr>
<tr>
<td>Neuroradiology</td>
<td></td>
</tr>
<tr>
<td>Interventional Radiology</td>
<td></td>
</tr>
<tr>
<td>Pediatric Radiology</td>
<td></td>
</tr>
<tr>
<td>Other Radiology</td>
<td></td>
</tr>
<tr>
<td>Discipline/Department/Division</td>
<td>Number of Privileged LIPs</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>--------------------------</td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>• Cardiothoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>• General Surgery</td>
<td></td>
</tr>
<tr>
<td>• Hand Surgery</td>
<td></td>
</tr>
<tr>
<td>• Neurosurgery</td>
<td></td>
</tr>
<tr>
<td>• Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>• Otolaryngology</td>
<td></td>
</tr>
<tr>
<td>• Oral and maxillofacial surgery</td>
<td></td>
</tr>
<tr>
<td>• Orthopedic Surgery</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Cardiothoracic Surgery</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Orthopedic Surgery</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Otolaryngology</td>
<td></td>
</tr>
<tr>
<td>• Pediatric Ophthalmology</td>
<td></td>
</tr>
<tr>
<td>• Pediatric General Surgery</td>
<td></td>
</tr>
<tr>
<td>• Plastic Surgery</td>
<td></td>
</tr>
<tr>
<td>• Surgical Oncology</td>
<td></td>
</tr>
<tr>
<td>• Urology</td>
<td></td>
</tr>
<tr>
<td>• Vascular Surgery</td>
<td></td>
</tr>
<tr>
<td>• Other Surgery</td>
<td></td>
</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
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<td>Other: (specify)</td>
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<tr>
<td>Other: (specify)</td>
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<tr>
<td>Other: (specify)</td>
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</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
<tr>
<td>Other: (specify)</td>
<td></td>
</tr>
<tr>
<td>b) Hospitalists</td>
<td></td>
</tr>
<tr>
<td>i) Does this hospital employ hospitalists (doctors who only provide inpatient care, or specialize primarily in inpatient care)?</td>
<td></td>
</tr>
<tr>
<td>☐ No (Skip to next section, part 9c)</td>
<td></td>
</tr>
<tr>
<td>☐ Yes</td>
<td></td>
</tr>
</tbody>
</table>
ii) Please indicate the services where hospitalists work and the number of hospitalist FTEs that the hospital has for each of the services. A person working 40 hours/week constitutes one FTE. A person working 20 hours/week would be 0.5 FTE.

<table>
<thead>
<tr>
<th>Service</th>
<th>Average monthly (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal medicine</td>
<td></td>
</tr>
<tr>
<td>Surgery</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
<tr>
<td>Total Hospitalists:</td>
<td></td>
</tr>
</tbody>
</table>

c) Other Hospital Staff
Please list the total number of FTEs of each type of employee that is employed per month in the following inpatient areas. A person working 40 hours/week constitutes one FTE. A person working 20 hours/week would be 0.5 FTE.

<table>
<thead>
<tr>
<th>Area</th>
<th>Nurse Practitioners</th>
<th>Physicians assistants</th>
<th>Registered Nurses</th>
<th>Licensed Practical Nurse</th>
<th>Nurse Aides</th>
<th>Other Professional Staff</th>
<th>Transport/ Administrative/ Clerical/other Ancillary Staff</th>
</tr>
</thead>
<tbody>
<tr>
<td>General Medical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgical</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult Intensive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric Intensive Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neonatal ICU</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Labor/Delivery/ Well Baby Units</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

i) How many Certified Registered Nurse Anesthetists are employed by your hospital?

ii) How many FTE open positions are you presently recruiting for in the following nursing disciplines?

Advanced Practice Nurses _____ FTE (e.g., CRNA, NP)

Registered Nurses _____ FTE

LPN Nurses _____ FTE
d) Unionization. What percent of the following individuals are members of a union?

- Nurses: ________
- Other hospital staff: ________
- Residents (if applicable): ________

e) Trainees

i) Students: Do you train students at your hospital?:
- □ No (Skip to next question 9e ii))
- □ Yes

Approximately how many of the following types of students are rotating through your hospital in an average month (2005)?

<table>
<thead>
<tr>
<th>Disciplines</th>
<th>Average Number of Students (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Doctor</td>
<td></td>
</tr>
<tr>
<td>Doctor of Osteopathy</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td></td>
</tr>
<tr>
<td>Pharmacy</td>
<td></td>
</tr>
<tr>
<td>Nursing</td>
<td></td>
</tr>
<tr>
<td>OT/PT</td>
<td></td>
</tr>
<tr>
<td>Physician Assistant</td>
<td></td>
</tr>
<tr>
<td>Medical Laboratory &amp; Cyto Technologists / Technicians</td>
<td></td>
</tr>
<tr>
<td>Radiology Technologists</td>
<td></td>
</tr>
<tr>
<td>Other:Specify</td>
<td></td>
</tr>
<tr>
<td>Other: Specify</td>
<td></td>
</tr>
</tbody>
</table>
ii) **Residents**: Do you offer physician residency training at your hospital?

- [ ] No (Skip to next question 10)
- [ ] Yes

Indicate whether your hospital is the primary training site for each residency program. If your hospital hosts residents from other programs, do not check the first box. If known, indicate approximately how many residents from each residency program are present in your hospital during any one month?

<table>
<thead>
<tr>
<th>Service</th>
<th>Check if Hospital Is Primary Teaching Site</th>
<th>Check if Residency Program Exists</th>
<th>Average Number of Residents Present in Hospital During a Month (2005)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Internal Medicine</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Transitional Year</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Family Practice</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Psychiatry</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Dental</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Pathology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Urology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Otolaryngology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Plastic Surgery</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Physical Medicine and Rehab</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
<tr>
<td>Preventive Medicine</td>
<td>☐</td>
<td>☐</td>
<td></td>
</tr>
</tbody>
</table>
## 14) Health Information Technology

### a) If you have health information technology, indicate in which areas of the hospital functionality exists

<table>
<thead>
<tr>
<th>Area of Hospital Functionality</th>
<th>Hospital Inpatient Wards</th>
<th>ICU</th>
<th>ED</th>
<th>Observation Unit</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Patient Demographic Information</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td><strong>Computerized Orders for Prescriptions</strong></td>
<td>□ Yes–some □ Yes – all □ No □ Unsure □ Turned Off</td>
<td>□ Yes–some □ Yes – all □ No □ Unsure □ Turned Off</td>
<td>□ Yes–some □ Yes – all □ No □ Unsure □ Turned Off</td>
<td>□ Yes–some □ Yes – all □ No □ Unsure □ Turned Off</td>
<td>□ Yes–some □ Yes – all □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td>If yes → <strong>Are drug interactions warnings or contraindications provided?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td>If yes → <strong>Are prescriptions sent electronically to the pharmacy?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td><strong>Computerized Orders for Tests?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td>If yes → <strong>Are orders sent electronically?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td><strong>Lab Results?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td>If yes → <strong>Are out of range levels highlighted?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td><strong>Imaging Results?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
<tr>
<td>If yes → <strong>Can the ordering physician view electronic images?</strong></td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
<td>□ Yes □ No □ Unsure □ Turned Off</td>
</tr>
</tbody>
</table>
## Facility Questionnaire

### Clinical Notes?

- **Hospital Inpatient Wards**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ICU**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ED**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Observation Unit**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Outpatient**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off

**If yes →**

- Do they include medical history and follow-up notes?
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ICU**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ED**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Observation Unit**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Outpatient**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off

- Do they include reminders for guideline-based interventions and/or screening tests?
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ICU**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **ED**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Observation Unit**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Outpatient**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off

### Public Health Reporting?

- **Clinical Areas**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Clinical Laboratory**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off

**If yes →**

- Are notifiable diseases sent electronically to public health reporting agencies?
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Clinical Areas**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off
- **Clinical Laboratory**
  - ☐ Yes
  - ☐ No
  - ☐ Unsure
  - ☐ Turned Off

---

**b) For any systems for which you checked “Yes” above, please check the box if these systems use international messaging and communication standards.**

<table>
<thead>
<tr>
<th>Type of information</th>
<th>International Standard</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Messaging</td>
<td>HL7</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Diagnosis and Procedures</td>
<td>ICD9</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Medical Terminology</td>
<td>SNOMED</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Radiology</td>
<td>DICOM</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Laboratory</td>
<td>LOINC</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Pharmaceuticals</td>
<td>NCPDP</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Provider Identifier</td>
<td>UPIN / NPID</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
c) If you have an electronic medical record, indicate in which direct patient care settings the EMR is linked (i.e., information from one area is available to the others).

<table>
<thead>
<tr>
<th></th>
<th>Inpatient Wards</th>
<th>ICU</th>
<th>ED</th>
<th>Obs Unit</th>
<th>Outpatient</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient Wards</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ICU</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ED</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Observation Unit</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Outpatient</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

15) Did your hospital receive any Medicaid Disproportionate Share Program Funding in 2006?
   ☐ Yes
   ☐ No

16) Medical Coding
   a) Does your coding staff use electronic coding software?
      ☐ No
      ☐ Yes. Vendor:__________________________________________________________
   b) Please provide the number of ICD-9 CM diagnosis and procedure codes for the last calendar year on a per patient basis.

<table>
<thead>
<tr>
<th></th>
<th>Average</th>
<th>Median</th>
<th>Maximum</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of Diagnosis</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of Procedures</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

17) Capital Investment
   a) Was this hospital in the process of, or did this hospital complete, building any new buildings within the last year?
      ☐ No
      ☐ Yes
      i) How many new buildings? ____________
      ii) What is the purpose of the new building (s)? Please check all that apply
      ☐ Academic
      ☐ New combined adult and pediatric hospital
      ☐ New Adult Inpatient Hospital
      ☐ New Pediatric Inpatient Hospital
      ☐ Adult outpatient building
      ☐ Pediatric Inpatient building
      ☐ Research
      ☐ Other, please specify ______________________________________
      ☐ Other, please specify ______________________________________

18) Translation Services
   a) Does this hospital have language translators on site?
      ☐ No
      ☐ Yes
      i) How many languages do the onsite translation services speak?_______
      ii) How many hours per day are onsite translation services available?_________
19) Do you have an Ethics Consultation Service?
   □ No
   □ Yes

   i) Approximately how many consultations did this group conduct during the last 12 months?
      __________ Consultations
APPENDIX D

NCHS
AND
RAND
INTRODUCTION
LETTERS
Dear

We would like to request your participation in a research project being conducted by the National Center for Health Statistics (NCHS) to redesign the National Hospital Discharge Survey (NHDS). Since 1965, the NHDS has been a primary source of information on the nation’s inpatient utilization in short-stay, non-federal hospitals in the United States. Although the NHDS has served the country well for over 40 years, it was formulated in the context of a health care delivery system and hospital and patient universe of previous decades. NCHS is therefore undertaking a redesign of the NHDS to evaluate the role that the survey might play in informing current and future policy and research issues. The NCHS has contracted with RAND Health, a division of the RAND Corporation and one of the largest private health research groups in the world, to assist them with this task.

We are asking you to be one of nine hospitals to participate in a feasibility study to test and refine the redesigned survey. It is our intention to design a hospital discharge survey that collects meaningful data in a way that is practical and efficient for hospitals across the county. Through the feasibility study, we hope to gain insight into any problems and issues involving the data elements, data collection process, or procedures so that we can address and correct these in the final survey. Your participation in the study is voluntary and there are no penalties for refusing.

Among the many variables to be tested as part of this study, some are protected health information (PHI). Their inclusion in the study will allow us to better understand the issues and problems related to their collection. PHI for this study include: name, address, zip code, social security number, medical record number, billing number, Medicare health insurance benefit/claim number, and dates of admission, birth, discharge, and procedures. The collection of this information will be used only to evaluate field methods and procedures for the feasibility study. Please be assured that there are several ways that the Privacy Rule (as mandated by the Health Insurance Portability and Accountability Act [HIPAA]) allows you to participate. In particular, disclosures of patient data are permitted for public health purposes and for research that has been approved by a CDC Institutional Review Board – both of which apply to this study. The Institutional Review Board at CDC’s National Center for Health Statistics has reviewed and approved all aspects of this study.
Please be assured that all data regarding patients and facilities will be held in the strictest confidence and used only for statistical purposes as required by Section 308(d) of the Public Health Service Act [42 United States Code 242m (d)] and Section 513 of the Confidential Information Protection and Statistical Efficiency Act (PL-107-347). Published documents resulting from this feasibility study will not include any patient or clinical data, but will focus only on the feasibility of collecting the data. All published summaries will be presented in such a way that no individual facility or patient can be identified.

We would like to discuss with you the possibility of your hospital participating in this study. Within the next several days, a representative from RAND will telephone you to arrange for an appointment. In the event you have questions about what participation in this study could mean for your hospital, please feel free to call the principal investigators of the project, Dr. Lee Hilborne or Robin Meili at RAND, toll-free, at 1-800-447-2631. Robert Pokras or Dr. Alan Simon at the National Center for Health Statistics is also available to answer any questions. They may be contacted at (301) 458-4439 and (301) 458-4338 respectively.

We have enclosed some information about the NHDS, including a description of the study and a list of frequently asked questions and answers. We hope that you will make the decision to participate in this valuable effort and look forward to speaking with you.

Sincerely,

[Signature]

Edward J. Sondik, Ph.D.
Director
National Center for Health Statistics
Centers for Disease Control and Prevention (CDC)

Enclosures
DATA USE AGREEMENT BETWEEN
National Center for Health Statistics/CDC
Department of Health and Human Services
And
NHDS Participating Hospital

The Privacy Rule as mandated by the Health Insurance Portability and Accountability Act (HIPAA) allows hospitals to disclose limited data sets (i.e., data sets with no direct patient identifiers) for research and public health purposes if there is a data use agreement between the hospital and NCHS/CDC. This document serves that purpose and describes how the data will be used and establishes who is permitted to receive or use the data.

Use of Data and Assurances of Confidentiality

The National Center for Health Statistics (NCHS) is charged, under Title 42, United States Code, Section 242k, with supporting statistical and epidemiological activities to improve the effectiveness, efficiency, and quality of health services in the United States. For purposes of health-related research and statistical analysis, NCHS conducts the National Hospital Discharge Survey (NHDS), which collects information about the care that is provided to hospital inpatients. Specifically, these data are used to describe hospital inpatients, the conditions treated, and the diagnostic and therapeutic services provided. The data from this feasibility study will be used to inform the redesign of the National Hospital Discharge Survey.

According to the Privacy Rule, you may release data for the NHDS to NCHS without patient authorization when the data set excludes direct identifiers of the individual patients or relatives of patients, employers, or household members of the patient. This feasibility study for the redesign of the NHDS will not collect direct identifiers at this hospital, such as patient name, social security number, Medicare health insurance benefit/claim number, address, or telephone number. We will collect date of admission, date of discharge, date of procedure(s), patient’s date of birth, and residential ZIP code, which are not directly identifiable, but are considered protected health information under the Privacy Rule.

Although the data provided to NCHS are not directly identifiable, the confidentiality of the data must be protected. As such, all employees of RAND, acting as the data collection agents for the NHDS, must first sign an affidavit, a legal document making them subject to the Privacy Act, the Public Health Service Act, and other laws that require the data to be protected. Under section 308(d) of the Public Health Service Act [42 USC 242m(d)], the only persons to be granted access privileges to the protected health information after collection will be staff of NCHS and its contractors who have (a) been authorized to work with the file, (b) signed the Nondisclosure Statement in the NCHS Staff Manual on Confidentiality and (c) have seen the NCHS Confidentiality Videotape. In addition, the Confidential Information Protection and Statistical Efficiency Act (CIPSEA), passed in 2002, provides additional protection of all statistical data collected under a pledge of confidentiality. Under CIPSEA, the penalties for willful disclosure of confidential statistical information (considered a class E felony) are imprisonment for up to 5 years, a fine of $250,000, or both.
Data files containing sampled hospital discharges in this feasibility study will not be released to the public. No authority can obtain identifiable data from NCHS without prior permission granted to them by the responding hospital. NCHS and its agents physically safeguard the data and are bound by statutory confidentiality restrictions of Section 308(d) of the Public Health Service Act [42 USC 242m(d)]. Under this law, no information collected may be used for any purpose other than that described above. Such information may not be published or released to anyone we have not described above if it would identify an individual to which it pertains or the establishment supplying it.

NCHS will be the custodian of the data files and, as such, will be responsible for observing all conditions of use and for establishing and maintaining the security arrangement to prevent unauthorized use of these files. This includes administrative, technical, and physical safeguards. Also, NCHS will be responsible for observing all conditions of use and for specifying authority for access to these files in accordance with the terms of this data use agreement. For more information on how NCHS protects your data see www.cdc.gov/nchs/about/policy/confiden.htm.

As required by the Privacy Rule [45 CFR 164.514(e)(4)(ii)], NCHS agrees to
- not use or further disclose the data collected under this agreement for any purposes not stated above,
- use appropriate safeguards to prevent other use or additional disclosures,
- report to you any non-agreed disclosures should they occur,
- ensure that any CDC contractors using the data agree to the above conditions, and
- not try to identify patients or sampled hospitals based on the data obtained via this agreement.

More information about the NHDS public use data files can be found at http://www.cdc.gov/nchs/about/major/hdasd/nhds.htm. Historically, NCHS has adhered to the requirements presented in this Data Use Agreement and has never had any inappropriate disclosure of its data. Thank you for your cooperation.

Edward J. Sondik, Ph.D.
Director
National Center for Health Statistics
Centers for Disease Control and Prevention (CDC)
November XX, 2006

To: Hospital CEO

Dear CEO:

Thank you for agreeing to meet with us to discuss <<HOSPITAL’S>> participation in the feasibility study for a redesigned National Hospital Discharge Survey. Likely joining us in the meeting will be our CDC-NCHS colleagues, Bob Pokras and Dr. Alan Simon. When we spoke with you last week, we discussed how the NHDS has served our nation well for over 40 years. However, given the changes in healthcare delivery, a redesigned survey will offer policy makers, researchers and hospitals a much more robust dataset on which to base future decision making.

We are looking forward to meeting with you and your colleagues in the next couple weeks. This letter includes items that will be helpful as preparatory information for our visit. An agenda for the meeting and suggested attendees are included on the third page. We anticipate that the meeting will take 1½ -2 hours.

In addition to the agenda, also find attached the following items:

• Description of Study. This description may be useful to you to communicate the nature of the study and your organization’s role in helping to redesign the NHDS to your staff, your Board and others who may wish to know about Lodi’s involvement in the community.

• Frequently Asked Questions – We assembled a list of questions that we think may be asked by members of the hospital staff. The questions range from the time required for participation to concerns about patient privacy and confidentiality. Of course, if the documentation we provided does not completely address your questions, please call us and we will be happy to discuss your issues and concerns.

• NCHS IRB approval letter – The National Center for Health Statistics Ethics Review Board, the CDC’s equivalent to your Institutional Review Board (IRB) or Human Subjects Protection Committee (HSPC), has approved the study and our protocols. The enclosed copy of the document may be helpful in providing the necessary documentation for committees or advisors at your facility on IRB and HIPAA issues.

• MMWR paper on participating in surveys with the CDC – This document reviews the special considerations that are given to public health agencies, including the CDC, related to compliance with HIPAA. Hospitals working with public health agencies are permitted to share patient information without prior patient consent. We are very sensitive to the importance of maintaining patient privacy and confidentiality – and will work with you to make sure that you are aware of all the provisions we have made to protect your patients’ information.

• Facility Form – This form asks about your facility. Some of the information requested parallels that submitted to the American Hospital Association. The additional information requested is relevant to the study and ultimately will be important when the Survey findings are analyzed. While you may not be able to complete this form
before our visit, please take a moment to look over it so that we may answer any questions that you might have. We are asking that if at all possible this form be completed within two weeks of its receipt.

• Patient Abstraction Form – This is the actual form that will be used to abstract information regarding the study patients by both you and RAND. It is divided into sections, some of which relate primarily to the medical record. Other sections ask about information that may be located in different places within the organization.

• Sampling Plan – To expedite the review process, we have been specific about the types of records we wish to review. The sampling plan provides direction to your staff to identify records for the study. The criteria are standard medical record criteria so we do not anticipate this will be difficult. However, if you have questions, please feel free to contact Megan Beckett at 310-393-0411x6762.

We look forward to the possibility of meeting with you on November 20th. In the meantime, please feel free to call or e-mail us with questions you have regarding the project or if we can assist you in any way.

Sincerely,

Robin C. Meili, MBA     Lee H. Hilborne, MD, MPH
Co-Project Director     Co-Project Director
meili@rand.org     leeh@rand.org
310-393-0411x7190     310-393-0411 x6400

Enclosures
National Hospital Discharge Survey Feasibility Test Hospital Induction Site Visit

Time: Approximately 1-½ to 2 hours

Suggested Hospital Attendees:
- • CFO / Financial Services
- • CIO
- • Health Information Management / Medical Records
- • Pharmacy
- • Privacy Officer
- • Study primary contact

AGENDA

I.  Introductions

II. Description of survey and feasibility test

III. Review introductory packet of materials

IV. Discussion of sampling and data collection process
   • Logistics
   • Personnel
   • Sampling
   • Financial and billing information
   • Medications
   • Other

V. Issues or concerns

VI. Set timeline and RAND abstractor site visit date
National Hospital Discharge Survey Feasibility Test
Hospital Induction Site Visit

Time: Approximately 2 hours

Suggested Hospital Attendees:
- CEO
- CFO
- CIO
- Medical Records
- Pharmacy
- Privacy Officer
- Study primary contact

AGENDA

I. Introductions

II. Description of survey and feasibility test

III. Review introductory packet of materials

IV. Discussion of sampling and data collection process
   - Logistics
   - Personnel
   - Sampling
   - Financial and billing information
   - Medications
   - Other

V. Issues or concerns

VI. Set timeline and RAND abstractor site visit date
APPENDIX F

STUDY DESCRIPTION
Project Description
Redesign of the National Hospital Discharge Survey (NHDS)

Brief Description
This study will develop and field test a redesigned conceptual framework for the National Hospital Discharge Survey (NHDS).

Background
The National Center for Health Statistics (NCHS) is responsible for assessing the health status and health care needs of the people of the United States. NCHS is responsible for a family of sample surveys which are designed to measure utilization of the health care delivery system, and which are used for a variety of purposes in the public and private sectors. A key component in the NCHS family of surveys is the National Hospital Discharge Survey (NHDS). First carried out in 1965, the NHDS has been a primary source of information on the nation’s inpatient utilization in short-stay, non-federal hospitals in the United States. Although the NHDS focuses on hospital inpatient care, it fits into a broader portfolio of surveys, called the National Health Care Survey, covering outpatient care, emergency room care, nursing home care, home health and hospice care, and ambulatory surgery center care. But while the NHDS has served the country well for 40 years, it is based on concepts for a health care delivery system and a hospital and patient universe of previous decades. For this reason, the NCHS has determined that a redesign of the NHDS is needed.

Study Goals
The goal of this project is to conduct a redesign of the NHDS. This project consists of the following five tasks:
1. Establish an administration and administrative plan for implementing the project, monitoring progress, and developing project deliverables.
2. Develop a conceptual framework for a redesigned NHDS.
3. Define the data elements required for a redesigned conceptual framework.
4. Develop, test, and finalize field procedures and methods.
5. Complete a final report for this phase of the redesign.

Methodology
The following methods will be used to develop the conceptual framework; collect data necessary to support the selected option; and develop, test, and finalize field procedures and methods.

1. Development of a Conceptual Framework. The research team will synthesize existing information on data needs and identify and evaluate possibilities and constraints for making changes. To accomplish this task, researchers will engage in discussions with NCHS staff, experienced RAND staff,
consultants familiar with the variety of data resources available, users of and stakeholders in the current data, and hospitals and organizations representing providers of the data. The team will synthesize the results of the data needs and development of conceptual framework options. The team will outline these options and develop decision criteria that will allow thoughtful consideration of each option. In coordination with the NCHS, the researchers will assemble a workgroup of recognized opinion leaders to review and provide input into the options and their implications, with the intent of identifying the most robust, usable, and practical option(s).

2. Collection of Data. In order to define data elements, the team will first specify the research questions that need to be answered by the survey in priority order. Then each question will be associated with the variables needed to answer it. Once the key variables are identified, the team will determine in what form and from what source the data can be collected.

3. Development, Testing, and Finalization of Field Procedures and Methods. In parallel to the development of a preliminary conceptual framework, the team will develop and field test procedures and methods. The goal of this task is to test and fine-tune the preliminary design of a framework and content by trying out field procedures. The framework will drive the design of a pilot study to be tested in up to nine hospitals. The goal of the pilot study is to gain insight into the problems and issues that need to be addressed or corrected in the final set of materials and procedures, including possible modifications of the framework and data items. To carry out the pilot test, the researchers will design a complete set of field materials that are as close as possible to what will be required to carry out the redesigned NHDS. The pilot study will involve hospitals from two geographic locations. Based on the results of the pilot study, the research team will develop a final well-defined set of field procedures that will allow for consistent data collection for a national sample of hospitals.
Frequently Asked Questions

Feasibility Study for the Redesign of the National Hospital Discharge Survey
October 26, 2006

1. What is the National Hospital Discharge Survey (NHDS)?
   First conducted in 1965, the NHDS has been an important source of information on inpatient utilization in short-stay non-federal hospitals in the United States. The current survey collects UB92 data and has served as a valuable source of information for policymaking, health care research, academic education, and various applications within the hospital industry. Although the NHDS focuses specifically on hospital inpatient care, it fits into a broader portfolio of surveys within the National Center for Health Statistics (NCHS). These surveys cover outpatient care, emergency room care, nursing home care, home health and hospice care, and ambulatory surgery center care. Information about the NHDS can be found at http://www.cdc.gov/nchs/about/major/hdasd/nhds.htm.

2. Why do you need to redesign the NHDS?
   Although the NHDS has served the country well for over 40 years, it was formulated in the context of a health care delivery system and hospital and patient universe of previous decades. The National Center for Health Statistics (NCHS) is therefore undertaking a redesign of the NHDS so that it better reflects the current healthcare context and continues to provide a valuable source of information for current and future policymaking, health care research, academic education, and various other applications within the hospital industry. For example, the redesigned NHDS can continue to produce a nationally-representative general purpose sample of hospital utilization and close gaps in available information about care delivered within a hospital (e.g., use of resources, more clinical depth, demographic depth, outcomes) while also permitting ad hoc or focused modules as needed for policy and research demands (e.g., disease-specific studies, workforce issues).

3. What is the purpose of this feasibility study?
   The NCHS is conducting this feasibility study to ensure that the redesigned NHDS can continue to be completed efficiently and without significant disruption of hospital work flow. In particular, the study will allow us to identify any problems and issues created by the new NHDS that need to be addressed or corrected before a more formal pilot is conducted. The procedures and abstraction tools employed during this initial feasibility study are designed to be as close as possible to what will be required to carry out the redesigned NHDS. We will use the findings from the study to identify possible modifications of the data collection procedures and data items. The redesigned survey will be further tested in a full-scale pilot in 2008. Your hospital will not be asked to participate in the pilot in 2008.

4. Who is sponsoring this study? What is the National Center for Health Statistics (NCHS)?
   The NCHS is sponsoring this study. The NCHS, a division of the Centers for Disease Control and Prevention (CDC), is the nation’s principal health statistics
agency and is responsible for assessing the health status and health care needs of people in the United States. The NCHS is responsible for a family of surveys that are designed to measure utilization of the health care delivery system, and which are used for a variety of purposes in the public and private sectors. More information about the NCHS can be found at: http://www.cdc.gov/nchs/.

5. **Who is conducting the study?**
RAND Health, a division of the RAND Corporation, is assisting the NCHS in redesigning the NHDS and will be working directly with the hospitals testing the study procedures and materials. RAND Health is one of the largest private health research groups in the world. The RAND Corporation is a non-profit research organization that conducts policy research in the public interest, including studies on health outcomes and quality of life. Information on RAND can be found at http://www.rand.org.

6. **What will be expected of us if our hospital agrees to participate in this study?**
Involvement in this feasibility study would include activities such as the following:
- Meet with RAND staff (and possibly NCHS staff) to identify the facility personnel who would be involved in the feasibility study and the location and means of access to the data of interest
- Complete the facility information form
- Identify a list of sample patients as prescribed by a RAND-provided sampling plan
- Identify a hospital contact to facilitate the project within the hospital and be available to RAND abstractor(s) during their site visit to facilitate interaction with the hospitals records, systems and personnel as required.
- Identify medical record abstractor(s) to pilot the abstraction tool. Using RAND-provided guideline materials, abstractors will collect the requested data elements for the patient sample in anticipation of a RAND-abstractor visit date.
- Provide RAND-abstractors access to the same sample patient records (and/or electronic data, as applicable) for a RAND-conducted, on-site abstraction
- Debrief with RAND and NCHS staff at the conclusion of the process
- Participate as needed in a limited number of follow-up telephone calls to clarify findings and provide input to the redesign process.

All activities involved in the feasibility study will be conducted either at participating hospitals or via electronic means, such as telephone or web conference. No travel will be required on the part of hospital personnel.

7. **How much information will you collect from the hospital?**
The data collection instrument includes both a core module that is 6 pages in length (54 questions) and three very brief disease specific modules. In addition to clinical
data elements, we will be requesting a medication list for each selected admission, expected payment and actual payment for the admission, and charges by revenue center. The data collection instrument used in the feasibility test will include more elements than are likely to be included in the final version of the redesigned instrument. We are using the feasibility test to assess the appropriate breadth (e.g., number of items the survey should include regarding aspects of care, such as clinical data, utilization, cost, quality and/or access) and depth (e.g., the level of detail for each data element) of survey items and to determine whether data elements are financially and operationally feasible to collect. We are also interested in testing whether all requested data elements can be abstracted, how long abstraction takes, and what concerns the hospital has with respect to providing requested information to the CDC.

8. **What data elements have been selected?**  
The data elements will include information contained on the UB92 (hospital bill), patient demographics and characteristics, a few clinical variables, some charge/reimbursement data, and elements that could be used to link to other data sources, such as name and Social Security Number (which are used, for example, to link to the National Death Index). Information from the UB92 has historically been collected from hospitals. This new form has added more detailed demographics and the other variables noted above.

9. **How many records from our hospital will you need to abstract?**  
We will request 20 records from your facility, selected according to specific criteria based on demographic information and discharge diagnoses.

10. **Will you be removing the medical and billing records from our hospital?**  
Hospital records or copies will not be removed from your facility. However, the NCHS has asked RAND to provide them with the completed abstraction forms. Forms with patient identifiable data will be placed in a FedEx envelope, which will be sealed before leaving the facility, and sent to RAND for analysis of completeness. Tracking will allow us to confirm that the envelope has reached RAND. Handling of the abstraction forms and protection of personal health information will be performed according to the data security procedures required by the NCHS Institutional Review Board (IRB) and RAND. They will be kept in a locked file cabinet while at RAND and data from these forms will be kept on password protected computers. No photocopies or electronic copies will be made and only designated RAND project staff who have signed Nondisclosure Affidavit’s with the NCHS will have access. Upon completion of the analysis, the abstraction forms and the data will be sent to the NCHS via FedEx with tracking.

11. **When will you be conducting the feasibility study?**  
We are estimating that the feasibility study will begin late 2006. We will work with hospitals and their staffs to ensure that the study is conducted at a convenient time.
12. **How long will participation take? How many days will we need to set aside for the abstraction?**

As a feasibility study, we are not entirely sure of the time needed to complete this work. We estimate participation will require approximately 4-8 hours with one or more senior hospital staff. It will also require time of one or more staff members for data collection activities from a maximum of 20 patient records, but the precise time will likely vary by site.

Upon your acceptance of participation, we will send you a hospital facility questionnaire to complete that asks basic demographic, volume, staffing and systems questions. This questionnaire will likely require several hours of your staff’s time, but will generally be information that you either naturally collect or report to others. Where you report it to others (e.g., the American Hospital Association) you will be able to provide your submission to that entity, if you wish, thereby mitigating some of the hospital’s response time. For our initial meeting, we estimate 1-2 hours staff time of the CEO or his/her delegate and other key staff for an initial induction interview and answer any questions you may have. A second form, a patient abstraction questionnaire, will be completed for 20 records. Abstraction preparation time will depend on how long it takes to draw the sample of patients, pull medical records, and/or access electronic data. Your facility abstractor should complete the sampled designated records. A RAND abstractor will need up to 2 full days in your hospital for the RAND-conducted abstraction. The same sampled records used by the facility abstractor and access to any additional records required for the abstraction (billing, pharmacy) should be ready and available for the RAND abstractor on the day scheduled for his or her arrival. During the time the RAND abstractor is on your premises, he or she will also need access to a person on your staff to assist in accessing records/data, if needed. There will be an approximately 1-hour debriefing session with RAND at the end of the second day, and some post-visit telephone debriefing with RAND, the NCHS, and other feasibility study sites.

13. **Who will do the data collection?**

Once patients are selected based on an algorithm we will provide, the data will be abstracted by a hospital staff medical record abstractor designated by your hospital prior to our re-visit to your hospital. This process will require that your facility will pull requested medical records and have other necessary data available for the hospital staff. This may be either printed in advance or an individual could be available who can access the data electronically. The same data sources, including medical records, and other documents or electronic records, will also be abstracted by a trained medical abstractor from RAND, allowing RAND staff to obtain a greater understanding of the strengths and weaknesses of the abstraction methodology.

14. **What do we need to do in order for you to do the abstraction?**
We will inform you of the type of information that is needed during our visit to test the abstraction tool, and we will need someone from your facility to have gathered or get access to the necessary medical and billing records for abstraction.

15. **What skill level does the abstractor from our facility have to have?**
   This person would need to know where to find or gain access to medical records and/or different departments within the hospital and how to find the data elements on our abstraction form. The individual who abstracts data from your facility should be familiar with hospital medical records and other administrative records. For example, the individual(s) reviewing and abstracting records for the Joint Commission’s ORYX measures will likely have the skills and experience necessary to assist with this project.

16. **Is there going to be training for the individual performing the abstraction? How long will the training be?**
   RAND will provide an introduction to the project along with detailed materials to guide the abstraction process. RAND will conduct one-on-one training with you over the phone. RAND will also have staff available to answer any specific questions an abstractor might have.

17. **How did you select our hospital/facility to participate?**
   Your hospital was selected because of your geographic location, hospital size, and types of services provided based on the American Hospital Association’s hospital information.

18. **Can another hospital/facility participate instead of us?**
   Your hospital was specifically selected because of the criteria mentioned above. It might be possible to select a hospital to serve in your place, but we are hoping you will find the contribution you will be making to the future of hospital data collection efforts worthwhile and will join us in these efforts.

19. **Who else is participating in the feasibility study?**
   We are recruiting a total of nine hospitals, located in California and the Washington D.C./Virginia/Maryland area. The identity of your hospital and other hospitals participating in this study is confidential. We will not identify these hospitals to each other. No data will be shared among hospitals although hospitals will participate in an anonymous joint debrief call at the end of the study.

20. **Can we get the results to the study?**
   Yes, we can provide you with a copy of our final report on the feasibility of data collection once the feasibility study is completed.

21. **What will happen with the information and feedback we and other hospitals participating in the feasibility study give you?**
Based on the results of the feasibility study, the research team will develop a final well-defined set of field procedures that will allow for consistent data collection for a national sample of hospitals and be tested in a pilot study of the redesigned NHDS in 2008.

All information collected will be the property of the NCHS and is confidential. RAND will not identify the hospitals or participating personnel to anyone outside the research project and the NCHS personnel working with us on the project.

Again, hospitals participating in the study can request a copy of the final report written by RAND to NCHS if they desire.

22. **Will you be contacting us again? Will we need to obtain information on an ongoing basis/long term?**
   If you are selected as one of the hospitals for the final redesigned NHDS in 2010, then the NCHS will contact you again to assess your interest in participating in these efforts. If you are not selected, then we will not be contacting you again to abstract any additional records.

23. **What are the patient privacy and confidential issues?**
   All personal health information will remain confidential and not disclosed to anyone outside the RAND project team and NCHS staff. Because this study is intended to test feasibility, our focus will be on issues such as whether the data elements could be abstracted and how long abstraction takes. The data will be used only for these purposes. This study has been approved by the IRB of the NCHS.

24. **Are there HIPAA implications for the hospital for participating in this study?**
   The study is being conducted under the auspices of the NCHS/CDC (federal government), for which special provisions exist for public health entities to facilitate participation under HIPAA.

   The Privacy Rule recognizes 1) the legitimate need for public health authorities and others responsible for ensuring the public's health and safety to have access to protected health information to conduct their missions, and 2) the importance of public health reporting by covered entities to identify threats to the public and individuals. The rule 1) permits protected health information disclosures without a written patient authorization for specified public health purposes to public health authorities legally authorized to collect and receive the information for such purposes, and 2) permits disclosures that are required by state and local public health or other laws HIPAA Regulations (45 CFR§164.501). Thus, HIPAA permits hospitals such as yours to participate in studies of this nature for public health purposes. Because RAND is serving as an authorized agent of the NCHS for this project, it is permissible to disclose data to RAND for the purposes of this project. HIPAA also permits covered entities to obtain the documentation and rely on the
approval of one IRB or privacy board. In this case, the hospital may rely on the approval of the NCHS IRB.

25. **Do we need to let our patients know that we are accessing their records for this study?**

The Privacy Rule permits disclosure of protected health information (PHI) without written patient authorization for specific public health purposes to public health authorities and their authorized agents, including federal public health agencies such as the CDC, of which NCHS is a part.\(^1\) Thus, HIPAA Regulations (45 CFR§164.501) do not require you to obtain patient authorization prior to disclosing protected health information to NCHS or RAND, as an authorized agent of NCHS.

26. **Whom do I contact for more information?**

You may contact Robin Meili (310) 393-0411 ext. 7190 or meili@rand.org or Lee Hilborne at 310-393-0411 ext. 6400 or leeh@rand.org. You may also contact Robert Pokras at 301-458-4439 or RPokras@cdc.gov or Alan Simon at 301-458-4338 or ASimon2@cdc.gov. Ms. Meili and Dr. Hilborne are RAND staff. Robert Pokras and Dr. Alan Simon are staff at the CDC, National Center for Health Statistics.

27. **OK, I’m interested in participating in the feasibility study. What are the next steps?**

We would like to meet in person with you and key members of your staff, including, as appropriate, your medical records and medical coding directors, and chief information officer. The meeting should take about 1-2 hours. The agenda for this meeting will include a briefing on the study purposes and plans for the feasibility study. Then we will need to confirm or update the information regarding your hospital that we have from the American Hospital Association database. This includes your annual number of discharges, births, emergency department visits, outpatient visits, surgeries, average lengths of stay, etc. In addition, we would like to ask you some questions regarding how you manage medical records and electronic data.

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\(^1\) HIPAA Privacy Rule and Public Health: Guidance from CDC and the US Department of Health and Human Services; MMWR Vol. 52, August 11, 2003.
APPENDIX H

ABSTRACTION FORM
We are requesting the following printouts for this abstraction:

1) Final diagnoses including ICD-9-CM codes, description and whether it was present on admission. (Question 46)

2) All surgical and diagnostic procedures by ICD-9-CM or CPT-4, description, procedure date, provider UPIN/NPI and type of Anesthesia if given. (Question 47)

3) A list of charges and totals by revenue center ID including dates and times (if available) when these charges were generated. (Question 51)

4) A list of all medications the patient received during this admission as recorded in the pharmacy system/record including the route, date and time of first administration. (Question 54)

If printouts are not available, there are manual abstraction instructions included within the attached pages.
### B. PATIENT RECORD IDENTIFICATION

1. **AHA Hospital #**
   - ___ ___ ___ ___

2. **HDS #:**
   - ___ ___ ___ ___

12. **If initial presentation is to the Emergency Department,** provide date and time of ED presentation:
   - MM ___ DD ___ YY ___ Arrival Time (24 hr time) ___ : ___
   - [ ] Patient not seen in ED immediately prior to this hospital stay

13. **If the patient was placed in Observation Status,** whether or not they were subsequently admitted, provide date and time of admission to observation:
   - MM ___ DD ___ YY ___ Adm to Obs Time (24 hr time) ___ : ___
   - [ ] Patient not on observation status during this hospital stay

14. **If the patient was an acute inpatient,** whether or not initially on observation status, provide date and time of acute admission or status change to acute:
   - MM ___ DD ___ YY ___ Adm to Acute Time (24 hr time) ___ : ___
   - [ ] Patient not an acute inpatient during this hospital stay

15. **If Acute Inpatient Admission, identify type:**
   - [ ] Emergency  [ ] Urgent  [ ] Elective  [ ] Newborn  [ ] Unable to tell  [ ] Not Applicable

16. **If patient was admitted to a critical care bed,** provide date and in and out time of first admission. If admitted to critical care more than once, record date/time for first and total critical care admissions.
   - 1st Adm: MM ___ DD ___ YY ___ Discharge MM ___ DD ___ YY ___
   - Time (24 hr time): Admission ___ : ___ Discharge ___ : ___
   - [ ] Patient not admitted to a critical care bed / Unknown | Total critical care admits ___

17. **Date and time of final discharge** either from observation or acute admission:
   - MM ___ DD ___ YY ___ Admission Time (24 hr time) ___ : ___

### C. PATIENT IDENTIFICATION and DEMOGRAPHICS

18. **City**
   - ___

19. **State**
   - ___

20. **Age**
   - (if no DOB) ___ ___ ___

21. **Sex**
   - [ ] Male  [ ] Female  [ ] Not stated

22. **Marital status**
   - [ ] Married  [ ] Widowed  [ ] Separated
   - [ ] Single  [ ] Divorced  [ ] Not stated

23. **Living Situation at Admission**
   - [ ] Alone, private residence  [ ] Skilled Nursing Facility  [ ] Incarcerated
   - [ ] Share private residence  [ ] Other Long Term Care  [ ] Other / not stated
   - [ ] Psychiatric facility  [ ] Homeless

24. **Race**
   - Mark all that apply
     - [ ] White
     - [ ] Black/African American
     - [ ] Asian
     - [ ] Native Hawaiian/Other Pacific Islander
     - [ ] American Indian/ Alaska Native
     - [ ] Other: ____________
     - [ ] Unknown

25. **Ethnicity**
   - [ ] Hispanic
   - [ ] Not Hispanic
   - [ ] Unknown

26. **Mode of Arrival**
   - [ ] Ambulance (air/ground)
   - [ ] Public service (non ambulance)
   - [ ] Personal transportation
   - [ ] Unknown

27. **Source of admission**
   - [ ] Physician referral
   - [ ] Acute → acute transfer
   - [ ] Other ED → acute transfer
   - [ ] Court / law enforcement
   - [ ] Other transfer
   - [ ] Unknown

28. **Education**
   - (If patient is < 18, education of parent/ caregiver)
   - [ ] Not HS grad  [ ] HS grad/GED  [ ] Some college  [ ] College grad  [ ] Post grad  [ ] Not stated

29. **Occupation:**
   - (If patient is < 18, note occupation of each parent/caregiver)
   - [ ] Student
   - [ ] Retired
   - [ ] Unemployed
   - [ ] Unknown

30. **English Proficient:**
   - Patient (if patient is > 7)
     - [ ] Yes
     - [ ] Unknown
     - Also include parent / caregiver if patient is < 18)
     - [ ] Yes
     - [ ] Unknown
     - [ ] No - Primary language is: ____________
     - [ ] No - Primary language is: ____________
### D. PATIENT CLINICAL VARIABLES (Obtained from Medical Record)

#### 31. Vital Signs Value On First Presentation
Check if not done within first 24 hours

<table>
<thead>
<tr>
<th>Variable</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>__ __ / __ __ mmHg</td>
<td></td>
</tr>
<tr>
<td>Heart Rate</td>
<td>__ __ per minute</td>
<td></td>
</tr>
<tr>
<td>Respiratory Rate</td>
<td>__ __ per minute</td>
<td></td>
</tr>
<tr>
<td>Temperature</td>
<td>__ __ °C / __ °F</td>
<td></td>
</tr>
<tr>
<td>Specify route</td>
<td>________</td>
<td>not noted</td>
</tr>
<tr>
<td>Oxygen saturation</td>
<td>__ __ % RA Suppl O2</td>
<td></td>
</tr>
<tr>
<td>Height</td>
<td>__ __ inches / cm</td>
<td></td>
</tr>
<tr>
<td>Weight</td>
<td>__ __ pounds / kg</td>
<td></td>
</tr>
</tbody>
</table>

#### 32. Clinical Laboratory Results Initial results
Check if not done within first 24 hours

<table>
<thead>
<tr>
<th>Test</th>
<th>Value</th>
<th>Unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hematocrit (Hct)</td>
<td>__ __ %</td>
<td></td>
</tr>
<tr>
<td>White Cell Count (WBC)</td>
<td>__ __ x1000/μL</td>
<td></td>
</tr>
<tr>
<td>Platelet Count (Plt)</td>
<td>__ __ x1000/μL</td>
<td></td>
</tr>
<tr>
<td>Creatinine (Cr)</td>
<td>__ __ mg/dL</td>
<td></td>
</tr>
<tr>
<td>Urea Nitrogen (BUN)</td>
<td>__ __ mg/dL</td>
<td></td>
</tr>
<tr>
<td>Potassium (K)</td>
<td>__ __ mmol/L</td>
<td></td>
</tr>
<tr>
<td>Sodium (Na)</td>
<td>__ __ mmol/L</td>
<td></td>
</tr>
</tbody>
</table>

#### 33. Activities of Daily Living
Does the medical record indicate that the patient has difficulty with any one of the following:

<table>
<thead>
<tr>
<th>Task</th>
<th>On Admission</th>
<th>At Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bathing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Dressing</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Toileting</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Transfer</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Continence</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Feeding</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Independent</td>
<td>- - -</td>
<td>- - -</td>
</tr>
<tr>
<td>No data</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Not applicable</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 34. Pain Assessment (within first 24 hours):

- Severe [☐]
- Moderate [☐]
- Mild [☐]
- Unknown [☐]

Pain scale: _____ of 10 or _____ of 5

#### 35. ASA Classification for Surgical Patients

- Class 1 [☐]
- Class 2 [☐]
- Class 3 [☐]
- Class 4 [☐]
- Class 5 [☐]
- Class 6 [☐]
- No data [☐]
- Not applicable [☐]

#### 36. Drug Allergies

- Yes (specify): ____________________________
- None [☐]
- Unknown/Not stated [☐]

#### 37. Tobacco use:

<table>
<thead>
<tr>
<th>Status</th>
<th>Cigarette</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Current user</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Quit ≤ 1 year ago</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Quit &gt;1 year ago/unknown</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

#### 38. For current/past cigarette smokers:

- ____ ____ Pack years
- Not available/applicable

#### 39. DNR Order For This Admission?

- No [☐]
- Yes, date of 1st order: MM ___ ___ DD ___ ___

#### 40. Stability at discharge (if patient discharged to home)

On the day prior to or day of discharge, were any of the following noted?

- Temperature > 37.8°C (100.0°F) [☐]
- Heart rate > 100 [☐]
- Respiratory rate > 24 [☐]
- Systolic BP < 90mm Hg [☐]
- Oxygen Saturation < 90% on room air OR < 95% on suppl O2 [☐]
- Not applicable (patient not discharged to home) [☐]

#### 41. Status/Disposition of the patient at discharge:

- Alive
  - Home (check boxes below if appropriate)
    - Home health services [☐]
    - IV medication [☐]
    - Patient instructed to call MD for follow-up [☐]
    - Follow-up MD appointment date in chart [☐]
    - Other tests/treatments scheduled [☐]
  - Transfer to another acute hospital [☐]
  - Transfer to acute rehabilitation [☐]
  - Transfer to psychiatric facility [☐]
  - Transfer to skilled nursing facility [☐]
  - Transferred to other long-term care institution [☐]
  - Other disposition [☐]
  - Left against medical advice [☐]
  - Disposition unknown [☐]
- Died – Where:
  - ED [☐]
  - Observation Unit [☐]
  - Med/Surg Unit [☐]
  - Critical Care [☐]
  - OR/Procedure Room [☐]
  - Unknown/Not stated [☐]
- Unknown [☐]
### E. MEDICAL RECORD CODED DATA

43. Attending Physician UPIN/NPI: ___________________

44. DRG Assigned To This Admission: ____ ____ ____

45. Admitting Diagnosis: _______________________  ICD-9-CM _______________________ Description

46. Final Diagnoses (including E-Codes) (up to 20)

<table>
<thead>
<tr>
<th>ICD-9-CM Code</th>
<th>Description</th>
<th>Present at Admission?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prin Dx</td>
<td></td>
<td>☐ Y ☐ N ☐ Unk</td>
</tr>
<tr>
<td>Oth Dx</td>
<td></td>
<td>☐ Y ☐ N ☐ Unk</td>
</tr>
</tbody>
</table>

47. Surgical and Diagnostic Procedures (up to 20)  ☐ Check box if none

<table>
<thead>
<tr>
<th>ICD-9-CM or CPT-4 Code*</th>
<th>Description</th>
<th>Procedure Date</th>
<th>Provider UPIN/NPI</th>
<th>Anesthesia Type (if given)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prin Px</td>
<td></td>
<td>MM ___ DD ___ YY ___ ___</td>
<td>☐ Loc ☐ Reg ☐ Gen ☐ Unk</td>
<td></td>
</tr>
<tr>
<td>Oth Px</td>
<td></td>
<td>MM ___ DD ___ YY ___ ___</td>
<td>☐ Loc ☐ Reg ☐ Gen ☐ Unk</td>
<td></td>
</tr>
</tbody>
</table>

* Use CPT-4 Code for Hospital Observation (Medicare Part B) Admissions
### F. Financial and Billing Record Data Elements

#### 48. Expected Source of Payment
- No source indicated
- Worker's compensation
- Medicaid / SCHIP
- Medicare
- Other Gov't (e.g., CHAMPUS, Tricare, VA)
- Private / commercial insurance
- Self-pay
- No charge
- Other

#### 49. Payment Type for Primary Insurance (if applicable)
- Indemnity/Fee for Service
- Preferred Provider (PPO)/Point of Service (POS)
- HMO/Other Managed Care
- Unknown, unable to tell
- Not applicable

#### 50. Charges, Expected Reimbursement, Actual Payment

<table>
<thead>
<tr>
<th>Duration Of Care</th>
<th>Expected Reimbursement</th>
<th>Actual Payment</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Observation Care</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inpatient Care – Intensive Care</td>
<td>_______ days</td>
<td></td>
</tr>
<tr>
<td>Inpatient Care – General Acute</td>
<td>_______ days</td>
<td></td>
</tr>
<tr>
<td>Rehabilitation/Step Down Care</td>
<td>_______ days</td>
<td></td>
</tr>
<tr>
<td>Total for This Hospital Encounter</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

#### 51. Charges Allocated by Revenue Center ID:
Please provide a printout of all charges and totals allocated by revenue center ID for this admission. With this printout include the date and time (if available) when charges were incurred.

### G. Information from Other Hospital Care Within 30 Days

#### 52. If the patient was treated at the hospital as an acute inpatient, observation status or in the emergency department within the 30 days prior to this hospital stay (index admission) or 30 days following discharge, provide the following information about the hospital encounter. If the patient was seen more than three times in any of these settings pre or post the abstracted admission, please list the three that were closest to the admission.

<table>
<thead>
<tr>
<th>Admission Date</th>
<th>Discharge Date</th>
<th>Care Location</th>
<th>Principal Diagnosis ICD-9-CM</th>
<th>Principal Procedure ICD-9-CM/CPT-4*</th>
<th>DRG (If Inpatient)</th>
</tr>
</thead>
</table>

**30 days prior to admission**

| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

**Index Admission**

| | | | | |

**30 days post discharge**

| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |

* Use most significant CPT procedure for previous observation status admissions.
### G. Medications

#### 53. Medications at Admission and Discharge: *(list only 20)*

<table>
<thead>
<tr>
<th>Medications the Patient Was Taking Immediately Preceding Admission</th>
<th>Medications Prescribed for the Patient at Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
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<td>3.</td>
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<td>4.</td>
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<td>5.</td>
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<td>12.</td>
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<td>13.</td>
<td></td>
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<tr>
<td>14.</td>
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- □ None
- □ Unknown / Not Stated

#### 54. Medications Received During the Admission:

Please attach a printout of all medications the patient received during this admission as an inpatient, emergency department or observation status patient. Do not include medications recorded on the operative or procedure forms. Include the route along with the date and time the patient received (or started to receive in the case of infusions) the medications. Drugs should be specified by the following, in order of preference: NDC codes, HCPCS codes (e.g., J Codes), Drug Generic Name, Drug Trade Name, Other. Indicate the source below:

Source:
- □ Medication Administration Record (printout attached or utilize 54A manual abstraction sheet)
- □ Billing Records (printout attached)
- □ Pharmacy Information System (printout attached)
- □ Electronic Medical Record (printout attached)
- □ Other (specify):

Check here if:
- □ None
- □ Unknown / Not Stated

If a printout can not be generated, please complete 54A using the medication administration record.
### 54A. Inpatient / Observation Status / Emergency Department Manual Medication Abstraction Form

List each drug administered the inpatient unit / emergency department or to an observation status patient at time of first administration only. Do not list multiple doses or changes in doses. *(Use additional sheets as needed)*

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Date</th>
<th>Time of first administration</th>
<th>Route</th>
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Check here if: □ None   OR   □ Unknown / Not Stated
CLINICAL MODULE FOR PATIENTS PRESENTING WITH ACUTE MYOCARDIAL INFARCTION / ACUTE CORONARY SYNDROME

Include only patients with principal diagnosis of Acute Myocardial Infarction or Acute Coronary Syndrome/Angina (ICD-9-CM Codes 410.x0, 410.x1 or 411.1)

C1) Date and time of first ECG associated with this hospital presentation/encounter
(not more than 1 hour prior to arrival)
Date _____/_____/____ ____ Time ___ ___:___ ___
☐ Check if no ECG performed

C2) ST elevation or LBBB on Initial ECG associated with this hospital presentation/encounter
(not more than 1 hour prior to arrival)
☐ No
☐ Yes

C3) First three troponin Levels following patient presentation/encounter.
☐ Check if no troponin levels were obtained
☐ Check if only CK-MB is reported

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<th></th>
<th>Date</th>
<th>Time</th>
<th>Level</th>
<th>Lab Reference Range</th>
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<td>__ /__ /__</td>
<td>___ :___</td>
<td>__________ng/mL</td>
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<td>Third</td>
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<td>___ :___</td>
<td>__________ng/mL</td>
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C4) Did the patient receive a beta blocker within 24 hours after hospital arrival?
☐ No
☐ Yes (skip to question 6)

C5) If a beta blocker was not given within 24 hours of arrival, is there a documented beta blocker contraindication at arrival?
☐ No
☐ Yes

C6) Did the patient receive a beta blocker at discharge?
☐ No
☐ Yes (Do not answer question 7)

C7) If no beta blocker was given at discharge, is there a documented beta blocker contraindication in the last 48 hours before discharge?
☐ No
☐ Yes
CLINICAL MODULE FOR PATIENTS WITH PSYCHIATRIC ADMISSION
Include only patients with primary diagnosis in ICD-9-CM range 290.0 – 299.9

P1) Patient admission to:
- Dedicated psychiatric unit
- General Acute Care bed

P2) Was a global assessment of functioning score conducted at admission?
- No
- Yes – Score: ___ ___ ___

P3) Was a global assessment of functioning score conducted at discharge?
- No
- Yes – Score: ___ ___ ___

P4) Was this a voluntary admission on the part of the patient?
- No
- Yes
- Unknown / Not stated

P5) Did this patient express suicidal ideations on admission?
- No
- Yes
- Unknown / Not stated
A1) Oxygen/Respiratory assistance initially given in the emergency room, or (if no emergency room stay) upon acute or observation admission (but not more than 8 hours following presentation).

Type of oxygen supplementation
- Oxygen given by “blow by”
- Oxygen given by nasal cannula
- Oxygen given by facemask
- Oxygen given by non-rebreather facemask
- Patient was intubated during the first 8 hours

☐ No supplemental oxygen required (skip to question A2)

If oxygen was given:

Concentration of oxygen given: ___ ___ ___ % ☐ Not available
Oxygen flow rate: ___ ___ . ___ liters per minute ☐ Not available

A2) Frequency of albuterol (Proventil®, Volmax®, Ventolin®, AccuNeb®) or levalbuterol HCl (Xopenex®) treatments indicated on the first physician order following admission to the hospital (regardless of ER stay time)

- Continuous administration of albuterol or levalbuterol
- Every 2 hours
- Every 3 hours
- Every 4 hours
- No order/no data

A3) Was patient intubated at any time during this hospitalization?

☐ No
☐ Yes

A4) Was a home management plan of care discussed with the patient/family?

☐ No
☐ Yes
APPENDIX I

SAMPLE LISTING SHEET
**A. FACILITY INFORMATION**

1. Hospital Name: 

2. AHA Hospital #: 

3. HDS #: 

**B. MONTHLY SAMPLE DATA**

4. Month: ___ ___ , 20___ ___

5. Group Identifier: A

6. Sample selected (Name): Observation / short stay

7. Total Number of Cases in Group: ________

Cases required for abstraction: 5

8a. Sample Randomization

a) Total Number of Cases in Group (7 above): ______ / 6 = ______ (X)

b) Round the result (X) up to the nearest whole number = _____ (Y)

c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization

a) Total Number of Cases in Group = 20/6 = 3.33

b) 3.33 rounded up = 4

c) Choose cases #4, 8, 12, 16, 20

**C. CASES SELECTED – List cases selected for abstraction**

<table>
<thead>
<tr>
<th>RAND ID #</th>
<th>Medical Record Number</th>
<th>Visit / Encounter Number</th>
<th>Other Identifier: ________________</th>
<th>Discharge Date MM / DD</th>
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A. FACILITY INFORMATION

1. Hospital Name: ____________________________
2. AHA Hospital #: ____________________________
3. HDS #: ____________________________

B. MONTHLY SAMPLE DATA

4. Month: ____, 20___
5. Group Identifier: B
6. Sample selected (Name): Normal Newborns
7. Total Number of Cases in Group: ______
   Cases required for abstraction: 1

8a. Sample Randomization
   a) Total Number of Cases in Group (7 above): ______ / 2 = ______ (X)
   b) Round the result (X) up to the nearest whole number = ______ (Y)
   c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization
   a) Total Number of Cases in Group = 15/2 = 7.5
   b) 7.5 rounded up = 8
   c) Choose case #8

C. CASES SELECTED – List cases selected for abstraction

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<tr>
<th>RAND ID #</th>
<th>Medical Record Number</th>
<th>Visit / Encounter Number</th>
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**A. FACILITY INFORMATION**

1. Hospital Name:  
2. AHA Hospital #: _____ _____ _____  
3. HDS #: _____ _____ _____  

**B. MONTHLY SAMPLE DATA**

4. Month: _____, 20___  
5. Group Identifier: C  
6. Sample selected (Name): Pediatrics  
7. Total Number of Cases in Group: ________  
   Cases required for abstraction: 2  

8a. Sample Randomization  
   a) Total Number of Cases in Group (7 above): _____ / 3  
      = _____ (X)  
   b) Round the result (X) up to the nearest whole number = _____ (Y)  
   c) Use this result (Y) to count every Yth case and select these for abstraction  

8b. Example: Sample Randomization  
   a) Total Number of Cases in Group = 15/3 = 5  
   b) 5 rounded up = 5  
   c) Choose cases #5, 10  

**C. CASES SELECTED – List cases selected for abstraction**

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### A. FACILITY INFORMATION

1. Hospital Name:

2. AHA Hospital #: ______ _____ _____ _____

3. HDS #: ______ _____ _____ _____

### B. MONTHLY SAMPLE DATA

4. Month: ____ ____ , 20____ __

5. Group Identifier: D

6. Sample selected (Name): AMI / Acute Coronary Syndrome

7. Total Number of Cases in Group: ______

   Cases required for abstraction: 2

8a. Sample Randomization

   a) Total Number of Cases in Group (7 above): ______ / 3 = ______ (X)

   b) Round the result (X) up to the nearest whole number = _____ (Y)

   c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization

   a) Total Number of Cases in Group = 11/3 = 3.67

   b) 3.67 rounded up = 4

   c) Choose cases #4, 8

### C. CASES SELECTED – List cases selected for abstraction

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<th>RAND ID #</th>
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<th>Visit / Encounter Number</th>
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**NATIONAL HOSPITAL DISCHARGE SURVEY**  
SAMPLE LISTING SHEET

### A. FACILITY INFORMATION

1. Hospital Name: 
2. AHA Hospital #: ______ ______ ______ ______
3. HDS #: ______ ______ ______ ______

### B. MONTHLY SAMPLE DATA

4. Month: ____ ___, 20_______
5. Group Identifier: E
6. Sample selected *(Name)*: Asthma
7. Total Number of Cases in Group: ________
   Cases required for abstraction: 2

8a. Sample Randomization
   a) Total Number of Cases in Group (7 above): ______ / 3 = ______ (X)
   b) Round the result (X) up to the nearest whole number = ______ (Y)
   c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization
   a) Total Number of Cases in Group = 10/3 = 3.33
   b) 3.33 rounded up = 4
   c) Choose cases #3, 6

### C. CASES SELECTED – List cases selected for abstraction

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<th>RAND ID #</th>
<th>Medical Record Number</th>
<th>Visit / Encounter Number</th>
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**NATIONAL HOSPITAL DISCHARGE SURVEY**  
**SAMPLE LISTING SHEET**

### A. FACILITY INFORMATION

1. Hospital Name: 

2. AHA Hospital #: ____ ____ ____ ____  

3. HDS #: ____ ____ ____ ____

### B. MONTHLY SAMPLE DATA

4. Month: ____ ___, 20____ ____  

5. Group Identifier: F

6. Sample selected *(Name)*: Psychiatric  

7. Total Number of Cases in Group: ________  
Cases required for abstraction: 2

8a. Sample Randomization  
   a) Total Number of Cases in Group (7 above): ______ / 3  
      = ______ (X)  
   b) Round the result (X) up to the nearest whole number = _____ (Y)  
   c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization  
   a) Total Number of Cases in Group = 8/3 = 2.67  
   b) 2.67 rounded up = 3  
   c) Choose cases #3, 6

### C. CASES SELECTED – List cases selected for abstraction

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<th>Medical Record Number</th>
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NATIONAL HOSPITAL DISCHARGE SURVEY
SAMPLE LISTING SHEET

A. FACILITY INFORMATION

1. Hospital Name:

2. AHA Hospital #: ______ ______ ______ ______

3. HDS #: ______ ______ ______ ______

B. MONTHLY SAMPLE DATA

4. Month: _____, 20____

5. Group Identifier: G

6. Sample selected (Name): All Other Patients

7a. Total Number of Cases in Group: ______

7b. Cases required for abstraction: 6

7c. + Any patients from an “empty” group = ______

7d. Cases required for abstraction (7b + 7c) = ______

8a. Sample Randomization

a) Total Number of Cases in Group (7a. above): ______ / 7d + 1 = ______ (X)

b) Round the result (X) up to the nearest whole number = _____ (Y)

c) Use this result (Y) to count every Yth case and select these for abstraction

8b. Example: Sample Randomization

a) Total Number of Cases in Group = 100/7 = 14.3

b) 14.3 rounded up = 15

c) Choose cases #15, 30, 45, 60, 75, 90

C. CASES SELECTED – List cases selected for abstraction

<table>
<thead>
<tr>
<th>RAND ID #</th>
<th>Medical Record Number</th>
<th>Visit / Encounter Number</th>
<th>Other Identifier: ________</th>
<th>Discharge Date MM / DD</th>
<th>Date Abstracted</th>
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APPENDIX J

FAX FORM FOR RAND ASSISTANCE IN RECORD RANDOMIZATION
FAX FORM FOR RAND TO WORK WITH YOUR INSTITUTION TO RANDOMLY SELECT RECORDS FOR ABSTRACTION

USE THIS FORM ONLY IF YOU ARE NOT ABLE TO RANDOMLY SELECT RECORDS ON YOUR OWN

To: Megan Beckett  
RAND  
FAX 310-451-6921

From:  
Name: ______________________________________  
Facility: ______________________________________  
Return Fax Number: _____________________________  
Telephone Number: _____________________________

Instructions
1. Generate a list of patients in each of the seven categories (A-G) above.  
2. Order the cases by terminal digit number and keep the list  
3. Record the total number of cases in each category below and FAX this form to RAND.  
4. RAND will provide an abstraction order based on the information you provide.  
5. Abstract cases in the order RAND specifies based on the list you generated in #2 above.  
6. If you have questions, contact Megan Beckett at 310-393-0411 x 6762  
7. **DO NOT INCLUDE ANY PATIENT INFORMATION ON THIS SHEET**

<table>
<thead>
<tr>
<th>Category</th>
<th>Total Number of Cases In This Category</th>
<th>Abstraction Order (FOR RAND USE ONLY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Observation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>B. Normal newborns</td>
<td></td>
<td></td>
</tr>
<tr>
<td>C. Pediatrics</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D. AMI/ACS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>E. Asthma</td>
<td></td>
<td></td>
</tr>
<tr>
<td>F. Psychiatric</td>
<td></td>
<td></td>
</tr>
<tr>
<td>G. All other Patients</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
APPENDIX K

FEASIBILITY ASSESSMENT

RECORD RETRIEVAL

RECORD ABSTRACTION – GENERAL

RECORD ABSTRACTION – CASE SPECIFIC
Please use this form to describe overall issues associated with retrieving the required records. One form should be completed by the individual most responsible for identifying the records required for abstraction.

<table>
<thead>
<tr>
<th>Question</th>
<th>Response</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you receive the background information associated with completing this project including an explanation of the project and the reason for specific record selection?</td>
<td>☐ Yes</td>
<td>☐ No (describe what was missing)</td>
</tr>
<tr>
<td>2. Did you receive sufficient instruction to fully understand what was expected from you in this project?</td>
<td>☐ Yes</td>
<td>☐ No (describe areas where more instruction would be helpful)</td>
</tr>
<tr>
<td>3. Did you feel you had sufficient background and experience to identify the required records?</td>
<td>☐ Yes</td>
<td>☐ No (describe areas that you found difficult)</td>
</tr>
<tr>
<td>4. What is your personal job title? (e.g., HIM professional, decision support)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If other individuals assisted with retrieving the information, please identify their job titles (e.g., nurse, coder, financial counselor)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please use the space below to provide suggestions or recommendations for future professionals assisting with this project in other facilities or how the process could be improved. Use additional paper if necessary.
Please use this form to describe overall issues associated with **abstracting records**.

**Complete one form for each abstractor.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No (describe what was missing)</th>
<th>No (describe areas where more instruction would be helpful)</th>
<th>No (describe areas that you found difficult)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did you receive the background information associated with completing this project including an explanation of the project and field materials?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did you receive sufficient instruction to fully understand what was expected in this project?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Did you feel you had sufficient background and experience to confidently answer the questions?</td>
<td>Yes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. What is your personal job title? (e.g., HIM professional, nurse)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. If other individuals assisted with the abstraction, please identify their job titles (e.g., nurse, coder, financial counselor)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please use the space below to provide suggestions or recommendations for future professionals assisting with this project in other facilities or how the process could be improved. Use additional paper if necessary.
For Each Item, Please Tell Us The Best/Most Reliable Source For This Information In Your Facility.

**Complete one form for your hospital.**

<table>
<thead>
<tr>
<th>Question</th>
<th>Optimal Location for Retrieval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Identification numbers</strong></td>
<td></td>
</tr>
<tr>
<td>3 HIC Number (Mdcr only)</td>
<td></td>
</tr>
<tr>
<td>4 Patient name</td>
<td></td>
</tr>
<tr>
<td>5 Medical record number</td>
<td></td>
</tr>
<tr>
<td>5a Mother’s medical record number for newborns</td>
<td></td>
</tr>
<tr>
<td>6 Billing number</td>
<td></td>
</tr>
<tr>
<td>7 Visit or Encounter number</td>
<td></td>
</tr>
<tr>
<td>9 Social security number</td>
<td></td>
</tr>
<tr>
<td>10/11/18/19 Address</td>
<td></td>
</tr>
<tr>
<td><strong>Type/Timing of care</strong></td>
<td></td>
</tr>
<tr>
<td>12 Emergency care</td>
<td></td>
</tr>
<tr>
<td>13 Observation care</td>
<td></td>
</tr>
<tr>
<td>14 Inpatient care</td>
<td></td>
</tr>
<tr>
<td>16 Critical care/ICU</td>
<td></td>
</tr>
<tr>
<td>17 Discharge date/time</td>
<td></td>
</tr>
<tr>
<td><strong>Demographic</strong></td>
<td></td>
</tr>
<tr>
<td>8 Birth date</td>
<td></td>
</tr>
<tr>
<td>20 Age</td>
<td></td>
</tr>
<tr>
<td>21 Sex</td>
<td></td>
</tr>
<tr>
<td>22 Marital status</td>
<td></td>
</tr>
<tr>
<td>23 Living situation @ adm</td>
<td></td>
</tr>
<tr>
<td>24 Race</td>
<td></td>
</tr>
<tr>
<td>25 Ethnicity</td>
<td></td>
</tr>
<tr>
<td>28 Education</td>
<td></td>
</tr>
<tr>
<td>29 Occupation</td>
<td></td>
</tr>
<tr>
<td>30 English proficiency</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Optimal Location for Retrieval</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------------------------</td>
</tr>
<tr>
<td><strong>Clinical Data</strong></td>
<td></td>
</tr>
<tr>
<td>31 Vital signs</td>
<td></td>
</tr>
<tr>
<td>32 Laboratory results</td>
<td></td>
</tr>
<tr>
<td>33 Activities of daily living</td>
<td></td>
</tr>
<tr>
<td>34 Pain assessment</td>
<td></td>
</tr>
<tr>
<td>35 ASA Classification</td>
<td></td>
</tr>
<tr>
<td>36 Drug Allergies</td>
<td></td>
</tr>
<tr>
<td>37/38 Tobacco use</td>
<td></td>
</tr>
<tr>
<td>39 DNR Order</td>
<td></td>
</tr>
<tr>
<td>40 Stability at discharge</td>
<td></td>
</tr>
<tr>
<td><strong>Admission &amp; Discharge Info</strong></td>
<td></td>
</tr>
<tr>
<td>15 Admission type</td>
<td></td>
</tr>
<tr>
<td>26 Mode of arrival</td>
<td></td>
</tr>
<tr>
<td>27 Source of admission</td>
<td></td>
</tr>
<tr>
<td>41 Status at discharge</td>
<td></td>
</tr>
<tr>
<td>42 Palliative care</td>
<td></td>
</tr>
<tr>
<td><strong>Providers of care</strong></td>
<td></td>
</tr>
<tr>
<td>43 Attending UPIN/NPI</td>
<td></td>
</tr>
<tr>
<td>47 Procedure doctor</td>
<td></td>
</tr>
<tr>
<td><strong>Medical Coding</strong></td>
<td></td>
</tr>
<tr>
<td>44 DRG Assignment</td>
<td></td>
</tr>
<tr>
<td>45 Admitting diagnosis</td>
<td></td>
</tr>
<tr>
<td>46 Final diagnoses</td>
<td></td>
</tr>
<tr>
<td>47 Final procedures</td>
<td></td>
</tr>
<tr>
<td><strong>Financial and Billing</strong></td>
<td></td>
</tr>
<tr>
<td>48 Expected source payment</td>
<td></td>
</tr>
<tr>
<td>49 Primary payment type</td>
<td></td>
</tr>
<tr>
<td>50 Duration of care (days in unit)</td>
<td></td>
</tr>
<tr>
<td>50 Expected/actual pmt</td>
<td></td>
</tr>
<tr>
<td>51 Charges by revenue center</td>
<td></td>
</tr>
<tr>
<td><strong>Previous/Subsequent Care</strong></td>
<td></td>
</tr>
<tr>
<td>52 Hospital care within 30 days</td>
<td></td>
</tr>
<tr>
<td>Question</td>
<td>Optimal Location for Retrieval</td>
</tr>
<tr>
<td>-----------------------------------------------</td>
<td>--------------------------------</td>
</tr>
<tr>
<td><strong>Medications</strong></td>
<td></td>
</tr>
<tr>
<td>53 Medications at admission and discharge</td>
<td></td>
</tr>
<tr>
<td>54 Medications during hospital stay</td>
<td></td>
</tr>
</tbody>
</table>

Specific Clinical Modules

<table>
<thead>
<tr>
<th>Question</th>
<th>Optimal Location for Retrieval</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Acute coronary syndrome module</strong></td>
<td></td>
</tr>
<tr>
<td>C1 ECG Date/Time</td>
<td></td>
</tr>
<tr>
<td>C2 ST Elevation/LBBB</td>
<td></td>
</tr>
<tr>
<td>C3 Troponin/CK levels</td>
<td></td>
</tr>
<tr>
<td>C4 Beta blocker given adm</td>
<td></td>
</tr>
<tr>
<td>C5 Beta blocker contraindicated on admission</td>
<td></td>
</tr>
<tr>
<td>C6 Beta blocker given discharge</td>
<td></td>
</tr>
<tr>
<td>C7 Beta blocker contraindicated at discharge</td>
<td></td>
</tr>
<tr>
<td><strong>Psychiatric Module</strong></td>
<td></td>
</tr>
<tr>
<td>P1 Admit location</td>
<td></td>
</tr>
<tr>
<td>P2 Adm Global Assess</td>
<td></td>
</tr>
<tr>
<td>P3 Disc Global Assess</td>
<td></td>
</tr>
<tr>
<td>P4 Voluntary admission</td>
<td></td>
</tr>
<tr>
<td>P5 Suicidal ideations</td>
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</tr>
<tr>
<td><strong>Asthma Module</strong></td>
<td></td>
</tr>
<tr>
<td>A1 Oxygen assistance</td>
<td></td>
</tr>
<tr>
<td>A2 Albuterol/Xopenex Rx</td>
<td></td>
</tr>
<tr>
<td>A3 Intubation</td>
<td></td>
</tr>
<tr>
<td>A4 Meds on admission</td>
<td></td>
</tr>
<tr>
<td>A5 Home care mgmt</td>
<td></td>
</tr>
</tbody>
</table>
Please use this form to document issues associated with abstracting records. The first section asks general questions about the process and the second section about specific data elements by category.

**Complete one form for every abstracted record.**

### Section 1 – Process Questions

1. Did you complete the form all at once (i.e., completed before going on to the next record)?  
   - Yes
   - No (describe how you broke up the work – e.g., all financial together)

2. What was the total time you spent abstracting this record?  
   - Minutes

### Section 2 – Specific Questions

(Check the question numbers and then provide an explanation of the challenges associated with the checked questions. Challenges include, for example, difficulty finding the data, multiple data locations in the record, problems retrieving the information from electronic systems, lack of clarity regarding the question, and uncertainty regarding understanding the question. Use additional paper if necessary)

**General form**

<table>
<thead>
<tr>
<th>Question Category and Specific Question Numbers</th>
<th>Description of Challenges with Abstraction</th>
</tr>
</thead>
<tbody>
<tr>
<td>Identification numbers</td>
<td></td>
</tr>
<tr>
<td>☐ 3 HIC Number (Medicare only)</td>
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<td>Demographics</td>
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| **Medications** | □ 53 Medications  
□ Admission/discharge  
□ 54 Meds during stay |
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<thead>
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