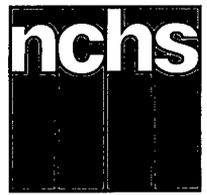


NATIONAL CENTER FOR
HEALTH STATISTICS



**The National
Committee on
Vital and Health
Statistics, 1989**



nchhs



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
Public Health Service
Centers for Disease Control

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ncvhs

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U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES
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Centers for Disease Control
National Center for Health Statistics

Hyattsville, Maryland
June 1990

NATIONAL COMMITTEE ON VITAL & HEALTH STATISTICS

RONALD G. BLANKENBAKER, M.D.
CHAIRMAN

GAIL F. FISHER, Ph.D.
EXECUTIVE SECRETARY

The Honorable Louis W. Sullivan, M.D.
Secretary, Department of Health
and Human Services (DHHS)
Washington, D.C. 20201

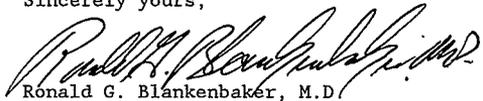
Dear Secretary Sullivan:

I am pleased to transmit to you the 1989 Annual Report of the National Committee on Vital and Health Statistics, as required by the Committee's Charter.

The Committee had a productive and rewarding year, which included significant collaboration with various DHHS agencies and outside organizations. Activities included completion of a revised Uniform Ambulatory Care Data Set, in tandem with an Interagency Task Force; joint sponsorship of a Workshop on Improving Cause-of-Death Statistics with the National Center for Health Statistics; and participation in the Tenth Revision Conference of the International Classification of Diseases.

The report describes the Committee's accomplishments during 1989 and its plans to extend and expand activities in 1990. The Committee also seeks to be responsive to emerging health data issues which you might identify.

Sincerely yours,



Ronald G. Blankenbaker, M.D.
Chairman

Foreword

As we enter the new decade of the 1990's, the need for accurate, timely and understandable statistics on the health of our citizens has never been more critical. During the 1980's, health policymakers struggled to curb rising health care costs while maintaining quality of care and access to high quality services. The inability to address these issues successfully led to a progressive expansion of the size of the medically indigent population. It became necessary to define "quality" better and to attempt to develop new mechanisms for assessing it. Now, the "effectiveness" of health care being provided, which includes financial considerations, is receiving special emphasis. These challenges have been magnified by the increasing number of older persons who utilize a disproportionately large segment of our health care resources. An indication of our lack of public consensus on how to deal with health care financing issues is the repeal during 1989 of most of the provisions in the Medicare Catastrophic Coverage Act of 1988.

The 1980's also saw the injection into our society of a deadly virus that causes acquired immunodeficiency syndrome (AIDS). This incompletely understood and politically sensitive disease, which has encountered social prejudice, has reminded us of the vulnerability of our data collection and analysis systems to external influences.

During the past decade, the National Committee on Vital and Health Statistics became more involved in major health policy issues and less oriented toward technical details. This, in part, has been a natural evolution, which was fueled by shrinking resources available to the Committee to deal with detailed statistical issues. Recognizing the unique role that it can play in addressing data issues that cut across departmental programs and heavily involve the private sector, the Committee has sought to strengthen this role in those areas where it can have the greatest positive impact.

This report summarizes the Committee's major activities over the past year. As previously, we also have addressed the processes through which the full Committee and subcommittees have functioned along with plans for the future. In these endeavors, we have tried to address the key, current statistical issues. Special emphasis has been placed on: quality and effectiveness of health care, minority populations and the medically indigent, delivery of health care in ambulatory facilities, quality of data, health care of the elderly, linkage of various data sets, medical classification and coding, long-term health care, health care financing, disease prevention and health promotion, assessment of health status at the community level, and AIDS. These efforts are a good beginning, but much more needs to be done. We

hope that what has been accomplished will stimulate others to pursue greater challenges for the improvement of health statistics in this country.

The members of the Committee deserve a special thanks for their relentless efforts. The Department of Health and Human Services has provided the Committee with an excellent, dedicated staff predominantly from the National Center for Health Statistics and the Health Care Financing Administration. We very much appreciate the support that they have provided to us, for without it none of the work described in this report could have happened. We also would like to commend the involvement of all of the various health-related organizations and agencies that have provided us with testimony and advice that were critically important to our deliberations. The Committee has found its continuing interactions with these committed individuals especially rewarding.

Ronald G. Blankenbaker, M.D.
Chairman, National Committee
on Vital and Health Statistics

Contents

Foreword	v
Executive Summary	1
Activities, Accomplishments, and Future Plans of the National Committee on Vital and Health Statistics.....	3
Medical Classification Systems.....	6
Long-Term Care Statistics	11
Ambulatory and Hospital Care Statistics	14
Health Statistics for Minority and Other Special Populations	18
Health Care Statistics	21
Appendixes	
Appendix I. Legislative Authority for the National Committee on Vital and Health Statistics From the Public Health Service Act.....	24
Appendix II. Charter	26
Appendix III. Membership Roster of the National Committee on Vital and Health Statistics	30
Meeting Dates	31
Appendix IV. Subcommittees of the National Committee on Vital and Health Statistics, Rosters, Meeting Dates, and Charges.....	32
Appendix V. Report of the Subcommittee on Long-Term Care Statistics: Review of DHHS Interagency Task Force Report on the Long-Term Care Facilities "Minimum Data Set"	43
Appendix VI. Report on the Uniform Ambulatory Care Data Set	47

Executive Summary

During 1989, the National Committee on Vital and Health Statistics, in its advisory capacity to the Department of Health and Human Services (DHHS), accomplished the following activities through the work of the full Committee and six subcommittees:

- Completed, in tandem with a DHHS Interagency Task Force, a systematic review and revision of the Uniform Ambulatory Care Data Set (UACDS). The Report on the proposed new UACDS was transmitted to the Assistant Secretary for Health and disseminated widely to interested organizations in the public and private sectors.
- Jointly sponsored, with the National Center for Health Statistics (NCHS), a Workshop on Improving Cause-of-Death Statistics, which included participation by 46 representatives of Federal, State, and professional organizations, and produced a number of significant recommendations.
- Submitted to the Assistant Secretary for Health a report that reviewed and supported the work of the DHHS Interagency Task Force on the Long-Term Care Facilities Uniform Data Set and endorsed the need for a pilot test of the data set prior to full implementation.
- Approved for transmittal to the Assistant Secretary for Health a resolution supporting the National Health Care Survey under development by NCHS and encouraging the Secretary of DHHS to provide adequate resources for proceeding with survey plans.
- Provided a recommendation to the Assistant Secretary for Health that NCHS develop a proposal to use the social security number as the unique personal identifier in the National Health Care Survey for the purpose of linking records and that this proposal be subject to a pilot test.
- Assisted NCHS in developing an efficient mechanism for obtaining external input to the development and policy implication of the National Health Care Survey.
- Continued to address the complex issues surrounding the uses of the International Classification of Diseases (ICD) in the United States in an effort to provide the necessary public-private sector interface for developing future recommendations on implementing and maintaining a classification in this country.
- Continued to monitor the resolution of issues concerning a copyright of the 10th revision of the ICD and the progress of ICD-10 towards its implementation dates.

- Held a public hearing on the availability of data concerning access and financing of medical care for the medically indigent population in the United States and began a process for developing recommendations regarding the national data requirements for this special population.
- Continued to focus on the uniformity and adequacy of data on race and ethnicity in national health surveys to produce data on minority populations.
- Actively followed and facilitated broad discussions on the development, by the Health Care Financing Administration, of the Minimum Data Set for Nursing Facility Resident Assessment and Care Screening, as mandated by the 1987 Omnibus Budget Reconciliation Act.
- Resumed an active role in following the statistical aspects of physician-payment systems and other data systems and research concerned with patient-provider encounters in both ambulatory and hospital care settings.
- Continued to follow quality of care and patient outcome research initiatives in the Department and agreed to focus increased attention on the importance of emerging and projected quality and effectiveness of care activities for relevance to existing data systems and implications for revisions to those systems.
- Provided comments to the Assistant Secretary for Health on the draft report, *Promoting Health, Preventing Disease: Year 2000 Objectives for the Nation*. Continued to follow disease prevention and health promotion statistical issues and related data issues on acquired immunodeficiency syndrome.
- Began discussion of the Committee's role in improving health status and health care assessment at the community level.
- Agreed to consider whether there was a need to reexamine the data elements and definitions contained in the Uniform Hospital Discharge Data Set.
- Reviewed and provided comments on the 1989 publication of *Health, United States*.

In 1990, the Committee will continue and expand efforts related to many of the above activities.

Activities, Accomplishments, and Future Plans of the National Committee on Vital and Health Statistics

The National Committee on Vital and Health Statistics (NCVHS) continued, during 1989, to work with a broad constituency of interested groups in the public and private sectors to enhance the collection and use of health statistics.

During the year, the Committee carried out substantive activities in the following selected areas through its active subcommittee structure:

- Medical classification systems
- Long-term care statistics
- Ambulatory and hospital care statistics
- Health statistics for minority and other special populations
- Health care statistics

The activities, accomplishments, and future plans of the subcommittees are detailed in the subsequent sections of this report. Membership lists, meeting dates, and charges for the subcommittees are included in appendix IV. The legislative authority, the charter, and the membership list and meeting dates of the full Committee can be found in appendixes I, II, and III, respectively.

The NCVHS Executive Committee and the full Committee gave consideration throughout the year to the many specific issues raised by the subcommittees and also addressed several additional topics, as described below.

In a continuing effort to be as responsive as possible to the full range of health data issues impacting the country, the Committee devoted time at its June meeting specifically to discuss the process for setting the NCVHS agenda. This discussion reaffirmed the need regularly to assess new and emerging issues in a systematic way and to determine their priority relative to current Committee activities. It was agreed to set aside time at each full Committee meeting for this purpose and, to the extent possible, to take into account the list of Characteristics for Assessing Emerging Issues that was developed by the Executive Subcommittee in 1986 and is contained in appendix V of the NCVHS 1986 Annual Report.

Earlier in the year, the Committee had received presentations on the universe of Public Health Service health data systems and on departmental health data systems and data needs. The Committee also met with the Office of Medical Applications of Research, National Institutes of Health, to discuss their data needs for technology assessment and transfer activities. As in previous years, the Committee worked with the National Center for Health Statistics (NCHS) on the development of *Health, United States*, the Secretary's annual report on the health of the Nation.

The quality of health care data is an ongoing concern of the NCVHS, and, in recent years, the Committee has taken a particular interest in improving the quality of cause-of-death information reported on the death certificate. Because this issue also is of keen interest to NCHS and the States, the NCVHS and NCHS collaborated during 1989 on sponsoring a Workshop on Improving Cause-of-Death Statistics. The workshop, which took place October 15-17, 1989, included participation by 46 representatives of Federal, State, and professional organizations. The overwhelming need recognized by all participants was for a broad-based educational effort involving physicians, the public, and policymakers. The Committee received a preliminary report on the workshop at its November meeting and expects to review the final report and recommendations at its February 7-9, 1990, meeting. Following this review, the NCVHS plans to transmit the report with comments to the Assistant Secretary for Health.

Although the Subcommittee on Disease Prevention and Health Promotion Statistics has been inactive for the past year and a half, the full Committee has continued to follow related activities in the Department and the broader community. Specific attention has been directed to the process for developing the Year 2000 Objectives for the Nation, and the NCVHS received several presentations and provided comments to the Department on this activity. The Committee considers the Year 2000 process a blueprint for disease prevention and health promotion during the next decade and views with enthusiasm the central role given to the development of adequate data at the Federal, State, and local levels for tracking and motivating progress. During its November meeting, a group of members agreed to convene over the next several months to discuss the Committee's role in improving health status and health care assessment at the community level.

The Committee also has taken a strong interest in quality and effectiveness of care activities within the Department, and it has received several presentations from the Health Care Financing Administration (HCFA) on this topic. The Committee was briefed during 1989 on the development by HCFA of a uniform clinical data set, and it intends to hold discussions in 1990 with the Public Health Service about the new initiatives in effectiveness of care research authorized by the 101st Congress. At the suggestion of the Executive Subcommittee, each NCVHS subcommittee agreed at the November NCVHS meeting to consider incorporating relevant quality and effectiveness of care data issues into its charge.

Data linkage was identified by the NCVHS several years ago as an extremely important statistical issue. In 1989, the Committee focused specifically on one aspect of this issue, when a resolution was passed on the use of a unique personal identifier in the National Health Care Survey under development by NCHS. Also

during the year, the National Association of Health Data Organizations issued a report by a panel of experts that recommended “. . . a strategy be developed for a unique Personal Identification number system to be used by providers, insurers, purchasers, and regulators . . .” The panel specifically asked the NCVHS to give priority consideration to help implement this recommendation. The NCVHS will continue to examine the many complex issues involved in obtaining and using a unique identifier across data systems in the coming year.

NCHS provides periodic briefings on occupational and international health statistics, each of which is being monitored by an individual NCVHS member. Briefings also have been received on statistical activities by the Public Health Service to describe the incidence, prevalence, distribution, and impact of human immunodeficiency virus and related disorders, including acquired immunodeficiency syndrome. Most recently, a Committee member has begun to monitor data issues related to reproductive, child, and family health.

Throughout all the activities described above and in the subsequent sections of this report, the National Committee has striven to identify and follow key health statistical issues as they emerge and develop and to make specific, indepth contributions where appropriate opportunities exist.

Medical Classification Systems

During 1989, the Subcommittee on Medical Classification Systems continued efforts to address the issues surrounding the use of the International Classification of Diseases (ICD) in this country. The testimony received and the working sessions were focused on the status of ICD-10, the development of coding guidelines, specialty-specific classifications, the coordination and maintenance function, and a single-procedure coding system. Insofar as the experience with ICD-9-CM will likely be a prototype for the implementation and maintenance of ICD-10, the Subcommittee sought public and private opinions of that experience and asked for recommendations for future modifications where those were appropriate.

Background

The Subcommittee on Medical Classification Systems was established in 1987 as a continuation of the Subcommittee on Disease Classification and Automated Coding of Medical Diagnoses, which had been functioning since 1983. The National Committee on Vital and Health Statistics (NCVHS) had long been committed to addressing the complex issues related to classification systems and the diversity of their application.

Current Year's Activities

The Subcommittee held three meetings during 1989—April 17–18, June 9, and October 10–11. These meetings combined public testimony and discussion with working sessions of the Subcommittee membership in an effort to provide the necessary public-private sector interface in addressing the issues that follow.

Status of ICD-10

1989 marked a major milestone for ICD-10, with the convening in September of the 10th Revision Conference of the International Classification of Diseases at the World Health Organization in Geneva, Switzerland. The Subcommittee was encouraged to find that the structure and content of ICD-10 reflects the needs and suggestions of the U.S. users. Clinical specialty societies and other interested groups gave generously of their time and expertise to assure the flexibility and utility of the classification in multiple settings. As a result, ICD-10 contains far greater detail than any of its

predecessors, detail that will discriminate among clinical entities as well as provide appropriate descriptors for alternate care settings.

The arrangement of ICD-10 reflects some internal reorganization to align chapters with related content, and all chapters are considered a part of the classification, replacing the concept of chapters that were considered "supplementary." An alpha-numeric structure was adopted, permitting future expansion to occur within the current framework. In addition, ICD-10 will be published as a three-volume set: Volume I, Tabular List; Volume II, Standards, definitions, and rules for use; and Volume III, The Alphabetic Index.

Although the World Health Organization (WHO) expects to implement ICD-10 in January 1993 for international reporting, the United States may require some delay in that time table. The Health Care Financing Administration (HCFA) has indicated that the earliest implementation for its programs would be October 1994, and more likely October 1995. Implementation schedules for the morbidity programs of the National Center for Health Statistics (NCHS) or for mortality vital statistics programs also are unknown. The potential use of different (and disparate) classifications for morbidity and mortality has not yet been addressed.

Copyright of ICD-10

The copyright issue occupied a prominent place on the agenda of each meeting of the Subcommittee during 1989. In 1988 the Subcommittee had expressed concerns over the proposed WHO copyright of ICD-10, concerns that were shared by both NCHS and HCFA. In October 1988, the Department of Health and Human Services had sent a letter to WHO expressing the United States' position on the copyright issue. The need to satisfy expanded demands for health information and the need to prevent competing or discordant classifications were cited among the reasons why the United States would need to create a modification of ICD-10. Copyright restrictions could have prevented such a modification effort. At the November 1988 meeting of the NCVHS, the Subcommittee had recommended, and the NCVHS endorsed, the important concept that there be no copyright by WHO that would impede the use of ICD-10 in this country.

In responding to the Department's letter of October 1988, WHO had indicated the need for a copyright to protect public interest, the volume of the ICD sales, and the quality of the ICD modification. Although the WHO response also suggested that there was no intent to claim copyright when the code was used for official government purposes, in the United States the determination of "official" uses is not made easily. There was a need to discuss practical ways of cooperation to assure the interest of both parties.

The Subcommittee pursued this issue with departmental and private sector representatives during its 1989 meetings. The U.S. delegation to the Revision Conference met with WHO officials during the conference in Geneva to further these discussions and to achieve a consensus on how to proceed. The discussions in Geneva led to the understanding that the U.S. Government could be granted broad authorization over the use of ICD-10 in this country. WHO ultimately requested a disciplined cooperation from member States that wish to modify the code, asking that they be informed

of any intent to modify, the rationale for modification, and a report on the experience with the modified code. This was intended to protect the role of centralization over classification decisions.

U.S. Modification of ICD-10

The United States historically has taken the lead in modifying the ICD for use in morbidity applications. Initially modest, the modifications grew more extensive with each successive revision, culminating in the structural modification and enhancements contained in ICD-9-CM. WHO has not been unresponsive to the morbidity applications of the ICD. Each ICD revision contained more detail, and the dual classification (dagger-asterisk) system implemented in ICD-9-CM and retained in ICD-10 was intended to satisfy user preference.

Providing for morbidity application in ICD-10 would not demand an extensive structural modification, but would likely be focused on several key issues:

- The use of 5th digits in ICD-10.
- Modification of instructional notations designed for mortality coding for application to morbidity.
- Insertion of rubrics added to ICD-9-CM and not provided for in ICD-10.

Specific work plans for the creation of a U.S. modification await further recommendations.

Maintenance of the Classification

Assuring continued use of the classification in the multiple program needs requires that certain maintenance functions be fulfilled. Among these are:

- Controlling the use of code extensions by different specialties.
- Defining criteria for the creation of extensions.
- The addition of rubrics for newly described disease complexes, e.g., AIDS or Lyme Disease.
- Response to coding questions.
- Creation and approval of coding guidelines.
- The need to review (for accuracy) the constant proliferation of materials related to the classification.

Structures currently exist to address some of the aspects of the maintenance requirements. Based on testimony received by the Subcommittee, important criteria for evaluating the structures include mechanisms for educational support and information dissemination of coding changes, modifications, guidelines, etc.; coding

skills; and comparability of coding among care sites. Additional discussion has centered on the adequacy and representation of current review bodies, timeliness of decisions, and responsiveness to morbidity data applications beyond reimbursement.

Uniform Procedure Code

The Subcommittee retains consideration of a uniform procedure code as part of its ongoing agenda. Although no formal proposals have been forthcoming, the Subcommittee continues to monitor the progress of the American Medical Association's contract with Coopers and Lybrand and their analysis and recommendations of the cost benefit of a single procedure code.

Preliminary Report on the Use of ICD Codes for Nursing Homes

Dr. Robert Mullin, a Subcommittee member, chaired a working group that met in January 1989 to receive testimony on the use of ICD codes in the long-term care environment. The working group heard testimony from the NCHS National Nursing Home Survey staff, the American Medical Record Association Section on Long-Term Care, and HCFA's Office of Research and Demonstrations. Both the testimony and additional discussion focused on the definitional differences of principal diagnosis in alternate care settings and concerns over the applicability of acute care coding guidelines to alternate care.

Continuing Work Plan

The Subcommittee intends to carry out the following work plan in 1990:

- Continue to monitor the progress of ICD-10 towards its implementation dates.
- Review and make recommendations concerning the structure and process necessary for a clinical application of ICD-10 in the United States.
- Review and make recommendations concerning the structure and process necessary for continued Government responsibility as well as formation of a public and private sector coalition to implement and maintain a classification in the United States.
- Provide liaison with the ICD-9-CM Coordination and Maintenance Committee.
- Assess the benefits and costs of converting to a single-procedure code in the United States.
- Address other medical classification systems as the need arises.

In addition to the above work of the Subcommittee, the full Committee has requested that, during 1990, indepth presentations be made in the following three areas related to medical classification systems:

- Current processes for maintaining and modifying the ICD-9-CM and the American Medical Association's Current Procedural Terminology (CPT-4) coding systems.
- Discussion with the Physician Payment Review Commission and the Prospective Payment Assessment Commission and other concerned parties on possible impacts of resource-based relative value scales on medical coding and related topics.
- Accountability of the medical classification management process in areas such as agenda setting, issue determination, and opportunity for public comment.

Long-Term Care Statistics

During 1989, the Subcommittee on Long-Term Care Statistics reviewed the DHHS Interagency Task Force Report on the Long-Term Care Facilities Uniform Data Set. The Subcommittee was supportive of the efforts and recommendations of the Task Force and endorsed the need for a pilot test of the data set prior to full implementation because of the proposed screening change to identify facilities. The Subcommittee's report was approved by the National Committee on Vital and Health Statistics, (NCVHS) at its June 1989 meeting and transmitted to the Assistant Secretary for Health. The Subcommittee is continuing to monitor the Long-Term Care Client Uniform Data Set, which is expected to be available from the Department of Health and Human Services for review during the coming year, and the progress on the Health Care Financing Administration (HCFA) nursing home resident assessment instrument, and will consider the latter's ramifications for the quality and availability of long-term care statistics. In the coming year, the Subcommittee will develop recommendations in these and related areas.

Recommendation

The 1989 Subcommittee report can be found in appendix V and includes the following summary:

The Subcommittee endorses the effort to identify long-term care facilities in their multiple forms, especially the intent to identify mental health and general health care facilities in the same data set. However, because the screener approach is new and its ramifications unclear, the Subcommittee recommends that the data set be pilot tested and that an evaluation of its effect be conducted before large-scale application by Government and private sector nursing facilities is endorsed. To this end, the Subcommittee plans to monitor progress on the implementation of an evaluation project and would like to be apprised of the design, execution, and results when they become available. Such an evaluation phase is critical to the ultimate usefulness of the Long-Term Care Facilities Uniform Data Set. The Subcommittee prefers the term *uniform* rather than *minimum* because the latter may be viewed as a constraint and suggests that these are the only data to be collected.

Background

In 1984, the predecessor to the current Subcommittee had been asked to comment on the adequacy of a proposed Long-Term Care Minimum Data Set (LTCDS), now

referred to as the Long-Term Care Client Uniform Data Set. It recommended that efforts with this data set be directed first at nursing home applications. Subsequently, in 1988, the newly named Subcommittee on Long-Term Care Statistics provided rationale and recommendations in two related areas: a nursing services list and a functional status classification. In July 1988, NCVHS was charged to review the final report of the DHHS Interagency Task Force on the Long-Term Care Facilities Uniform Data Set. Concurrently, the Subcommittee on Long-Term Care Statistics undertook this review and continued other efforts on its work plan.

Current Year's Activities

Review of the Long-Term Care Facilities Uniform Data Set was completed by the Subcommittee and endorsed by the full Committee in June 1989. The Subcommittee also focused considerable attention during the year on HCFA's Minimum Data Set for Nursing Facility Resident Assessment and Care Screening. This data set was mandated by the 1987 Omnibus Budget Reconciliation Act. In a series of meetings, the Subcommittee heard reports on the minimum data set from HCFA contractors, who are developing the resident assessment instrument, as well as from industry, State, academic, and private sector representatives. Different perceptions of the content of the data set, time required to complete the form, and uses and value of the data surfaced, ranging from favorable to quite critical.

Subsequently, the HCFA contractor provided the Subcommittee a draft report of the findings of a small-scale trial completed in two States and a modified and shortened data form resulting from the experience. Throughout 1990, the Subcommittee will continue to monitor the development of this minimum data set and the reaction of the community very closely and will be assessing the results from the expanded 10-State trial of the minimum data set that was fielded in October 1989. A presentation on the activity by the HCFA project officer was given to the full NCVHS in November 1989.

The original law mandating the resident assessment instrument also provided for the possible development of a national nursing home client data base using information from the assessment. Although the successful implementation of the minimum data set would have first priority, the opportunity for a national data system for yet undetermined uses is being explored by the Subcommittee.

Part of the 1987 Nursing Home Reform Act included a provision for mandatory prescreening and an annual review of residents with mental illness and mental retardation. The Subcommittee heard a report on the status and ramifications of this requirement from a HCFA representative. There are potential problems with the definitions and implementation of this law. The Subcommittee will monitor this area because of its importance for future data collection and because of the Subcommittee's charge to consider possible linkage of long-term care to mental health data bases.

The Subcommittee is monitoring data on the aging population. The Chairman, or his representative, attended meetings of the U.S. Government-sponsored Forum on

Aging-Related Statistics in June and November 1989 and will plan to attend future meetings. Areas of mutual interest will be explored.

Continuing Work Plan

The Subcommittee intends to carry out the following work plan in 1990:

- Review the Interagency Task Force report on the Long-Term Care Client Uniform Data Set.
- Monitor the Interagency Forum on Aging-Related Statistics planning for a possible longitudinal health and retirement study, consideration of the White House Conference on Aging, and discussion of the Year 2000 goals for older persons.
- Monitor the final development of a resident assessment instrument for nursing homes by HCFA, review the Secretary's recommendation, and consider the potential problems in implementation, such as resource needs, as well as opportunities for the formation of a national data base to improve patient care.
- Consider any recommendations for a survey of board and care homes.
- Continue a review of quality of life assessment strategies in long-term care facilities.
- Examine possible linkage of long-term care to mental health data bases.
- Encourage better descriptions of bed supply rates for long-term care and their variation in the country.

Ambulatory and Hospital Care Statistics

The Subcommittee on Ambulatory Care Statistics completed a major element of its charge with the submission of the Report on the Uniform Ambulatory Care Data Set (UACDS) to the National Committee on Vital and Health Statistics (NCVHS) at the June 1989 NCVHS meeting. The Report represented 2 years of work on the UACDS by the Subcommittee and an Interagency Task Force chaired by the Health Care Financing Administration (HCFA). Although initially two separate reports were envisioned, the close working relationship that developed between the Subcommittee and Task Force resulted in consensus on a single uniform data set. The full Committee and the Interagency Task Force each submitted the report to the Assistant Secretary for Health in June. The Department will be considering dissemination and implementation issues over the coming year, and the Subcommittee will monitor this process.

After the completion of the UACDS, the Subcommittee resumed an active role in following the statistical aspects of physician payment systems and other data systems and research concerned with patient-provider encounters. A new charge for the Subcommittee was approved by the full Committee at the November NCVHS meeting. Because many of the issues covered in the charge also have relevance for hospital care data, the Subcommittee's name was changed to the Subcommittee on Ambulatory and Hospital Care Statistics. The Subcommittee will pursue several elements of its new charge in the coming year.

Recommendations

The Report on the Uniform Ambulatory Care Data Set of the Subcommittee on Ambulatory Care Statistics and the Interagency Task Force on the UACDS can be found in appendix VI. The report is the result of a thorough and systematic review of the Uniform Ambulatory Medical Care Minimum Data Set, which was published in 1981. An earlier version of the data set had been published in 1976.

The current report recommends a common core of data items with uniform definitions for inclusion in the records of all ambulatory health care and for uniform abstraction from existing records into ambulatory care data bases. The common core

delineates information that characterizes the patient, the provider, and the encounter. The report also recommends definitions of "provider," "ambulatory care," and "encounter."

The purpose of the UACDS is to improve the comparability of ambulatory care data by defining a core of items most likely to be needed by a variety of users for multiple applications. The Subcommittee consulted widely with both public and private sector organizations in developing the data set and believes that, as a result, the report represents a broad consensus on both the data elements and definitions for a core UACDS. Overall conclusions and recommendations are as follows:

- The NCVHS Subcommittee and the Interagency Task Force believe that a common data set is essential to carrying out stewardship responsibilities for programs that finance or directly provide ambulatory care. Research efforts also will be enhanced by conformance with uniform categories and definitions.
- The items in the data set are the common core of data recommended for adoption in the health care delivery and financing programs of the Department of Health and Human Services that require data on individual ambulatory encounters on a continuing basis.
- When items in this data set are included in other departmental data systems, such as those conducted as part of research and survey programs, the recommended definitions and minimal classifications should be followed.
- It further is recommended that other Federal and State organizations, as well as institutions, professional organizations, and insurance companies that collect ambulatory care data, endorse the definitions and agree to use the data set to the maximum extent possible.
- It is expected that there will be a phase-in period during which data collectors will implement recommended data items that currently are not being collected. Additional evaluation and fieldtesting may be required for some items.
- The ability to link records is considered an essential aspect of the data set.
- Programs and other organizations collecting and using health data must assume the responsibility for safeguarding those data and protecting citizens' rights to confidentiality under applicable laws and regulations and must modify approaches or seek solutions where inadequate safeguards exist.
- Relevant billing instruments should capture adequate data for current and emerging applications, and it is important that they be updated as frequently as necessary to be consistent with the most current recommendations on data items and definitions.

Background

The Subcommittee on Ambulatory Care Statistics was formed at the June 1987 NCVHS meeting as a direct outgrowth of the work of the Subcommittee on Statistical Aspects of Physician Payment Systems. The latter began as a work group in 1984, with

the concurrence of the Assistant Secretary for Health, and had recommended in its final report that a thorough and systematic review of all items in the Uniform Ambulatory Medical Care Minimum Data Set be undertaken by the NCVHS and the Department. The Subcommittee on Ambulatory Care Statistics was created specifically to respond to this recommendation and to provide liaison with the Interagency Task Force, which was established by the Assistant Secretary for Health in the spring of 1987 to carry out the departmental review of the data set. Following completion of this major activity, the Subcommittee's charge was revised in November 1989 and its name was changed to the Subcommittee on Ambulatory and Hospital Care Statistics.

Current Year's Activities

During the first half of 1989, the Subcommittee held several meetings separately and in conjunction with the Interagency Task Force to develop the revised Uniform Ambulatory Care Data Set. In March, the Interagency Task Force submitted the draft final report to the Assistant Secretary for Health for informal circulation to agencies within the Department for comments. Concurrently, the Subcommittee sent the draft report to the extensive list of external organizations and individuals who had shown a continuing interest in the Subcommittee's work. On May 2, the Subcommittee and Interagency Task Force held a joint meeting to discuss all comments received from the agencies and the external reviewers. The report was then finalized for transmittal to the NCVHS and to the Department in June 1989.

The Subcommittee began developing and reviewing suggestions for updating its charge at a working session held during the June NCVHS meeting. This process continued at a meeting held on August 24 and was finalized at the November 1989 NCVHS meeting, when the full Committee approved a revised charge and change in name for the Subcommittee. The August 24 meeting also provided the opportunity for the Subcommittee to receive an update on a variety of HCFA data activities related to patient-provider encounters and to be briefed on data implications of physician payment reform legislation under consideration by the U.S. Congress.

The Subcommittee continues to follow with interest the implementation by HCFA of the requirement in the Medicare Catastrophic Coverage Act of 1988 for physicians to code diagnostic information on all bills. Implementation of the Unique Physician Identification Number for every physician who provides services for which Medicare payment is made also is being followed. Both diagnostic coding and unique provider identification are recommended in the UACDS.

Development by HCFA of the Common Working File offers considerable promise for improving Medicare claims processing, and it also has data and research implications. The system will operate through nine regional sectors and will include on-line eligibility information and linked Part A and Part B claims data for every Medicare beneficiary in the sector. The ability to link data on patients from different sources and about different encounters is an important aspect of the UACDS.

The Subcommittee also is following research and demonstration activities on prospective payment methodologies for ambulatory care, with particular emphasis on different approaches for defining products of ambulatory care.

Over the past few years, the NCVHS has raised the need to review and possibly revise the Uniform Hospital Discharge Data Set (UHDDS); and, at the June NCVHS meeting, the Subcommittee agreed to consider this issue further. Following discussion at the August 24 meeting, the Subcommittee included in its charge a commitment to assess the need to reexamine the data elements and definitions contained in the UHDDS. As part of this assessment, the Subcommittee will consider the congruence of the UHDDS to the UACDS and the adequacy of the Medicare Uniform Bill (UB-82) as the principal vehicle for collecting the UHDDS.

Continuing Work Plan

The Subcommittee will pursue the following work plan in 1990:

- Monitor the responses within the Department of Health and Human Services to the final report on the UACDS.
- Follow the efforts of the Uniform Claim Form Task Force for the HCFA 1500 to seek greater standardization of the definitions in use for place or site of health care services.
- Provide continuing liaison with the Health Care Financing Administration, the National Center for Health Statistics, and other relevant agencies concerning the statistical aspects of physician payment systems and other data systems and research concerned with patient-provider encounters.
- Develop a recommendation to the full Committee on whether to undertake a review and revision of the UHDDS. Address in this recommendation concerns about improving the recording of external cause-of-injury codes (E-codes) in hospital discharge data.
- Follow the status of relative value scale research and related physician payment reform legislation and the associated data requirements.
- Consider the importance of emerging and projected quality and effectiveness of care activities for relevance to existing data systems and implications for revisions to those systems.

Health Statistics for Minority and Other Special Populations

The Subcommittee on Minority Health Statistics directed its attention during 1989 to the availability of data concerning access and financing of medical care for the medically indigent population in the United States. A public hearing was held to provide background information on the data issues, and the Subcommittee presented an interim report to the National Committee on Vital and Health Statistics (NCVHS) at the Committee's November meeting. In the coming year, the Subcommittee will focus and develop recommendations regarding the national data requirements for the medically indigent population. This expansion of the Subcommittee's charge was reflected in a recommendation presented by the Subcommittee at the November NCVHS meeting for a new charge and a change in name to the Subcommittee on Health Statistics for Minority and Other Special Populations. These changes were endorsed by the full Committee. The Subcommittee also will continue to review the uniformity and adequacy of the coding of race and ethnicity in national health surveys to produce data on minority populations.

Findings

At the November 1989 meeting of the NCVHS, the Subcommittee on Minority Health Statistics presented an interim report that summarized its findings on the data needs of the medically indigent population. The following points were emphasized:

- Current data appear to be inadequate to address the needs of indigent care.
- The definition of the "medically indigent" tends to be operationally defined by reimbursement programs and thus varies by program and locality.
- Standardized definitions would facilitate comparisons across studies that will increase understanding of the problem.
- Data that currently are collected to cover this population vary in terms of intent and detail, thus providing little on which policy issues can be derived or resolved.

Background

The Subcommittee on Minority Health Statistics was established by the NCVHS in 1986 after the Secretary's Task Force on Black and Minority Health noted that there was need for data on minority populations and identified a need to improve and fully utilize available sources of data.

Subsequently, the Subcommittee recognized the need to expand its focus on populations defined by race and/or ethnicity to include other groups whose health status and health care utilization needs and patterns required special attention that could not be addressed adequately through current data systems. To reflect this expanded focus, the Subcommittee's name was changed in November 1989 to the Subcommittee on Health Statistics for Minority and Other Special Populations.

Current Year's Activities

Early in 1989, the Subcommittee agreed to look into the issue of indigent care data based on its recognition that (1) the number of persons without health insurance in the United States and their problems with access to medical care has emerged as one of the most compelling health policy issues of the 1980's, (2) new health care delivery and financing trends are exacerbating problems of access and financing health care and, (3) little attention has been given to the data problems associated with defining the "medically indigent" population, estimating its size, evaluating the adequacy of its care, and determining its cost.

In this connection, the Subcommittee conducted a public hearing on May 3, 1989, to receive testimonies on data issues of the medically indigent population. Presentations were made by representatives of agencies within the Public Health Service and agencies and associations in the private sector. Three issues commonly held high priority concerns. The first was inadequacy of current data, including missing populations, the need for local data, and the causes and extent of medical indigence. The second was the need for standardization of definitions for medical indigence, poverty, uninsured status, and uncompensated and/or charity care. The third issue concerned policy coordination and funding for the collection and analysis of medical indigence data. The type of data currently collected does not represent a comprehensive plan of attack to gain mastery of the problem.

At the September 6, 1989, Subcommittee meeting, the newly appointed Director of the Office of Minority Health and the newly appointed Associate Director of Minority Health, Centers for Disease Control (CDC), were invited attendees. The primary objective of this meeting was to acquaint these two officials with the charge and interests of the Subcommittee and to set the stage for identifying mutual areas of endeavor that could benefit from supportive or collaborative efforts.

The Office of Minority Health expressed a strong commitment to work with the Subcommittee and indicated that the most pressing area for collaborative efforts related to developing strategies to address the serious need for data for State and local areas. The Associate Director of Minority Health, CDC, also expressed his concern over the dearth of data available to assess State and local health problems.

In presenting its interim report at the November NCVHS meeting, the Subcommittee concluded that the data issues surrounding medical indigence are sufficiently important for the National Committee to address. Because these issues overlap minority health data issues in many aspects, the Subcommittee recommended that they become part of its charge and work agenda. The full Committee concurred.

Continuing Work Plan

The Subcommittee intends to carry out the following work plan in 1990:

- Conduct a survey of the uniformity and adequacy of the coding of race and ethnicity on national health surveys for the purpose of determining the ability of the data systems to produce data on minority populations.
- Meet periodically with the Office of Minority Health and collaborating offices.
- Develop standardized conceptual and operational definitions of medical indigence.
- Conduct a survey of agencies to determine what health data they are collecting relative to the medically indigent population.
- Continue to pursue various avenues to encourage the Health Care Financing Administration and the Social Security Administration to improve the racial and ethnic identifiers in the Medicare and Medicaid data systems.

Health Care Statistics

During 1989, the Subcommittee on Health Care Statistics monitored the plans by the National Center for Health Statistics (NCHS) to carry out the Subcommittee's earlier recommendation that the National Academy of Sciences (NAS) be asked to form a panel to provide advisory support on developing the National Health Care Survey. This effort culminated in the award by NCHS of a contract to the NAS National Research Council for such a panel study. The Subcommittee also developed a resolution of support for the National Health Care Survey, which urged the Secretary to provide adequate resources to proceed with survey plans. This resolution was approved by the National Committee on Vital and Health Statistics (NCVHS) at its February meeting and transmitted to the Assistant Secretary for Health.

The Subcommittee's review, in late 1988, of the adequacy of existing data sets to meet the proposed coverage of settings by the National Health Care Survey had revealed that the personal identifier was defined differently in each of the three major data sets. The respective chairs of the Subcommittees on Health Care Statistics, Ambulatory Care Statistics, and Long-Term Care Statistics were requested at the February NCVHS meeting to try to reach some agreement on a recommendation for the use of a consistent personal identifier for the client across the different components of the National Health Care Survey. A recommendation was presented at the June meeting and approved, with modification, by the full Committee for transmittal to the Assistant Secretary for Health.

Recommendations

At the February meeting of the NCVHS, the following resolution was passed, based on the recommendation of the Subcommittee on Health Care Statistics:

The National Health Care Survey is a mechanism through which the National Center for Health Statistics (NCHS) proposes to combine many of its existing provider-based surveys into an integrated survey system, relying to the extent possible on approved minimum data sets. This system will use an integrated sampling approach which should improve the analytic utility of the surveys. It will also attempt to eliminate data gaps and expand coverage of providers to important new areas (e.g., emergency rooms). In addition, the survey will provide NCHS with a framework for pursuing follow-up studies of patients in all surveyed settings, thus enabling the development of data on outcomes, subsequent care, and other information.

The National Committee on Vital and Health Statistics supports NCHS in its development of this important data system and encourages the Secretary to support the Center with adequate resources to proceed with its plans to implement the survey as quickly as possible. We also urge that every effort be made to attain optimal sample sizes, depending on goals, and work toward continuous collection cycles in all of these surveys.

The following resolution on the use of a personal identifier in the National Health Care Survey was passed by the NCVHS at its June meeting and transmitted to the Assistant Secretary for Health:

The National Health Care Survey is an initiative to collect and combine information from several separate data systems. Some of these systems contain personal identifiers; others do not. In order to evaluate the care received by all segments of the population, not just through a course of illness but over time, it is essential in this survey to link patient records across data systems. The social security number is the only practical patient identifier that could be used for this purpose, and the cost of creating a new identifier would be prohibitive. Therefore, the National Committee on Vital and Health Statistics recommends that the National Center for Health Statistics (NCHS) develop a proposal to use the social security number in the National Health Care Survey for the purpose of linking records and that this proposal be subject to a pilot test. In doing so, established procedures, consistent with the strictures of the Privacy Act and Section 308(d) of the Public Health Service Act, will be used to protect confidentiality.

The letter transmitting the above resolution to the Assistant Secretary for Health noted that, "There was a strong consensus on the Committee for the concept of a unique personal identifier to allow for linkage of patient records. The majority of the Committee members supported the use of the social security number for this purpose A minority, while favoring the concept, believed further clarification was needed on the statutory provisions under which the social security number would be collected and protected."

Background

After receiving several presentations from NCHS about the development of the National Health Care Survey, the NCVHS determined that this was a significant activity that merited more attention by the Committee. During the June 1988 meeting, the Subcommittee on Health Care Statistics was established to review the NCHS plans for the survey and monitor the survey's development.

Current Year's Activities

A major focus of the Subcommittee's charge is to assist the NCHS in obtaining sufficient internal and external input to the development and policy implication of the National Health Care Survey. This process began in 1988 with a recommendation to NCHS by the Subcommittee that the NAS be asked to form a panel to provide

advisory support on developing the survey. During 1989, the Subcommittee monitored NCHS plans to carry out this recommendation. NCHS awarded a contract to the National Research Council of NAS in August, and a member of the Subcommittee was asked and agreed to serve on the advisory panel. Recognizing that the survey development had major implications for the future availability of health care information, the Subcommittee also prepared a resolution of support for the survey, which was adopted by the full Committee in February.

Review of the adequacy of existing data sets to meet the proposed coverage of settings by the National Health Care Survey was another key responsibility in the Subcommittee's charge. As part of this review, the Subcommittee noted various inconsistencies among the Uniform Hospital Discharge Data Set, the Uniform Ambulatory Care Data Set, and the Long-Term Care Uniform Data Set. These inconsistencies were discussed with the respective subcommittees that were addressing these data sets, and in most cases it was felt that comparable statistics could be developed from the different care settings.

The issue of a need for a consistent personal identifier to facilitate record linkage across the individual surveys and with external data files was raised with the full Committee in February. Although survey development could proceed without this issue being resolved, it was felt that recommending policy in this area would be useful. The chairs of the Subcommittees on Health Care Statistics, Ambulatory Care Statistics, and Long-Term Care Statistics were charged with the responsibility to develop a recommendation by the June meeting. Concluding that the social security number (SSN) was the only unique identifier currently available that would enable NCHS to link records in data bases held by NCHS and other Government agencies, the proposed recommendation encouraged NCHS to attempt to obtain the patient's SSN in provider-based surveys for use as the primary personal identifier. This recommendation related only to the NCHS use of the SSN in the National Health Care Survey and did not modify the current minimum data sets.

The full Committee considered the proposed recommendation at its June meeting and passed a modified version, recommending that NCHS develop a proposal to use the SSN in the National Health Care Survey for the purpose of linking records and that this proposal be subject to a pilot test.

Continuing Work Plan

The Subcommittee considers the contract between NCHS and NAS an efficient mechanism for obtaining external input to the National Health Care Survey. Further, the Subcommittee has completed its initial review of the uniform data sets related to the survey and believes that future work on these data sets can be carried out by other NCVHS subcommittees. Nonetheless, the NCVHS believes that it is appropriate, either through the current Subcommittee or another approach, to follow the development of the NAS study and to stay involved with the National Health Care Survey on a periodic basis. At the November NCVHS meeting, it was agreed that consideration of the future status of this Subcommittee would take place in early 1990 in conjunction with discussion of restructuring several subcommittees in order to be more responsive to the need for data to assess health status and health care at the community level.

Appendix I. Legislative Authority for the National Committee on Vital and Health Statistics From the Public Health Service Act

Section 306 subsection (k) of Public Health Service Act

- (1) There is established in the Office of the Secretary a committee to be known as the National Committee on Vital and Health Statistics (hereinafter in this subsection, referred to as the "Committee") which shall consist of sixteen members.
- (2) (A) The members of the Committee shall be appointed by the Secretary from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. Except as provided in subparagraph (B), members of the Committee shall be appointed for terms of four years.
 - (B) (i) In the case of membership terms on the Committee under this subsection (as in effect prior to January 1, 1988) which expire in calendar year 1988, the appointments to three such terms in such calendar year shall be for a period of four years and the appointments to two such terms in such calendar year shall be for a period of three years, as designated by the Secretary.
 - (ii) In the case of membership terms on the Committee under this subsection (as in effect prior to January 1, 1988) which expire in calendar year 1989, one such term shall be extended for an additional consecutive one-year period, as designated by the Secretary.
 - (iii) In the case of membership terms on the Committee under this subsection (as in effect prior to January 1, 1988) which expire in calendar year 1990, two of such terms shall each be extended for an additional consecutive one-year period, as designated by the Secretary.
- (3) Members of the Committee shall be compensated in accordance with section 208(c).
- (4) It shall be the function of the Committee to assist and advise the Secretary—
 - (A) to delineate statistical problems bearing on health and health services which are of national or international interest;
 - (B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;
 - (C) to determine, approve, and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use (i) within the Department of Health and Human Services, (ii) by all programs administered or funded by the Secretary, including the Federal-State-local cooperative health statistics system referred to in subsection (e), and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans' Administration, the Department of Defense, and other Federal agencies concerned with health and health services;

- (D) with respect to the design of and approval of health statistical and health information systems concerned with the collection, processing, and tabulation of health statistics within the Department of Health and Human Services, with respect to the Cooperative Health Statistics System established under subsection (e), and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j)(i);
 - (E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;
 - (F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest; and
 - (G) to issue an annual report on the state of the Nation's health, its health services, their costs and distributions, and to make proposals for improvement of the Nation's health statistics and health information systems.
- (5) In carrying out health statistical activities under this part, the Secretary shall consult with, and seek the advice of, the Committee and other appropriate professional advisory groups.

Appendix II. Charter



THE SECRETARY OF HEALTH AND HUMAN SERVICES
WASHINGTON, D.C. 20201

CHARTER

NATIONAL COMMITTEE ON VITAL AND HEALTH STATISTICS

PURPOSE

The Secretary is charged under Section 306(k) of the Public Health Service Act, as amended, 42 U.S.C. 242k(k), with the responsibility to collect, analyze and disseminate national statistics on vital events; the extent and nature of illness and disability of the population of the United States; the impact of illness and disability of the population on the economy of the United States, and on other aspects of the well-being of its population; environmental, social, and other health hazards; determinants of health; health resources and the supply of services by health institutions; utilization of health care; health care costs and financing; family formation, growth, and dissolution; to undertake research, demonstrations, and evaluations respecting new or improved methods for obtaining current data on the matters referred to above; to undertake epidemiological research, demonstrations, and evaluations on such matters; to provide selected technical assistance to State and local jurisdictions; to coordinate health statistical and epidemiological activities of the Department; and to engage in cooperative endeavors with other countries to foster research consultation and training programs in statistical activities.

This Committee shall provide advice, consultation, and assistance and make recommendations to the Secretary through the Assistant Secretary for Health on policies and plans in developing major national systems of health data collection in the Department, on coordination of Federal health data requirements, and on analysis over a wide range of questions relating to general health problems of the population, health care resources, the use of health care services and health care financing and expenditures. In these matters, the Committee shall consult with the Health Care Financing Administration (HCFA) and other components of the Department, other Federal entities and non-Federal organizations as appropriate.

AUTHORITY

Section 306(k) of the Public Health Service Act, as amended, 42 U.S.C. 242k(k). The Committee is governed by provisions of Public Law 92-463 which sets forth standards for the formation and use of advisory committees.

FUNCTION

It shall be the function of the Committee to assist and advise the Secretary:

- (A) to delineate statistical problems bearing on health and health services which are of national or international interest;
- (B) to stimulate studies of such problems by other organizations and agencies whenever possible or to make investigations of such problems through subcommittees;

(C) to determine, approve and revise the terms, definitions, classifications, and guidelines for assessing health status and health services, their distribution and costs, for use: (i) within the Department of Health and Human Services; (ii) by all programs administered or funded by the Secretary; and (iii) to the extent possible as determined by the head of the agency involved, by the Veterans Administration, the Department of Defense, and other Federal agencies concerned with health and health services;

(D) with respect to the design of and approval of health statistical and health information systems concerned with collection, processing, and tabulation of health statistics within the Department of Health and Human Services, and with respect to the standardized means for the collection of health information and statistics to be established by the Secretary under subsection (j) (1);

(E) to review and comment on findings and proposals developed by other organizations and agencies and to make recommendations for their adoption or implementation by local, State, national, or international agencies;

(F) to cooperate with national committees of other countries and with the World Health Organization and other national agencies in the studies of problems of mutual interest;

(G) in the development of a report on the state of the Nation's health, its health services, their costs and distributions, to make proposals for improvement of the Nation's health statistics and health information systems, at such intervals as may be required by the Congress;

(H) in establishing standards to assure the quality of health statistical and epidemiological data collection, processing, and analysis; and

(I) with respect to data on the effects of the environment on health.

STRUCTURE

The Committee shall consist of 16 members, including the Chairperson. The members of the Committee shall be appointed by the Secretary, or designee, from among persons who have distinguished themselves in the fields of health statistics, health planning, epidemiology, and the provision of health services. The Secretary, or designee, shall appoint the Chair for a one-year period, renewable at the discretion of the Secretary or designee.

Members shall be invited to serve for overlapping four-year terms. Terms of more than two years are contingent upon the renewal of the Committee by appropriate action prior to its termination. Any member appointed to fill a vacancy occurring prior to the expiration of the term for which his/her predecessor was appointed shall be appointed only for the remainder of such term. A member may serve after the expiration of his/her term until his/her successor has been appointed.

Subcommittees composed of members of the parent Committee may be established to provide the Committee with background study and proposals for consideration and action. The Chair shall appoint members from the parent Committee to the subcommittees and designate a Chair for each subcommittee. The Chair shall appoint ad hoc subcommittees, composed solely of members of the parent Committee, as necessary to address specific issues for consideration. The subcommittees shall make their recommendations to the parent Committee. Timely notification of the subcommittees and ad hoc subcommittees, including charges and membership, shall be made in writing to the Department Committee Management Officer by the Executive Secretary of the Committee.

Management and support services shall be provided by the National Center for Health Statistics, Centers for Disease Control.

MEETINGS

Meetings shall be held at the call of the Chair, but not less than annually, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all meetings.

Meetings of the subcommittees shall be held, as necessary, at the call of the respective Chair, with the advance approval of a Government official who shall also approve the agenda. A Government official shall be present at all subcommittee meetings. All subcommittees shall report their findings to the Committee.

Meetings shall be open to the public except as determined otherwise by the Secretary; notice of all meetings shall be given to the public.

Meetings shall be conducted, and records of the proceedings kept, as required by the applicable laws and departmental regulations.

COMPENSATION

Members who are not full-time Federal employees shall be paid at the rate of \$188 per day, plus per diem and travel expenses in accordance with the Standard Government Travel Regulations.

ANNUAL COST ESTIMATE

Estimated annual cost for operating the Committee and Subcommittees, including compensation and travel expenses for members but excluding staff support, is \$93,024. Estimated annual man-years of staff support required is 2.5, at an estimated annual cost of \$102,478.

REPORTS

An annual report shall be submitted to the Secretary through the Assistant Secretary for Health, not later than January 31 of each year, which shall contain as a minimum a list of members and their business addresses, the Committee's functions, dates and places of meetings, and a summary of Committee activities and recommendations made during the fiscal year. A copy of the report shall be provided to the Department Committee Management Officer.

TERMINATION DATE

The duration of the National Committee on Vital and Health Statistics is continuing, and a new charter shall be filed no later than July 23, 1990, the date of the expiration of the next two-year period following the date of the statute establishing this advisory committee, in accordance with Section 14(b)(2) of Public Law 92-463.

APPROVED

July 20, 1988
Date



Otis R. Bowen, M.D.
Secretary

Appendix III. Roster of the National Committee on Vital and Health Statistics

Department of Health and Human Services Office of the Assistant Secretary for Health

Chairman

Ronald G. Blankenbaker, M.D. (1990)
Vice President for Medical Affairs
St. Vincent Hospital
and Health Care Center
2001 West 86th Street
Indianapolis, Indiana 46260

Nancy L. Cannon, Ph.D. (1993)
Vice President
Care Management Operations
LifePlans, Inc.
Two University Office Park
Waltham, Massachusetts 02154

Frederick A. Connell, M.D. (1992)
Acting Director
Maternal and Child Health Program
School of Public Health and
Community Medicine
University of Washington, SC-37
Seattle, Washington 98195

Ex Officio

Manning Feinleib, M.D., Dr.P.H.
Director
National Center for Health Statistics
3700 East-West Highway
Hyattsville, Maryland 20782

Jane L. Delgado, Ph.D. (1990)
President and Chief Executive Officer
National Coalition of Hispanic Health
and Human Services Organizations
1030 15th Street, NW, Suite 1053
Washington, D.C. 20005

Executive Secretary

Gail F. Fisher, Ph.D.
Associate Director
Office of Planning and Extramural
Programs
National Center for Health Statistics
3700 East-West Highway
Hyattsville, Maryland 20782

William R. Felts, Jr., M.D. (1991)
Professor of Medicine
George Washington University
Medical Center
2150 Pennsylvania Avenue, NW
Washington, D.C. 20037

Current Membership

Stephen F. Gibbens (1990)
730 Arcady Road
Montecito, California 93108

(Date Appointment Expires)

Laurence G. Branch, Ph.D. (1992)
Boston University School of Medicine
80 East Concord Street, M-936
Boston, Massachusetts 02215

Judith Miller Jones (1992)
Director
The National Health Policy Forum
2011 I Street, NW, Suite 200
Washington, D.C. 20006

Sister Irene V. Kraus (1993)
President
Daughters of Charity National
Health System
11775 Borman Drive
St. Louis, Missouri 63146-6905

Risa J. Lavizzo-Mourey, M.D. (1993)
Acting Director
Program in Geriatric Medicine
University of Pennsylvania
Ralston-Penn Center
3615 Chestnut Street
Philadelphia, Pennsylvania 19104-2683

Joseph R. Martin (1990)
General Manager
Center for Hospital and
Health Care Information
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

David Mechanic, Ph.D. (1992)
Institute for Health, Health Care
Policy, and Aging Research
Rutgers University
30 College Avenue
New Brunswick, New Jersey 08903

Robert L. Mullin, M.D. (1990)
Director of Continuing Care
Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Bruce Steinwald (1991)
Vice President
Health Technology Associates
Columbia Square
555 13th Street, NW
Washington, D.C. 20004-1109

George H. Van Amburg (1993)
State Registrar and Chief
Office of the State Registrar and
Center for Health Statistics
Michigan Department of Public Health
P.O. Box 30195
Lansing, Michigan 48909

Karel M. Weigel, R.R.A. (1991)
Division of Administrative Services
Mayo Clinic
200 S.W. First Street
Rochester, Minnesota 55905

Members Retired During 1989

Mary Anne Freedman
Director
Division of Public Health Statistics
Vermont Department of Health
P.O. Box 70
Burlington, Vermont 05402

James K. Hutchison
Chief Actuary
The Blue Cross and Blue Shield
Association
676 North St. Clair Street
Chicago, Illinois 60611

William H. Kirby, Jr., M.D.
Principal
Health Management Services, Inc.
401 Walpole Court
Timonium, Maryland 21093

Meeting Dates

All meetings held in Washington, D.C.

February 8-10, 1989

June 7-9, 1989

November 1-3, 1989

Appendix IV. Subcommittees of the National Committee on Vital and Health Statistics

Executive Subcommittee

Current Roster

Chairman

Ronald G. Blankenbaker, M.D. (1990)
Vice President for Medical Affairs
St. Vincent Hospital and
Health Care Center
2001 West 86th Street
Indianapolis, Indiana 46260

Judith Miller Jones (1992)
Director
The National Health Policy Forum
2011 I Street, NW, Suite 200
Washington, D.C. 20006

Joseph R. Martin (1990)
General Manager
Center for Hospital and
Health Care Information
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Bruce Steinwald (1991)
Vice President
Health Technology Associates
Columbia Square
555 13th Street, NW
Washington, D.C. 20004-1109

Ex Officio

Gail F. Fisher, Ph.D.
Executive Secretary
National Committee on Vital and
Health Statistics
3700 East-West Highway
Hyattsville, Maryland 20782

Staff

Jack Anderson, NCHS
Marjorie S. Greenberg, NCHS
Thomas S. Vissman, NCHS

Meeting Dates

Meetings held in Washington, D.C.

February 8, 1989 (working session)
May 12, 1989 (working session)
November 2, 1989 (working session)

Meeting held in Charlottesville, Virginia

September 11-13, 1989
(working session)

Functions and Process for the Executive Subcommittee National Committee on Vital and Health Statistics

Background

At the November 8, 1985, meeting of the National Committee on Vital and Health Statistics (NCVHS), based on the recommendations of the Ad-hoc Subcommittee on Policy and Directions, there was established an Executive Subcommittee of the NCVHS.

Purpose

The Executive Subcommittee was established to assist the Chairman, NCVHS, in administering the activities of the NCVHS to facilitate and expedite accomplishment of policies determined by the full Committee and in providing liaison with governmental and nongovernmental organizations. The functions and procedures governing the Executive Subcommittee are subject to approval and modification by the full Committee.

Composition

The Chairman of the NCVHS is the Chairman of the Executive Subcommittee. Additionally, the Chairman, NCVHS, shall appoint, subject to ratification of the full Committee, three members to the Executive Subcommittee on an annual basis, with the option of reappointment, if appropriate. When appropriate, the three members will be selected one member each from those who have 1, 2, or 3 years, respectively, remaining in their terms of appointment to the NCVHS. The NCVHS Executive Secretary, or designee, will be an ex officio member of the Executive Subcommittee.

Functions

Specific responsibilities of the Executive Subcommittee are to:

- Identify and recommend issues for full Committee and subcommittee attention.
- Develop Committee agendas, with a view toward planning several agendas in advance.
- Develop annual NCVHS Report.
- Coordinate and facilitate subcommittee activities.
- Advise National Center for Health Statistics or other appropriate agency on allocation of annual NCVHS budget and on resource needs for future years.
- Conduct other business delegated to it by the full Committee.

Procedures and Process

The Executive Subcommittee is empowered to act between full Committee meetings on those activities delegated to the Subcommittee, their actions subject to ratification by the full Committee.

Specific activities include:

1. In interim periods between the full Committee meetings of the NCVHS, the Executive Subcommittee will monitor, through telephone calls, mail, and/or meetings, the progress of work and other activities relevant to the current approved program of the full Committee. Working with staff and subcommittee Chairmen, activities will be facilitated, and problems and issues identified and resolved to accomplish the planned program.

2. The Executive Subcommittee will review work plans developed by the subcommittees and make recommendations to the full Committee.
3. The Subcommittee may confer with chairmen of other subcommittees or with others to consider particular problems or issues impacting on the work of the full Committee. These may include senior personnel in the Department and other public and private agencies with interest in considerations appropriate to the responsibilities of the Committee.
4. Minutes of any meetings of the Subcommittee will be prepared and mailed to the full Committee membership and/or presented at the next full Committee meeting. If work progresses by mechanisms other than meetings, appropriate reports will be made to the full Committee membership.
5. The Chairman of the NCVHS, or his designee, will report on the activities of the Subcommittee at each full meeting. This report will include an outline of the areas of concern of the Subcommittee and proposed plans for subsequent followup and activity.
6. In unusual events where some actions, previously not approved by the Committee, may be required by the NCVHS and a meeting has not been scheduled, the Subcommittee may consider alternatives and make recommendations to the full Committee by mail or telephone. With concurrence, approved actions may be taken by the Chairman or other formally appointed representatives of the Committee.
7. In the absence of the Chairman at an Executive Subcommittee or full Committee meeting, the Executive Subcommittee member with the most seniority on the NCVHS would act as Chairman.

Subcommittee on Medical Classification Systems

Current Roster

Chairman

Karel M. Weigel, R.R.A. (1991)
Division of Administrative Services
Mayo Clinic
200 S.W. First Street
Rochester, Minnesota 55905

William R. Felts, Jr., M.D. (1991)
Professor of Medicine
George Washington University
Medical Center
2150 Pennsylvania Avenue, NW,
Rm. 405C
Washington, D.C. 20037

Joseph R. Martin (1990)
General Manager
Center for Hospital and
Health Care Information
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Robert L. Mullin, M.D. (1990)
Director of Continuing Care
Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Bruce Steinwald (1991)
Vice President
Health Technology Associates
Columbia Square
555 13th Street, NW
Washington, D.C. 20004-1109

Staff

Richard Havlik, M.D., NCHS
Lynnette Araki, NCHS
Edward Bacon, Ph.D., NCHS
Eileen McCarthy, NCHS
Sue Meads, NCHS
Patricia Brooks, HCFA

Meeting Dates

Meetings held in Washington, D.C.

January 11, 1989 (working session)
April 17-18, 1989
June 9, 1989 (working session)
October 10, 1989 (working session)
October 11, 1989

Charge to the Subcommittee on Medical Classification Systems

It shall be the charge to this Subcommittee to monitor, evaluate, and formulate recommendations as appropriate concerning the progress in the following areas:

1. The progress toward the development of ICD-10; to review and evaluate areas where conflicting proposals emerge and to participate in the development of recommendations that are most compatible with priority concerns in the United States.
2. The progress of international decisions regarding ICD-10 as related to needs in the United States that would require the development of an ICD-10-CM. To consider alternative mechanisms and suggested time tables if an ICD-10-CM were perceived as necessary.

3. The progress of activities moving toward the development of a single classification system for procedures in the United States to be used for physician fee for services, diagnostic reporting, and hospital inpatient care reimbursement that will respond to data user needs.
4. The ongoing refinement of diagnosis-related groups (DRG's), case mix indexes, and severity indexes.
5. The progress in a number of related areas: systems for automated coding of medical diagnoses and improved medical terminology and nomenclature, quality of diagnostic data, and other related areas.
6. Continue to work with the existing ICD-9-CM Coordination and Maintenance Committee, chaired by the Health Care Financing Administration and the National Center for Health Statistics, to ensure the utility and integrity of ICD-9-CM in its broadly based multi-use applications throughout the United States.

Subcommittee on Long-Term Care Statistics

Current Roster

Chairman

Laurence G. Branch, Ph.D. (1992)
Boston University School of Medicine
80 East Concord Street, M-936
Boston, Massachusetts 02215

Nancy L. Cannon, Ph.D. (1993)
Vice President
Care Management Operations
LifePlans, Inc.
Two University Office Park
Waltham, Massachusetts 02154

Stephen F. Gibbens (1990)
730 Arcady Road
Montecito, California 93108

Judith Miller Jones, (1992)
Director
The National Health Policy Forum
2011 I Street, NW, Suite 200
Washington, D.C. 20006

David Mechanic, Ph.D. (1992)
Institute for Health, Health Care
Policy, and Aging Research
Rutgers University
30 College Avenue
New Brunswick, New Jersey 08903

George H. Van Amburg (1993)
State Registrar and Chief
Office of the State Registrar and
Center for Health Statistics
Michigan Department of Public Health
P.O. Box 30195
Lansing, Michigan 48909

Staff

Richard Havlik, M.D., NCHS
Lynnette Araki, NCHS
Joan Van Nostrand, NCHS

Aurora Zappolo, OHPE, OASH

Martin Feuerberg, HCFA
Mary Waid-Simon, HCFA

Meeting Dates

Meetings held in Washington, D.C.

April 10, 1989
June 9, 1989 (working session)
August 15, 1989

Charge to Subcommittee on Long-Term Care Statistics

The care of the chronically ill and dependent is of increasing public policy importance. Demographic trends and reduced mortality are resulting in substantial increases in the number of older persons, especially the very old, and their share of the total population. The increasing prevalence of chronic conditions and dependency that accompanies aging implies substantial increases in the population needing long-term health care and personal services and raises serious concerns about the availability and affordability of such services. The absence of comprehensive financing concentrated in a single program has created difficulties in assembling information required for analysis of policy choices.

Similar concerns about information adequacy exist regarding care of the chronically mentally ill and the mentally retarded and developmentally disabled. Efforts to "deinstitutionalize" and "mainstream" have increased substantially the potential sources of care and, unfortunately, the potential for inadequate care. Increased fragmentation of the service system has also made collection of adequate data on these persons and their services more problematic.

Therefore, the National Committee establishes the Subcommittee on Long-Term Care Statistics to describe and assess the adequacy of information available pertaining to long-term care policy issues and to recommend steps to reduce any deficiencies. Specifically, the 1990 Charge for the Subcommittee on Long-Term Care Statistics is:

1. Review the Interagency Task Force report on the Long-Term Care Client Uniform Data Set.
2. Monitor the Forum on Aging's consideration of the National Research Council's recommendations in *The Aging Population in the Twenty-First Century*, especially the planning for a possible longitudinal health and retirement study and review of current functional classification techniques; consider those recommendations directed to the National Committee; and monitor general aging issues.
3. Monitor the development and review the Secretary's recommendation for a resident assessment instrument for nursing homes by the Health Care Financing Administration as mandated by the Omnibus Budget Reconciliation Act of 1987.
4. Review recommendations for a proposed survey of board and care homes.
5. Initiate a review of quality of life assessment strategies in long-term care facilities.
6. Examine possible linkage of long-term care to mental health data bases.
7. Encourage better descriptions of bed supply rates for long-term care and their variation in the country.

Subcommittee on Ambulatory and Hospital Care Statistics

Current Roster

Chairman

William R. Felts, Jr., M.D. (1991)
Professor of Medicine
George Washington University
Medical Center
2150 Pennsylvania Avenue, NW
Washington, D.C. 20037

Nancy L. Cannon, Ph.D. (1993)
Vice President
Care Management Operations
LifePlans, Inc.
Two University Office Park
Waltham, Massachusetts 02154

Judith Miller Jones (1992)
Director
The National Health Policy Forum
2011 I Street, NW, Suite 200
Washington, D.C. 20006

Robert L. Mullin, M.D. (1990)
Director of Continuing Care
Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Bruce Steinwald (1991)
Vice President
Health Technology Associates
Columbia Square
555 13th Street, NW
Washington, D.C. 20004-1109

Staff

Marjorie S. Greenberg, NCHS
Jim Delozier, NCHS

William Sobaski, HCFA

Meeting Dates

All meetings held in Washington, D.C.

January 12-13, 1989

May 2, 1989

June 9, 1989 (working session)

August 24, 1989

November 1, 1989 (working session)

Charge to Subcommittee on Ambulatory and Hospital Care Statistics

1. Monitor the responses within the Department of Health and Human Services to the final report on the Uniform Ambulatory Care Data Set, which was submitted to the Assistant Secretary for Health by the NCVHS and the Interagency Task Force. Monitor any implementation plans that are developed by the agencies.
2. Follow the efforts of the Uniform Claim Form Task Force for the HCFA 1500 to seek greater standardization of the definitions in use for place or site of health care services.
3. Provide continuing liaison with the Health Care Financing Administration, the National Center for Health Statistics, and other relevant agencies concerning the statistical aspects of physician payment systems and other data systems and research and development projects concerned with patient-provider encounters.

4. Follow these data systems and related activities by receiving periodic updates, having an opportunity to react to developments and, where appropriate, framing recommendations concerning their future course. Among those activities for which data policy, data coordination, and data quality issues will be reviewed are (a) progress towards implementing the Medicare Common Working File, (b) status of the revision of the HCFA 1500, (c) progress towards implementation by the Medicare program of the unique physician identification number (UPIN), (d) status of research and demonstration projects on prospective payment methodologies for ambulatory care, (e) Medicaid data development, and (f) development of the National Practitioner Data Bank.
5. Follow plans for implementing the data aspects of the Medicare Catastrophic Coverage Act of 1988, including the drug benefit and the requirement for physician coding of diagnoses on the HCFA 1500. Examine issues of data quality and coordination.
6. Follow the status of relative value scale research and related physician payment reform legislation and the associated data requirements.
7. Consider the importance of emerging and projected quality of care activities for relevance to existing data systems and implications for revisions to those systems. Examine data quality issues related to measurement of the effectiveness and quality of care.
8. Assess the need to reexamine the data elements and definitions contained in the Uniform Hospital Discharge Data Set (UHDDS), its congruence with the Uniform Ambulatory Care Data Set, and the adequacy of the UB-82 as the principal vehicle for collecting the UHDDS. Develop a recommendation on this issue by the February 1990 NCVHS meeting.

Subcommittee on Health Statistics for Minority and Other Special Populations

Current Roster

Chairman

Risa J. Lavizzo-Mourey, M.D. (1993)
Acting Director
Program in Geriatric Medicine
University of Pennsylvania
Ralston-Penn Center
3615 Chestnut Street
Philadelphia, Pennsylvania 19104-2683

Frederick A. Connell, M.D. (1992)
Acting Director
Maternal and Child Health Program
School of Public Health and
Community Medicine
University of Washington, SC-37
Seattle, Washington 98195

Sister Irene V. Kraus (1993)
President
Daughters of Charity National
Health System
11775 Borman Drive
St. Louis, Missouri 63146-6905

Joseph R. Martin (1990)
General Manager
Center for Hospital and
Health Care Information
American Hospital Association
840 North Lake Shore Drive
Chicago, Illinois 60611

Staff

Jacqueline P. Davis, NCHS
Diane Makuc, Ph.D., NCHS
Patricia Golden, NCHS

Warren Hewitt, OMH, OASH

Frank Emerson, HCFA
Mary Waid-Simon, HCFA

Meeting Dates

Meetings held in Washington, D.C.

May 3, 1989
June 9, 1989 (working session)
September 6, 1989
December 12, 1989

Charge to Subcommittee on Health Statistics for Minority and Other Special Populations

Recognizing the importance to the Department of Health and Human Services (DHHS) of collecting and disseminating valid and reliable health data on minority and other special populations, it shall be the Subcommittee's charge to:

1. Review and make recommendations on the uniformity and adequacy of the collection, analysis, and dissemination of minority health data.
2. Work with and support the Office of Minority Health and collaborating offices in their data-related minority health activities.
3. Examine health data issues related to the medically indigent, including the medically underserved, uninsured, and underinsured to determine whether DHHS systems adequately address these issues and make recommendations.

Subcommittee on Health Care Statistics

Current Roster

Chairman

(Inactive since June 1989; no chairman)

Laurence G. Branch, Ph.D. (1992)
Boston University School of Medicine
80 East Concord Street, M-936
Boston, Massachusetts 02215

David Mechanic, Ph.D. (1992)
Institute for Health, Health Care
Policy, and Aging Research
Rutgers University
30 College Avenue
New Brunswick, New Jersey 08903

Staff

Edward L. Hunter, NCHS
Edward Bacon, Ph.D., NCHS
R. Clifton Bailey, Ph.D., HCFA

Meeting Dates

Meetings held in Washington, D.C.

February 8, 1989 (working session)
June 9, 1989 (working session)

Charge to Subcommittee on Health Care Statistics

The Subcommittee on Health Care Statistics is charged to:

1. Review the activities underway at the National Center for Health Statistics (NCHS) to develop the National Health Care Survey program. The Subcommittee should assist NCHS in obtaining sufficient internal and external input to the development and policy implication of the survey. As part of this process, the Subcommittee should assure that user needs are assessed and that appropriate priorities are set to respond to these needs.
2. The Subcommittee will coordinate its activities with other Subcommittees to assure that their concerns are considered in developing strategies and content for health care surveys.
3. Assume the Executive Subcommittee's current role of reviewing the status of uniform data sets not currently under study by a subcommittee. This review will focus on the adequacy of existing data sets to meet the proposed coverage by the Health Care Survey. The Subcommittee will recommend to the Committee the need for review and/or revision of existing data sets or the development of new data sets.

Appendix V. Report of the Subcommittee on Long-Term Care Statistics: Review of DHHS Interagency Task Force Report on the Long-Term Care Facilities "Minimum Data Set"¹

Introduction

The arena of long-term care is changing. Simple assumptions that long-term care (LTC) is synonymous with nursing home care are incorrect. Instead, there is a mixture of types of patients receiving care in nursing homes, as well as different sources of care for those with long-term need. The Interagency Task Force is to be commended for its efforts to establish a taxonomy to document uniformly the definitions of LTC facilities.

The Subcommittee recognizes the difficulty in developing a set of objective criteria to identify accurately other LTC facilities of interest. The traditional definitions of such facilities (e.g., licensure status) are widely recognized as insufficient, but appropriate alternative definitions or criteria are still problematic. How can we ensure that unlicensed facilities providing long-term care services actually receive the initial screening information that determines whether they will meet the revised criterion as a LTC facility?

The Subcommittee further believes that, in order to reflect accurately the current long-term care environment, consideration must be given to expanding the facilities "minimum data set" to include long-term care providers that are not facilities as defined but which provide LTC services. Examples include adult day care programs and home health services, to name a few.

Because of the complexity and dynamism of the situation in the LTC arena, the Subcommittee strongly endorses the Task Force's recommendation that an evaluation study be conducted using the "minimum data set" on a test basis before widespread application is attempted by either the Government or the private sector. This evaluation should also examine the feasibility of expanding the providers covered as noted in the above paragraph.

¹The Subcommittee prefers the term *uniform* rather than "minimum" because the latter may be viewed as a constraint and suggests that these are the only data to be collected. Depending on the use, more or different data might be necessary. Uniform connotes comparable and sufficient data for various uses.

In addition, the Subcommittee recommends the conduct of an evaluation study to assess the impact of these changes on data comparability with previous years' collection. In particular, it will be necessary to determine if the strategy to use a screening criterion to define a LTC facility, rather than relying on the conventional names, is more useful in capturing policy ramifications. Instead of focussing on specific elements of the "minimum data set," the Subcommittee has identified specific areas for evaluation.

Major Areas of Evaluation

- *25-day length of stay*—The impact of setting an arbitrary limit of an average length of stay of more than 25 days for residents to qualify as a LTC facility must be assessed to determine what types of facilities may be excluded by this definition. If an arbitrary length of stay is used, concordance with the 30-day length of stay used by NCHS, by the Uniform Hospital Discharge Data Set, and by the hospital industry should be encouraged. In addition, there is a need to establish an indicator of major patient subgroups to encompass both very long-term and other stay patients because the current trend calls for institutions to serve multiple populations within the same facility. Perhaps adding another duration indicator, such as the length of stay of discharges or recent admissions, might be a more accurate measure instead of using only a mean or median number of length-of-stay days to characterize the facility.
- *Overnight screener*—Screener number 2 is logically redundant to screener number 1; that is, length of stay as typically used implies overnight accommodations. If screener number 1 is intended to include duration of treatment, with or without overnight accommodation, there is potentially substantial ambiguity in the current version.
- *Protective oversight or health care*—The implications of the qualifier "protective oversight or health care" need much more consideration. Although these are overlapping concepts, adequate characterization could be improved to avoid ambiguity among potential respondents.
 - a. Instead of a "yes or no" category for protective oversight, it might be better to achieve a gradation of two or three additional levels. Presumably, almost all would have minimal protective oversight, although for some it might be the major component.
 - b. Health care should also have more gradations, either in the screener or in the detail collected on those with a positive response.
 - c. The separation of the screener into these two segments might be advantageous.

- *Terms for impaired functioning*—The terms “impaired functioning” and “impaired adaptive functioning” could be misconstrued. The first connotes physical disability; whereas the second covers the broad spectrum of being completely dependent or in a locked ward to having difficulty with alcohol or drugs. These terms should be defined more specifically.

Additional Areas Needing Evaluation

- *Nursing services*—More detail on the nursing services offered by the LTC facilities will assist in distinguishing those facilities from mixed use facilities. In addition, the frequency of providing such services would assist in differentiating those providing more specialized care from the more custodial group.
- *Types of residential facilities*—Facilities that are part of a larger varied residential organization require proper characterization. For example, long-term care facilities within life-care facilities where residents are provided different levels of services based on need should be identified. In addition, screening questions will need to be applied broadly to prevent omission or undercounting of these facilities.
- *Contrasting bed usage*—The number of certified or licensed beds would be useful to contrast actual beds currently in use.
- *Integrate data sets*—To adequately evaluate the facilities data set, there will be a need to integrate the facilities’ “minimum data set” with the client data set. Thus, inconsistent definitions, such as the 25-day and 30-day lengths of stay, need to be corrected. Further, when the client data set is completed, the two data sets will need to be evaluated together.
- *Uses of “minimum data set”*—The Subcommittee recognizes that to be of greatest value, the “minimum data set” should be adopted by other Government agencies and by the private sector in addition to its use within the Department. Evaluation of such uses, particularly in the private sector, should be included.
- *Board and care homes*—Board and care homes represent a major challenge to the Government, both in terms of enumeration and in collecting information of use, need, and quality. This aspect of the minimum data set merits special emphasis and careful consideration.
- *Special categories*—A specific category for AIDS patients should be added to the “treatment population normally served.” Possibly, other subgroups, such as children, should be identified separately.
- *Type of nursing facilities*—Besides designating a facility as owned or leased by a “chain,” it would be important to obtain information on whether the facility is part of a health maintenance organization or part of a managed care system, operating under management agreements or operating under special arrangements.

- *Types of personnel*—In view of new personnel training requirements, it might be necessary to categorize the employees of the facilities into smaller classifications, e.g., nurses aides.

Summary

The Subcommittee endorses the effort to identify LTC facilities in their multiple forms, especially the intent to identify mental health and general health care facilities in the same data set. However, because the screener approach is new and its ramifications unclear, the Subcommittee recommends that the data set be pilot tested and that an evaluation of its effect be conducted before large scale application by Government and private sector nursing facilities is endorsed. To this end, the Subcommittee plans to monitor progress on the implementation of an evaluation project and would like to be apprised of the design, execution, and results when they become available. Such an evaluation phase is critical to the ultimate usefulness of the LTC facilities' "minimum data set."

June 28, 1989

Appendix VI. Report of the Subcommittee on Ambulatory Care Statistics and the Interagency Task Force on the Uniform Ambulatory Care Data Set

Introduction

The interest of the National Committee on Vital and Health Statistics (NCVHS) and the Department of Health and Human Services (DHHS) in ambulatory care data is a lengthy one. A brief synopsis of major milestones and a history of the development of the Uniform Ambulatory Care Data Set are presented at the end of this report. The written history began with the 1972 Chicago Conference on Ambulatory Medical Care Records. From this Conference and subsequent work of a technical consultant panel, the first Uniform Minimum Basic Data Set on Ambulatory Medical Care Records was published by the Department in 1976. A second technical consultant panel reevaluated the data set, resulting in the publication of a revised Uniform Ambulatory Medical Care Minimum Data Set in 1981. Although widely disseminated, this data set has not been officially acted upon by the Department.

The most recent reassessment of the data set is reflected in this document and represents the joint work of the NCVHS Subcommittee on Ambulatory Care Statistics and the departmental Interagency Task Force on the Uniform Ambulatory Care Data Set. The charges and membership of each group are also presented later. The Interagency Task Force was charged with ascertaining the data needs of departmental agencies, whereas the NCVHS Subcommittee reviewed the data set from the broader perspective of other governmental agencies, the research community, and the private sector. Although initially two separate reports were envisioned, the close working relationship between the Subcommittee and Task Force resulted in consensus on a single uniform data set. During these deliberations the terms "minimum" and "medical" both were removed from the data set's name. The process of achieving consensus that every major user should require every item, as a minimum, was viewed as limiting and nonproductive. "Medical" was eliminated because it was considered too closely identified with services that only physicians might deliver.

The NCVHS Subcommittee and the Interagency Task Force believe that a common data set is essential to carrying out stewardship responsibilities for programs that finance or directly provide ambulatory care. Research efforts also will be enhanced by conformance with uniform categories and definitions. The changing dynamics in ambulatory care will demand that this data set be reviewed periodically to assure that it reflects the information most needed for making management and policy decisions.

Confidentiality represents a continuing concern, which extends beyond the activities of the Subcommittee and the Task Force. It must be acknowledged that, wherever health

or other personal data are collected, there is always the risk of inappropriate disclosure and invasion of personal privacy. The absence of such information, however, presents other serious risks. Programs and other organizations collecting and using health data must assume the responsibility for safeguarding those data and protecting citizens' rights under applicable laws and regulations and must modify approaches or seek solutions where inadequate safeguards exist.

Purpose

The purpose of the Uniform Ambulatory Care Data Set is to improve the comparability of ambulatory care data by defining a common core of standard data items with uniform definitions. These items are considered to be those most likely to be needed by a variety of users for multiple applications. It is recognized, however, that the items will not necessarily be sufficient to meet the total data needs of any one user group and that providers of ambulatory care and collectors of ambulatory care data may supplement this data set in accordance with their particular requirements. For example, a reimbursement data set may include an auxiliary set of items needed for eligibility and coordination of benefits, whereas a data set for assessing quality and effectiveness of care may define additional pieces of information that should be obtained from a patient's medical record.

The items in this data set are recommended for inclusion in the records of all ambulatory health care but do not, themselves, define a complete patient record. Although desirable, all items do not need to be recorded in the individual patient health record. Some items, for example, may be included in registration or billing records. In such instances, however, the capability should exist to link data from the various data sources. This ability to link records is considered an essential aspect of the data set. In addition, some data items need only be recorded once and updated when necessary.

The data items also are the common core of data recommended for adoption in the health care delivery and financing programs of the Department of Health and Human Services that require data on individual ambulatory encounters on a continuing basis. In addition, when items in this data set are included in other data systems, the recommended definitions and minimal classifications should be followed. It further is recommended that other Federal and State organizations, as well as institutions, professional organizations, and insurance companies that collect ambulatory care data, endorse the definitions and agree to use the data set to the maximum extent possible. Finally, it is expected that there will be a phase-in period during which data collectors will implement recommended data items that currently are not being collected. Although several studies have been conducted over the years on the availability of the data items in various ambulatory care settings, additional evaluation and fieldtesting may be required for some items.

Whereas the 1981 data set defined those items that should be entered in the records of all ambulatory health care, this revision emphasizes that, to the extent possible, these items should be abstracted uniformly from those records into ambulatory care data bases. This brings the data set into accordance with the Uniform Hospital Discharge Data Set and reflects the fact that an increasing number of public and

private sector groups are recognizing the need for collecting and analyzing data on ambulatory care for a variety of purposes. These purposes include patient care, quality assurance, reimbursement, policy development, management and planning, and research. Although the 1981 report pointed in this direction, the focus was primarily on health records, and the definitions in some cases did not lend themselves to uniform retrieval. Consistent with the 1981 version, however, neither a survey or other data collection system nor a specific data collection form is recommended. Nonetheless, the considerable efforts of the Uniform Claim Form Task Force in fostering uniformity through the common claims form for physician services, the HCFA 1500, is recognized. Because the history of inpatient data indicates that information from billing instruments is likely to be used for purposes well beyond remuneration, relevant billing instruments should capture adequate data for current and emerging applications. It is also important that they be updated as frequently as necessary to be consistent with the most current recommendations on data items and definitions.

Summary of Recommendations

The Subcommittee on Ambulatory Care Statistics of the NCVHS and the DHHS Interagency Task Force on the Uniform Ambulatory Care Data Set have identified the following core set of items for inclusion in a Uniform Ambulatory Care Data Set. These items are recommended for inclusion in the records of all ambulatory health care and for uniform abstraction from existing records into ambulatory care data bases. They delineate information that characterizes the patient, the provider, and the encounter. A few items are designated as "optional." There was sufficient interest in these items to recommend uniform definitions; however, these optional items would not be considered mandatory for health care delivery and financing programs of the Department that require data on individual ambulatory encounters on a continuing basis.

Patient Data Items

1. Personal identification
2. Residence
3. Date of birth
4. Sex
5. Race and ethnic background
6. Living arrangement and marital status (optional)

Provider Data Items

7. Provider identification
8. Location or address
9. Profession

Encounter Data Items

10. Date, place, and address of encounter, if different from Item 8
11. Patient's reason for encounter (optional)
12. Problem, diagnosis, or assessment
13. Services
14. Disposition
15. Expected sources of payment
16. Total charges

This list of items is consistent with the data set recommended by the NCVHS to the Secretary of DHHS in 1980 and published by the Department in 1981. Item definitions have been modified in a number of cases to reflect current needs, and the separate items for diagnostic, therapeutic, and preventive services have been combined into one services item. Type of practice has been eliminated as issues related to setting or financial arrangement are captured under place of encounter or expected sources of payment. The definition of a provider has been considerably expanded, with corresponding impact on the definition of an encounter. An optional item for living arrangement and marital status has been added. Finally, the address of the encounter, if different from the provider's address, has been included, along with an extensive list of places of encounter.

Definitions

The Subcommittee and Interagency Task Force developed the following definitions for "provider," "ambulatory care," and "encounter." These definitions form the framework for the Uniform Ambulatory Care Data Set, because the core items are recommended for each ambulatory care encounter with a provider.

A. Individual Provider

An individual provider is a health professional who delivers services or is professionally responsible for services delivered to a patient, who is exercising independent judgment in the care of the patient, and who is not under the immediate supervision of another health care professional.

In addition to physicians and dentists, this definition includes a wide range of health professionals, such as nurse practitioners, physical therapists, psychologists, optometrists, chiropractors, and podiatrists, who meet the criteria stated in the definition. The pathologist who is responsible for a laboratory and the radiologist who interprets an x ray are included because they are professionally responsible for services delivered to a patient and exercise independent judgments in those responsibilities, even though earlier definitions used in the ambulatory medical care data set did not include such physicians responsible for ancillary services because they frequently did not have direct contact with the patient. The purpose of this expanded definition is to assure that data on the services rendered to a patient are captured when the services occur and where the data are most likely to originate. The definition excludes, for example,

the technician in a laboratory who draws the blood or the nurse who carries out a specific test, such as measuring blood pressure, which was ordered by another health professional, as these individuals are considered not to be exercising independent judgment and to be under immediate supervision. In the former case, the pathologist is the provider, and in the latter case, the health professional who ordered the test is the provider, even if he or she has no direct contact with the patient when the service is delivered. Pharmacists and suppliers of appliances and equipment are not considered to meet the definition of a provider in this data set.

Additional Provider Data Element

The Subcommittee and Interagency Task Force also recommend collecting, where feasible, an additional data element to identify the health professional provider who initiated the encounter if different from the provider who delivered or was responsible for the services delivered. This item is considered useful for both quality and utilization review and sufficiently important to be part of the core set of recommended items. This initiating or ordering health professional may be responsible, on a continuing basis, for developing and managing the plan of care for the patient or, more simply, may have made an initial referral to another health professional for assessment, treatment, therapy, or laboratory tests. Examples would include the physician who prescribed the physical therapy, who ordered the laboratory tests, or who referred the patient to another specialist. Certain problems are recognized with collecting the item. For example, the provider of services may not always have access to the initiating provider's numeric identifier. Confidentiality issues could be a factor, although automated systems should be able to associate a provider's name with his or her numeric identifier. Furthermore, the continuing role of the initiating provider in the patient's course of care will be ambiguous in the data set without further detail and record linkage. At a minimum, it may be useful at least to know that the services were ordered or the patient was referred by another provider. It is recommended that this additional item be tested for utility and feasibility where it is not currently being collected.

B. Ambulatory Care

Ambulatory health care comprises services provided to patients who are neither hospitalized nor institutionalized as inpatients in a health care facility that is the site of the encounter.

As an example, a physician visit to a nursing home patient at a nursing home would be considered inpatient care, whereas that same patient's visit to the physician's office would be defined as ambulatory care. In order to operationalize this definition it may be necessary to identify specifically which institutions constitute health care facilities and which do not, falling more in the category of residential or custodial care. The definition also has implications for a health care facility to maintain a record for a visit to an inpatient by an outside provider or for adequate linkage of records between institutions and providers. For further detail, see the discussion on place or site of encounter.

C. Encounter

An encounter is a professional contact between a patient and a provider who delivers services or is professionally responsible for services delivered to a patient.

A professional contact occurs between a patient and a provider when the patient is physically present or when the provider is analyzing a specimen or interpreting an image of the patient for the referring physician. Thus, an encounter occurs when a patient receives ancillary services through a separate provider when those services are not captured at the time of the original encounter with the provider ordering the services. A professional contact also can occur between a patient and provider on the telephone and by other communication mechanisms from remote sites, but data system policies may differ on whether such a contact constitutes an encounter and what data elements should be recorded or collected for these contacts. A provider conference with a collateral, e.g., the parent of a patient who is a child, irrespective of who initiates the contact, could be considered an encounter. In cases of family systems therapy, where multiple family members are present, an encounter should be counted for each of the family members, even if only one bill is generated. On the other hand, provider consultation with another provider about a patient in the absence of the patient or referral of the patient to another provider is not considered an encounter. Provider consultation with a third party for the purpose of developing and obtaining services for a patient, e.g., a case manager seeking housing arrangements for a patient or a provider complying with preadmission certification requirements for a patient, can represent appropriate services but should not be considered an encounter. For purposes of this data set, receiving services from a pharmacist or a supplier also does not constitute an encounter.

Uniform Ambulatory Care Data Set

The recommended data set for ambulatory care follows. It represents the outcome of Subcommittee and Interagency Task Force meetings as informed by consultation with the broader community of data users. Differences in content or definition from the 1981 data set are described.

Patient Data Items

1. Personal Identification

- a. Name: Surname, first name, and middle name or initial.
- b. Numeric: A unique number for the individual that links personal characteristics of the person to all services received by the person within a health care system and across systems when services are covered under a third-party (government or private) reimbursement or funding arrangement.

Comment: a. Name: The 1981 data set specifies "Surname, first name, and middle initial." This revision suggests middle name rather than

initial, where available and feasible to collect, to further facilitate patient identification and record linkage. Individual users may decide that they need more detail, such as maiden name. Additional information probably will be needed for reimbursement applications and coordination of benefits, such as the insured's name if different from the patient's name, and the relationship of the insured to the patient. The designation and definition of these items currently is under the purview of the Uniform Claim Form Task Force, and the Subcommittee and Interagency Task Force endorse uniformity in developing these items.

- b. **Numeric:** The ability to link services for the individual across health care systems and reimbursement mechanisms is considered an extremely important goal. It is recognized that replacement of the multiple numbers now in use by a unique identifying number for each individual, applicable regardless of health care source or third-party arrangement, is complex. The Subcommittee and Interagency Task Force support the statement in the 1981 data set that a convenient number for this purpose would be the social security number, with a modifier, as necessary, for patients without their own numbers to enhance individual identification of recipients of health care. The social security number, for the most part, is unique and lifetime; and the trend is towards its broader use, including in the Medicare Program. However, the Subcommittee and Task Force recognize certain statutory prohibitions on the mandatory collection of social security number by Government agencies and totally support the need to protect personal privacy whatever numeric identifier is used. When the use of social security number is not feasible, other constructions for unique identification will need to be devised, but it must be recognized that these could require a new bureaucracy and considerable additional expense.

2. Residence (usual residence, full address, and zip code)

Comment: The item should relate to the usual residence, although the record may also contain a temporary address. Provision needs to be made for changes in usual residence. Depending on the needs of the particular data system, it may also be advisable to obtain a second forwarding address or permanent address if different from the usual address. Reimbursement applications will also require the insured's address if different from the patient's. The address should be in sufficient detail (street name and number, city or town, county, State, and Zip Code) for followup or outreach. The information also is becoming increasingly important for conducting population-based analyses for policy purposes. The five-digit Zip Code is the minimum required, but the nine-digit Zip Code is considered desirable. Data systems, where it is useful, should make provision for collecting nine digits. It should be recognized that "county" may not be captured on an encounter form, but a system should have the capability to compute county and metropolitan statistical area (MSA) from the address. For persons with no fixed address, at least the city in which the care was rendered should be noted.

3. Date of Birth (month, day, year)

Comment: A minimum of three digits are required for year. If birth date is not known, interpolate year of birth from age. For reimbursement applications, insured's birth date and birth date of spouse may both be required.

4. Sex

- a. Male
- b. Female

5. Race and Ethnic Background

a. Race:

- (1) American Indian/Eskimo/Aleut
- (2) Asian or Pacific Islander
- (3) Black
- (4) White
- (5) Other Race

b. Ethnicity

- (1) Hispanic Origin
- (2) Not of Hispanic Origin

Comment: The above categories are those used by the Department in the Uniform Hospital Discharge Data Set (UHDDS) and the Long-Term Care Minimum Data Set and are recommended to try to maintain comparability between institutionalized and ambulatory patients. The Department specifically uses the category American Indian/Eskimo/Aleut rather than the Office of Management and Budget (OMB) category of American Indian or Alaskan Native, because Alaskan Native can include American Indians and could also be considered anyone born in Alaska. The Subcommittee notes that the ethnicity identifier is an indication of Hispanic origin rather than a generic classification of ethnicity and that some localities may want to collect additional information on ethnic origin. To the extent that finer distinctions can be made within a particular racial or ethnic group that will enhance the analyses, it is also desirable, as long as such categories can be aggregated into the basic categories designated above. For example, within Hispanic origin, it often is useful to differentiate among Mexican Americans, Cubans, and Puerto Ricans. The OMB states that a person's racial and/or ethnic background is determined by the way in which the person chooses to be identified in his or her community. Nonetheless, it is known that some providers record this item based on observation. It is recognized that there often are problems collecting accurate racial and ethnic identifiers and that the data only can be collected as permitted by law, but the information is considered important and useful for a variety of analytic purposes. This is one of the items that may not need to be collected at every encounter if it is available for abstraction from the patient's health care record or contained in an enrollment file.

6. Living arrangement and marital status (optional)

The Subcommittee and Interagency Task Force recognize that a person's social support system can be an important determinant of his or her health status, access to health care services, and use of services. Frequently, marital status and/or living arrangement are used as surrogates for the social support system available to a patient. It is recommended that, when this information is needed for program design, targeting of services, utilization and outcome studies, or other research and development purposes, the following definitions should be used for living arrangement and marital status. In terms of measurement of social support the item on living arrangement will have greater utility than the item on marital status. However, the ultimate selection of items needs to be made on the basis of the context and purpose of the data collection.

Living Arrangement

- a. Alone
- b. With spouse (alternate: with spouse or unrelated partner)
- c. With children
- d. With parent or guardian
- e. With relatives other than spouse, children, or parents
- f. With nonrelatives
- g. Unknown

Multiple responses can be made to this item because of living arrangements that are a combination of spouse, children, parents, and nonrelatives.

In those data systems that choose to collect marital status in lieu of or in addition to living arrangement, the following categories should be used:

Marital status

- a. Married—A person currently married. Classify common law marriage as married.
- b. Never married—A person who has never been married or whose only marriages have been annulled.
- c. Widowed—A person widowed and not remarried.
- d. Divorced—A person divorced and not remarried.
- e. Separated—A person legally separated or otherwise absent from spouse.
- f. Unknown.

These categories are mutually exclusive. Cohabitation should be grouped with married unless the purpose of data collection is specifically for health insurance benefit determination.

Longitudinal studies will have the opportunity to examine transitions from one type of living arrangement or marital status to another.

Provider Data Items

An "individual provider" has been defined as a health professional who delivers services or is professionally responsible for services delivered to a patient, who is exercising independent judgment in the care of the patient, and who is not under the immediate supervision of another health care professional. An "encounter" is defined as a professional contact between a patient and a provider during which services are delivered.

The following characteristics should be collected for the provider of record for each encounter. If a user decides to collect the additional provider data element, discussed above under definitions, for the provider who initiated the encounter if different from the provider who delivered or was responsible for the services delivered, consideration also will have to be given to the necessary identification elements required for this item.

7. Provider Identification

- a. **Name:** Surname, first name, and middle name or initial
- b. **Numeric:** A unique number that distinguishes the provider from all other providers and is the same for the provider in all settings where he may be in practice.

- Comment:**
- a. **Name:** As in the case of patient identification, middle name rather than initial is suggested if available and feasible to collect to facilitate provider identification and record linkage.
 - b. **Numeric:** Many providers practice in more than one health care setting. Use of a unique number for each provider will make it possible to identify all of the patients that the provider encounters in various settings and to distinguish his patients from those of another provider in the same setting. A single provider identification number will also benefit the provider, for it can replace the many different numbers with which he may currently identify himself in different situations. At the same time, it is acknowledged that some insurers also require the provider's tax identification number.

The replacement of the multiple numbers now in use by a unique identifying number for each individual provider, applicable regardless of health care source or third-party arrangement, is analogous to the complex situation previously addressed for patient identifiers. The Subcommittee again supports the statement in the 1981 data set that a convenient number for this purpose would be the social security number, with a modifier to indicate that health

services are the object. However, the Subcommittee and Interagency Task Force recognize the Department's current decision not to use the social security number for this purpose and conclude that, if the use of social security number is not feasible, other constructions need to be devised. The Subcommittee and Interagency Task Force further recognize HCFA's current initiative to develop a HCFA- or carrier-assigned number for Medicare providers. However, this effort will apply only to the medical doctors (M.D.'s), doctors of osteopathy (D.O.'s), dentists, optometrists, chiropractors, and podiatrists who treat Medicare patients and will have to be expanded to include all the health professionals who qualify as providers under this data set.

8. Location or Address

(Full address and Zip Code for the location of the office or facility that is the usual or principal place of practice)

Comment: The address should be in sufficient detail (street name and number, city or town, county, State, and Zip Code) for followup or outreach. Where Zip Code is used, it must be five digits as a minimum, but the nine-digit Zip Code is considered desirable, and data systems finding it useful should make provision for collecting nine digits. Systems also should have the ability to compute county and metropolitan statistical area from the address. The provider must make a consistent selection for this item even if he spends his time equally among sites of practice.

9. Profession (the one in which the provider is currently engaged)

- a. Physician (M.D. or D.O.) or Dentist (DDS or DMD)
List specialty and or subspecialty (limit up to three)
- b. Other Licensed or Certified Health Care Professional
List field of practice or specialty
- c. Other Health Care Provider
List self-designated field of practice or specialty

Comment: This element includes both certified and self-designated profession. Categories "b" and "c" are provided for a wide range of personnel who are the principal (or solo) providers at an encounter. Examples are nurse practitioners, health associates functioning as health practitioners, psychiatric social workers, and clinical psychologists. The Subcommittee and Interagency Task Force recognized certain problems with self-designated specialty or subspecialty but did not identify a practical alternative. Development of further guidance for this item would be useful.

Encounter Data Items

10. Date, Place or Site and Address of Encounter, if different from item 8

- a. Date of Encounter: Month, day, and year

Comment: Each encounter generates a date of service related to the other characteristics of the visit. Linking encounters for the same patient determines

when services started, categorizes services into episodes of care, and identifies gaps in prescribed schedules for care. The Subcommittee and Interagency Task Force recognize that, under batch billing, one can lose the specificity of data elements associated with each encounter date; but the objective of these recommendations is to encourage identifying a unique date of record for each encounter. Automated data systems will facilitate this objective.

b. Place or Site of Encounter

(see list which follows)

Comment: The accompanying list is similar to the draft list developed by the Uniform Claim Form Task Force for the HCFA 1500. Inpatient facilities have been retained for completeness. Also, it has been assumed that outpatient services that meet the definition of ambulatory care potentially could take place in most, if not all, of these facilities. Ambulatory care has been defined as services provided to patients who are neither hospitalized nor institutionalized as inpatients in a health care facility that is the site of the encounter. Consideration was given to developing a greatly abbreviated list that would collapse sites into a number of general categories. However, it was decided that it was preferable to retain the specificity and level of detail in the accompanying list, which will permit others to aggregate sites for their own purposes. Furthermore, it was determined that it was necessary at this stage to collect the detailed information in order to make subsequent decisions about aggregations. Greater specificity in definition probably will be needed for several of the sites, and additional sites could be added. Suggestions include 24-hour observation units, involuntary confinement sites, and work-site clinics. Modifications of the draft list include a distinction between freestanding and hospital-based for ambulatory surgical facilities, birthing centers, and hospices; updating of definitions for mental health facilities; substitution of "Home" for "Patient's Home" to reflect generally "care in a private residence," because often patients stay with relatives in lieu of their legal address; and the addition of "Freestanding Walk-in Urgent Visit Center," "Freestanding Radiology Imaging Services Facility," and "Freestanding Clinic." The Uniform Claim Form Task Force did not list these latter facilities, in part because of difficulties with their definitions. No special license or certification are required, and it has been suggested that "these places of service cannot be distinguished from a Clinic, Ambulatory Surgical Center, or other Group Practice." Nonetheless, the Subcommittee and Interagency Task Force felt their separate existence should be reflected in the list. It should be noted that the Subcommittee had recommended previously that a consensus group such as the Uniform Claim Form Task Force evaluate the categories and definitions currently in use for ambulatory sites of care and determine the extent to which standardization is feasible. The efforts of the Uniform Claim Form Task Force in this regard are acknowledged and appreciated.

c. Address of Facility where Services Rendered, when different from item 8

Comment: This is an addition to the 1981 data set. The address should be in sufficient detail (street name and number, city or town, county, State, and Zip Code) for geographic analyses and in some cases, for the essential purpose of obtaining the patient record. Where Zip Code is used, it must be five digits, as a minimum, but the nine-digit Zip Code is considered desirable, and data systems

finding it useful should make provision for collecting nine digits. Systems also should have the ability to compute county and metropolitan statistical area from the address. Although in many cases, this item will be the same as item 8, provider's address, it will be important for various population-based, utilization and access analyses to know the actual location of the encounter when it differs from the provider's usual or principal place of practice.

It was recognized that some data collections also will need to obtain the facility's tax identification number and that this number could have utility for record linkages, for example, in the case of charge data. Further, where services are provided under an organized system of care, there may be interest in obtaining the tax identification number of the organized entity. The latter number could serve three purposes. First, it could facilitate record retrieval when the record is maintained at a central site other than the address of the provider (item 8) or the address of the encounter site (item 10c). Second, it could help distinguish a pattern of unrelated encounters with different individual providers from a series of similar encounters which were provided under an organized system of care. Third, as suggested above, it could help in record linkage where there is a facility charge (see item 16—Total Charges). However, given the policy and legal issues involved in obtaining tax identification numbers, and the time and cost considerations of adding data elements to the core data set, the Subcommittee and Interagency Task Force concluded that items 8 and 10c should satisfy the majority of data needs.

List for Place of Encounter

(1) Office

Location where the health professional routinely provides health examinations, diagnosis, and treatment of illness or injury on an ambulatory basis.

(2) Home

Care in a private residence.

(3) Hospital Inpatient

An institution (other than psychiatric) that primarily provides diagnostic, therapeutic, and rehabilitation services to inpatients for a variety of medical conditions, both surgical and nonsurgical, by or under the supervision of physicians.

(4) Hospital Outpatient

A portion of a hospital that provides diagnostic, therapeutic, and rehabilitation services to sick or injured persons who do not require hospitalization or institutionalization at the time of the encounter.

(5) Hospital Emergency Room

A portion of a hospital where emergent diagnosis and treatment of illness and/or injury is rendered.

(6) Freestanding Clinic

Specific facilities that provide ongoing outpatient medical care, such as Health Maintenance Organization clinics, Neighborhood Health Centers, health department clinics, community health centers, and family planning clinics.

(7) Rural Health Clinic

A certified facility that is located in a rural medically underserved area, under the general direction of a physician, and provides outpatient primary medical care.

(8) Freestanding Walk-in Urgent Visit Center

Facilities that provide initial, urgent medical care or specialized diagnostic services but provide minimal followup services.

(9) Ambulatory Surgical Facility

a. Freestanding

b. Hospital based

A facility used as a setting to provide surgical services on an outpatient basis.

(10) Independent Laboratory

A laboratory certified to perform diagnostic and/or clinical tests independent of a physician's office or hospital.

(11) Freestanding Radiology or Imaging Services Facility

A facility independent of a hospital that provides any one or a combination of such radiology services as diagnostic and/or therapeutic radiology, nuclear medicine, computerized axial tomography (CAT) scan procedures, magnetic resonance services or diagnostic ultrasound, and other imaging services.

(12) Skilled Nursing Facility

An institution that primarily provides inpatient skilled nursing care and related services to patients who require medical, nurse, or rehabilitative services but who do not need the intensive care of an inpatient hospital.

(13) Intermediate Care Facility

An institution that primarily provides health-related care and services to individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide, but, because of their physical condition, require care and services (above the level of room and board).

(14) Custodial Care Facility

A facility that provides room, board, and other personal assistance services generally on a long-term basis, and that usually does not include a medical component.

(15) Birthing Center

- a. Freestanding
- b. Hospital based

A facility that provides a setting for labor, delivery, and immediate postpartum care, as well as immediate care of newborn infants.

(16) Hospice

- a. Freestanding
- b. Hospital based

A facility that provides palliative and supportive care for terminally ill patients and their families. (Use home as place of service for hospice care provided in the home.)

(17) Intermediate Facility Care (Mentally Retarded)

An institution that primarily provides health-related care and services to mentally retarded individuals who do not require the degree of care or treatment that a hospital or skilled nursing facility is designed to provide, but, because of mental condition, require care and services (above the level of room and board).

(18) Outpatient Mental Health Clinic

An organization that provides only ambulatory mental health services on either a regular or emergency basis. The medical responsibility for all patients, clients, and/or direction of the mental health program is generally assumed by a psychiatrist.

(19) Psychiatric Hospital

An entity (public or private) either operated as a hospital by a State (e.g., State mental hospital) or licensed as a hospital by the State (e.g., private psychiatric hospital), which is primarily concerned with providing 24-hour inpatient mental health care to mentally ill patients.

(20) Residential Treatment Center for Emotionally Disturbed Children

An organization whose primary purpose is the provision of individually planned programs of mental health treatment services in conjunction with residential care, primarily to children and youth under the age of 18.

(21) Mental Health Partial Care Organization

A freestanding organization offering only day or evening partial care or partial hospitalization. Partial care or hospitalization is a planned program of mental health treatment services generally provided in visits of 3 or more hours to groups of patients, that may involve intensive short-term therapy and rehabilitation; sustainment, maximization, or socialization through recreation, and/or occupational program activities, including sheltered workshops; and/or education, rehabilitation, and training, including special education classes, therapeutic nursery schools, and vocational training.

(22) **Multiservice Mental Health Organization**

An organization that directly provides inpatient, residential, outpatient, and/or partial care and is not classifiable as a psychiatric or general hospital or as a residential treatment center for emotionally disturbed children.

(23) **General Hospital with Psychiatric Services**

(For use with patients receiving psychiatric services in a hospital inpatient site that is not a psychiatric hospital.) An organization that provides psychiatric services, either in a separate psychiatric inpatient, outpatient, or partial hospitalization service with assigned staff and space or outside of separate psychiatric services, e.g., psychiatric services are provided in a medical-surgical service.

(24) **Residential Substance Abuse Treatment Facility**

A facility that provides treatment for substance (alcohol and drugs) abuse to live-in residents who do not require acute medical care. Services include individual and group therapy and counseling, family counseling, laboratory tests, drugs and supplies, psychological testing, and room and board.

(25) **Comprehensive Outpatient Rehabilitation Facility**

A facility primarily engaged in providing (by or under the supervision of a physician) diagnostic, therapeutic, and restorative services to outpatients on an ambulatory basis for the rehabilitation of injured, disabled, or sick persons.

(26) **Inpatient Rehabilitation Center**

A medical rehabilitation facility that provides diagnostic and inpatient rehabilitative treatment services for disease or injury.

(27) **End Stage Renal Disease Treatment Facility**

A facility that provides dialysis treatment, maintenance and/or training to patients on an outpatient or home-care basis.

(28) **Ambulance**

A vehicle (land, air, or water) specifically designed and equipped for lifesaving and transporting the sick or injured.

(29) **Other Unlisted Facility**

Other service facilities not identified above.

11. Patient's Reason for Encounter (optional)

Includes the patient's stated reason at the time of the encounter for seeking attention or care. This item attempts to define what actually motivated the patient to seek care.

Comment: The Subcommittee and Interagency Task Force recommend this as an optional research item for special studies and consider it particularly useful for the first visit although it may also have selected uses for repeat visits. The patient's reason for an encounter with a provider is not always the sign and symptom pattern recorded by the provider after completion of a sequence of history taking, examination, investigation, and assessment by the provider. Although this sign and symptom pattern might be accurate, it may not explain the patient's concerns and expectations. Capturing such information, where available, can contribute to utilization, quality of care, and epidemiologic studies and should improve the ability of the provider and the health care system to understand the relationship between the patient's perceived need and the provider's decisions regarding this need. It may eventually result in information relative to the natural history of disease and changes in health seeking behavior.

Several systems have been tested and used for coding the patient's reason for encounter and should be considered for retrieval, further testing, and analysis of this information by data systems. These coding systems include the International Classification of Primary Care developed by a working party for the World Organization of National Colleges, Academies, and Academic Association of General Practitioners/Family Physicians and the Reason for Visit Classification used in the National Ambulatory Medical Care Survey conducted by the National Center for Health Statistics.

12. Problem, Diagnosis, or Assessment

Describes all conditions requiring evaluation and/or treatment or management at the time of the encounter as designated by the provider. It is recommended that the standard coding convention for this purpose should be the widely used International Classification of Diseases and, if existent, its clinical modification (currently ICD-9-CM), with all codes available for use. This approach should accommodate the coding of symptoms, ill-defined conditions, and problems when a firm diagnosis has not been established.

The condition that should be listed first is the diagnosis, problem, symptom, or other reason for encounter shown in the patient's health care record to be chiefly responsible for the ambulatory medical care services provided during the encounter. List additional codes that describe any co-existing conditions. Do not code diagnoses documented as "probable," "suspected," "questionable," or "rule out" as if they are established. Rather, code the condition(s) or symptom(s) to the highest degree of certainty for that encounter.

Comment: It is recognized that data systems that currently are not capturing this information will require an implementation phase, but the item is considered essential for any ambulatory care data set. Information on all patient problems and diagnoses requiring attention at the encounter are needed to assess the quality of care delivered, to determine what types of health problems are being seen and treated in the different types of ambulatory care facilities, and for

assessing the appropriateness of the setting used to perform the services. Information on multiple diagnoses is important for developing severity indexes and assessing resource requirements and use. Clear guidelines are needed for recording this item in the ambulatory setting. These guidelines should endeavor to assure collection of data that can be compared in all settings.

13. Services

Describe all diagnostic services of any type including history, physical examination, laboratory, x ray or radiograph, and others that are performed pertinent to the patient's reasons for the encounter; all therapeutic services performed at the time of the encounter; and all preventive services and procedures performed at the time of the encounter. Also, describe, to the extent possible, the provision to the patient of drugs and biologicals, supplies, appliances and equipment.

The diagnostic, therapeutic, and preventive services should be captured in connection with the encounter where they are provided. The HCFA Common Procedure Coding System (HCPCS), which is based on CPT-4 for physician services and has been augmented for nonphysician services, currently is the most inclusive coding system for fostering uniformity in reporting these services. Drugs and biologicals will, in most cases, be provided by pharmacists; and supplies, appliances, and equipment usually are provided through specialized suppliers. Because neither pharmacists nor suppliers meet the data set's definition of a provider, provision of services through these individuals will not be interpreted as constituting an encounter. Thus obtaining information on these services will require linkage of encounter records with records maintained or generated by the respective pharmacist or supplier. Currently, HCPCS only includes information on injectable medications, and there is no universally adopted system for coding other drugs and biologicals. However, given the passage of the Medicare Catastrophic Coverage Act of 1988, the development of such a system is anticipated. When this system is established, the ability to link patient encounter records with it is desirable. When information on durable medical equipment, prosthetics, and orthotics is captured, it is recommended that HCPCS, which includes codes for many of these services, be used. If provision of these services generates a bill, patient encounter records can be linked with these bills.

Although this is considered optional, if a data system finds it useful to know whether or not medications were prescribed as a screen for linking with a pharmaceutical data file, a simple "yes" or "no" item can be added to the data set, as follows:

Were medications prescribed at this encounter?

- 1) Yes
- 2) No

Where linkage is not feasible and information on medication therapy either ordered or provided at the encounter is required by a data system for purposes of research and analysis, either an open-ended question on new and continued medications or a tailored checkoff list of medications should be developed to meet the specific needs of the data system.

Although data systems based on billing records only will contain information about services actually provided, the patient health care record also should include notation of services prescribed or ordered by the provider.

Comment: This item aggregates the three separate items for diagnostic, therapeutic, and preventive services contained in the 1981 data set. Distinctions among these three types of services were considered ambiguous and unnecessary for the purposes of the data set. The 1981 data set recommended also recording all services ordered or scheduled but not performed at the time of the encounter. Although these services should be recorded in the patient's health care record, it is considered impractical from the point of view of data collection to capture for an individual encounter any services other than those actually performed or delivered at the encounter. The expansion of the definition of a provider to include providers of ancillary services and providers of other services ordered at the encounter, such as physical therapy, enables this modification from the 1981 data set and should permit services to be associated with the provider who delivered them. The important issues will be the ability to link all services actually received by a given patient, to reconstruct the sequence of events, to avoid double-counting, and to address the goal of constructing episodes of care, where appropriate. For example, a patient might be receiving several services from more than one professional who are billing separately, but under a plan of care established by one of the providers. The recommended additional provider item to identify the ordering or initiating provider will facilitate this information development. Further, full advantage should be taken of all codes available in HCPCS to capture information on new patients versus established patients, initial visits and followup visits, referrals, and consultations.

14. Disposition

The provider's statement of the next step(s) in the care of the patient. As many categories as apply should be reported. At a minimum, the following classification is suggested.

- a. No followup planned
- b. Followup planned
 - (1) Return anticipated as necessary but not scheduled.
 - (2) Return to the current provider at a specific date.
 - (3) Telephone followup.
 - (4) Returned to referring provider.
 - (5) Referred to other individual provider.
 - (6) Referred to other provider for consultation.
 - (7) Referred to an adjunctive provider agency.
 - (8) Transferred to other individual provider.
 - (9) Admit to acute care hospital.

(10) Admit to residential health care facility.

(11) Other.

Comment: Home health care and rehabilitative care agencies are examples of adjunctive provider agencies. Data users may choose to make finer distinctions where the information is available, and it will add to their administrative and research purposes.

15. Patient's Expected Sources of Payment

a. Primary source

The primary source that is expected to be responsible for the largest percentage of the patient's current bill.

b. Secondary Source

The secondary source, if any, that will be responsible for the next largest percentage of the patient's current bill.

c. Other Source(s)

The categories for primary, secondary, and other sources are as follows:

- (1) Blue Cross and Blue Shield.
- (2) Other health insurance companies.
- (3) Other liability insurance.
- (4) Medicare.
- (5) Medicaid.
- (6) Workers compensation.
- (7) Self-insured employer plan.
- (8) Health Maintenance Organization (HMO).
- (9) CHAMPUS.
- (10) CHAMP VA.
- (11) Other government payers.
- (12) Self-pay.
- (13) No charge (free, charity, special research or teaching).
- (14) Other.

Comment: The above categories are consistent with those used in the current Uniform Hospital Discharge Data Set with a further breakout for other liability insurance, self-insured employer plan, health maintenance organization (HMO), CHAMPUS and CHAMP VA. The addition to the data set of a secondary source of payment and a possible third and other sources reflects the increasing interest among private and public insurers in coordination of benefits. This information is more likely to be available from registration forms and billing records than from the patient's health care record. It is recognized that as the expected source(s) at

the time of the encounter, this information has limitations and may overstate some categories and understate others. However, it is still considered useful to collect for trend purposes and for some indication of patients' coverage by third-party payers. For utility in reimbursement applications, actual policy numbers will be necessary to collect and would verify basic coverage if not coverage for specific services.

d. Payment mechanism (related to this service)

- (1) Fee-for-service.
- (2) HMO or pre-paid plan.
- (3) Unknown or unidentified.

Comment: The 1981 data set included some information on payment mechanism under both type of practice and expected source of payment. This revision recommends creating a separate item for this information under expected sources of payment. Where the information can be obtained and it is considered useful for research purposes, data collectors may want to gain more detail about the payment arrangement, such as preferred provider organizations, independent practice associations, and comprehensive medical plans. However, such detail is unlikely to be available on a routine basis.

16. Total Charges

All charges for procedures and services rendered to the patient during this encounter. This includes a technical component or facility fee when billed separately from the professional component.

Comment: Patient health care records, from which most other components of the ambulatory care data set are to be captured, do not usually include fiscal information. However, in most ambulatory care settings, information on charges associated with the encounter can be obtained as a byproduct of the billing activity, offering the only readily available approximation of the fiscal dimensions of ambulatory care services. As in the case of services, this item has been limited to charges for services rendered by the provider during the encounter, in contrast to the 1981 data set, which also attempted to capture charges for procedures and services ordered during the encounter. It is recognized that this item is difficult to capture in a uniform way and often will involve linkages of records, particularly when a technical or facility component is billed separately from the professional component. Further, the data set may not include all the information necessary for making these linkages and, in these cases, the total charges obtained will be a partial or undercount. Nonetheless, the Subcommittee and Interagency Task Force believe that charges represent an important element in most data systems and encourage research and developmental work that will enhance the utility of the data collected.

To the extent possible, it would be considerably more valuable to obtain a breakdown of itemized charges associated with specific services. Further, linkage with administrative records would permit subsequent collection of *allowed* charges or benefits by type of service, which may be useful information for some applications.

Charge data linked with information on patient characteristics, provider characteristics, and the encounter could, if uniformly and systematically collected, yield substantially improved aggregate information on the scope, characteristics, and distribution of ambulatory care charges; and provide the sampling frame required for more profound and sophisticated ambulatory care cost investigations that are needed to determine actual costs, make cost comparisons, and develop and monitor cost-related policies.

History of Uniform Ambulatory Care Data Set Major Milestones

- 1969: National Conference on Hospital Discharge Abstract Systems, leading to development of the Uniform Hospital Discharge Data Set.
- 1972: Conference on Ambulatory Medical Care Records (Chicago) developed minimum data set for inclusion in all patient records.
- 1973: National Committee on Vital and Health Statistics (NCVHS) established Technical Consultant Panel to review initial ambulatory care minimum data set.
- 1974: The National Committee on Vital and Health Statistics (NCVHS) approved revised recommended minimum data set, published in 1976 in *Ambulatory Medical Care Records: Uniform Minimum Basic Data Set. A report of the United States National Committee on Vital and Health Statistics*, DHEW Pub. No. (HRA)76-1453, Series 4, No. 16.
- 1975: Methodological development and testing project conducted in a sample of 16 group practices under the sponsorship of National Center for Health Statistics. NCVHS established second Technical Consultant Panel to reevaluate minimum data set.
- 1980: NCVHS approved and transmitted to the Secretary revised minimum data set, published in 1981 in *Uniform Ambulatory Medical Care Minimum Data Set*, DHHS Pub. No. (PHS) 81-1161.
- 1984: NCVHS established Subcommittee on Statistical Aspects of Physician Payment Systems.
- 1986: NCVHS approved and transmitted to the Assistant Secretary for Health the report of the Subcommittee, published in 1987 in *Statistical Aspects of Physician Payment Systems*, DHHS Pub. No. (PHS) 87-1461, Series 4, No. 24.
- 1987: NCVHS established Subcommittee on Ambulatory Care Statistics, and the Department of Health and Human Services established Interagency Task Force on the Uniform Ambulatory Medical Care Minimum Data Set.
- 1987-89: Subcommittee and Interagency Task Force held series of separate and joint meetings.

NCVHS Subcommittee on Ambulatory Care Statistics presented Interim Report at NCVHS meeting on June 1-3, 1988.

Subsequent meetings of Subcommittee and Interagency Task Force reviewed and refined Interim Report. The two groups reached consensus on a single final report with separate transmittals.

Report circulated to agencies within the Department and to interested external organizations for comment March-April 1989.

Subcommittee and Interagency Task Force met on May 2, 1989, to address all comments.

Final report submitted to NCVHS and to the Department in June 1989.

The history of the Uniform Ambulatory Care Data Set begins with participation in the 1972 Chicago Conference on Ambulatory Medical Care Records. That action was, in turn, stimulated by the earlier National Conference on Hospital Discharge Abstract Systems of June 1969. One of the main conclusions of the 1972 Conference participants was as follows: "We believe that the first and most important steps now are to identify the basic core of data germane to all functions served by ambulatory care data and to introduce uniform terms, definitions, and classifications for this data set. A major concern of the Conference is the proliferation of different ambulatory medical record and reporting systems being introduced by federally sponsored health programs, by medical foundations and institutions, and by commercial data processing companies. We propose that a minimum uniform basic data set form a part of each patient's medical record, so that it will be universally available for abstracting, reporting and analysis." At the close of the conference the U.S. National Committee on Vital and Health Statistics (NCVHS) was asked to refine and develop a uniform minimum basic data set to appear in ambulatory medical care records and to specify formats for recording information for each item in the data set.

In 1973 the National Committee identified a technical panel of 12 consultants on Ambulatory Medical Care Records. Their report, approved in 1974 by the NCVHS, was published in 1976, entitled *Ambulatory Medical Care Records: Uniform Minimum Basic Data Set A report of the United States National Committee on Vital and Health Statistics*, DHEW Pub. No. (HRA) 76-1453, Series 4, No. 16.

The following statement was made in the foreword of that document by Abraham M. Lilienfeld, M.D.: "In selecting and defining this minimum basic data set, the consultants were guided by two types of purposes that are served by the maintenance of ambulatory medical care records: (1) the improvement of ambulatory patient care; and (2) a variety of management, planning, educational, and research uses that can be carried out only when data have been abstracted from records and analyzed. Although the consultants' decisions on items to be included in the data set were influenced by the data needs for the second type of purposes, they have not specified the subset of the items on which data would need to be abstracted, assembled for groups of patients, and analyzed to serve any particular purpose."

During 1975, a methodological development and testing project was conducted in a sample of 16 group practices under the sponsorship of the National Center for Health Statistics (NCHS). In that same year, the NCVHS established a second technical consultant panel to reevaluate the minimum data set. In 1980, the NCVHS approved and transmitted to the Secretary the panel's revised data set, which was published in 1981 in *Uniform Ambulatory Medical Care Minimum Data Set*, DHHS Pub. No. (PHS) 81-1161. The charge to that second panel was as follows:

1. "To review terms, definitions, and classifications currently approved by the NCVHS for the Uniform Ambulatory Medical Care Minimum Data Set (UAMCMDs).
2. "To consider the UAMCMDs in relationship to multiple needs including at least Federal health programs and federally-funded health programs: statistical

purposes; utilization review; PSRO use; health planning; the Cooperative Health Statistics System; and epidemiological, evaluative, and clinical research; and to potentiate the provision of primary health care services to communities.

3. "To recommend formats, timing, and circumstances for capturing and recording data elements and for the flow of the data thru information brokers, data processors, State centers for health statistics, and other units responsible for sampling, aggregating, and tabulating the data.
4. "To recommend a format to be used for the UAMCMDS.
5. "To recommend the use of coding and classification schemes for appropriate items of the UAMCMDS.
6. "To recommend solutions for the problems of geographic coding so that jurisdictions can be accommodated.
7. "To recommend mechanisms for revising the UAMCMDS and the periodicity for such revisions.
8. "To make other recommendations relative to the promulgation and implementation of the UAMCMDS.
9. "To consider problems of confidentiality."

The third look at ambulatory care data, reflected in this document, again was initiated by the National Committee on Vital and Health Statistics and began with the work of the Subcommittee on Statistical Aspects of Physician Payment Systems in 1984. That work is documented in a report entitled *Statistical Aspects of Physician Payment Systems*; DHHS Pub. No. (PHS) 87-1461, Series 4, No. 24. The report notes that, after two decades of documenting utilization and costs of inpatient care, both public and private insurers have suddenly been confronted with an enormous shift in patient care from inpatient to outpatient settings. This change caused Medicare administrators to give a priority to the development of Part B Medicare Annual Data (BMAD). The Subcommittee cited the importance of that step and strongly recommended the need for review of ambulatory care in other settings and programs, particularly with respect to precare and aftercare. They reported:

"It is timely to undertake a full review of the adequacy of the Uniform Ambulatory Medical Care Minimum Data Set. The current data set defines those items that should be entered in the records of all ambulatory health care. A revision should bring the data set into accordance with the Uniform Hospital Discharge Data Set by also specifying those items which should be abstracted uniformly from existing records. The increasing interest in comparable ambulatory care data bases with standardized definitions, evidenced by the presentations made before the subcommittee, supports the reassessment of the Uniform Ambulatory Medical Care Minimum Data Set at this time. Significant changes in the care delivered in ambulatory settings and in the requirements for data have occurred since the last review and revision . . . This review and revision process

should be carried out by the National Committee on Vital and Health Statistics and, concurrently, by an interagency task force established within the Department.”

The Subcommittee on Ambulatory Care Statistics was created specifically to respond to this mandate and to provide liaison with the Interagency Task Force on the UAMCMDS, which was established by the Assistant Secretary for Health in the spring of 1987 to carry out the departmental review of the data set. The charges of the Subcommittee and the Interagency Task Force are contained in the next section. From the beginning of their deliberations, the Subcommittee and the Interagency Task Force, which was chaired by the Health Care Financing Administration, have worked in close parallel. Both of the groups' interim and final reports were timed to coincide, with the intent to complete the parallel reviews and recommend a revised data set by June 1989. The working relationship between them was congenial, extremely helpful, and resulted in strengthening both efforts. Whereas the Task Force was charged with ascertaining the data needs of departmental agencies, the Subcommittee reviewed the data set from the broader perspective of other governmental agencies, the research community, and the private sector.

The Subcommittee met with members of the Interagency Task Force in a working session on April 16–17, 1988, to develop a first draft of a revision to the 1981 version of the Uniform Ambulatory Medical Care Minimum Data Set. The Subcommittee's reconsideration of the data elements and definitions in that data set up to that point resulted in a proposed revision, contained in the Subcommittee's Interim Report of May 1988. This interim report was presented at the NCVHS meeting of June 1–3, 1988, and was the basis of discussions at the June 28 and July 19, 1988, meetings of the Interagency Task Force. These further discussions set the ground work for the meeting of the Subcommittee with Task Force members on August 15–16, 1988. The tentative conclusions reached at that meeting, with some additional input from the September 20, 1988, meeting of the Interagency Task Force, were reflected in two revised documents, dated September 8 and September 29, respectively. A further revision was the result of the Subcommittee meeting held October 3, 1988, and contained preliminary recommendations for all of the data elements.

During a meeting on December 20, 1988, the Interagency Task Force reached consensus that its report and that of the NCVHS Subcommittee should describe the same core data set. The Task Force agreed to continue working with the Subcommittee on finalizing the data elements and definitions for a new Uniform Ambulatory Care Data Set and on development of a common final report based on the Subcommittee's interim report. These joint efforts continued at the Subcommittee's meeting on January 12–13, 1989, and subsequent Task Force meetings on January 17 and February 16, 1989. In March the Interagency Task Force submitted the draft of the final report to the Assistant Secretary for Health for informal circulation to agencies within the Department for comments. Concurrently, the Subcommittee sent the draft report to the extensive list of external organizations and individuals who had shown a continuing interest in the work of the Subcommittee. On May 2, the

Subcommittee and Interagency Task Force held a joint meeting to discuss all comments received from the agencies and the external reviewers. The report was then finalized for transmittal to the NCVHS and the Department in June 1989.

Charge to Subcommittee on Ambulatory Care Statistics

1. Conduct a thorough and systematic review of the Uniform Ambulatory Medical Care Minimum Data Set (UAMCMDS) for the purpose of developing a revised version which meets current and anticipated needs. Carry out this review by receiving appropriate input from other governmental agencies, the research community, and the private sector.
2. Serve as liaison to the departmental interagency task force established to review the UAMCMDS from an internal perspective, comment on task force reports and deliberations, and react to task force recommendations.
3. Monitor and review the efforts of the Uniform Claim Form Task Force to investigate the definitions currently in use for place or site of ambulatory medical care service and to seek greater standardization in these definitions. Assure the timely input of other departmental agencies with related data activities into this process.
4. Provide continuing liaison with the Health Care Financing Administration, the National Center for Health Statistics, and other relevant agencies concerning the statistical aspects of physician payment systems and other data systems covering patient-provider encounters in ambulatory medical care settings.
5. Monitor these data systems and related activities by receiving periodic updates, having an opportunity to react to developments, and, where appropriate, framing recommendations concerning their future course.
6. Prepare an interim report to the National Committee on Vital and Health Statistics on the UAMCMDS by June 1988 and a final report by June 1989.

Charge to the Interagency Task Force on the Uniform Ambulatory Care Data Set

1. Conduct a thorough and systematic review of the Uniform Ambulatory Medical Care Minimum Data Set (UAMCMDS) for the purpose of developing a revised version that meets current and anticipated needs of the Department of Health and Human Services (DHHS).
2. Carry out the review of the UAMCMDS by receiving appropriate input from DHHS agencies and other DHHS task forces dealing with uniform minimum health data sets.
3. Serve as liaison to the Subcommittee on Ambulatory Care Statistics, which has been established to review the UAMCMDS from a Government-wide and private sector perspective. Comment on Subcommittee reports and react to Subcommittee recommendations.
4. Provide continuing liaison with other subcommittees dealing with patient-provider encounters in ambulatory medical care settings, e.g., Subcommittee on Long-Term Care Statistics and Subcommittee on Medical Classification Systems.

7. Prepare an interim report to the National Committee on Vital and Health Statistics (NCVHS) on the UAMCMDS by June 1988.
8. Prepare a draft report on the UAMCMDS by December 1988 and prepare a final report to the NCVHS by April 1989. The final report must be submitted to the NCVHS not later than June 1989.

National Committee on Vital and Health Statistics Subcommittee on Ambulatory Care Statistics

Chairman (June 1987–June 1988)

Carmalt B. Jackson, Jr., M.D.
Medical Advisory Services
16902 Hidden Timber Wood
San Antonio, Texas 78248

Robert L. Mullin, M.D.
Director of Continuing Care
Hospital of Saint Raphael
1450 Chapel Street
New Haven, Connecticut 06511

Chairman (June 1988–)

William R. Felts, Jr., M.D.
Professor of Medicine
George Washington University
Medical Center
2150 Pennsylvania Avenue, NW
Washington, D.C. 20037

Bruce Steinwald
Deputy Director
Prospective Payment Assessment
Commission
300 7th Street, SW, Suite 301-B
Washington, D.C. 20024

Staff

Members

Judith Miller Jones
Director
The National Health Policy Forum
2011 I Street, NW, Suite 200
Washington, D.C. 20006

Marjorie S. Greenberg, NCHS
Jim Delozier, NCHS

Alan Bradt, HCFA (June 1987–June 1988)

Stephen King, M.D, HCFA
Frank Kirby, HCFA
Janet Wise, HCFA
Mary B. Cooper, HCFA

William H. Kirby, Jr., M.D.
Principal, Health Management
Services, Inc.
401 Walpole Court
Timonium, Maryland 21093

DHHS Interagency Task Force on the Uniform Ambulatory Care Data Set

Chairman (June 1987–October 1988)
Frank Kirby
Health Care Financing Administration
Bureau of Data Management and
Strategy

Office of Statistics and Data
Management
GD2, Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Chairman (October 1988-)

Stephen King, M.D.
Health Care Financing Administration
Bureau of Eligibility, Reimbursement
and Coverage
181 East High Rise
6325 Security Boulevard
Baltimore, Maryland 21207

Members

Mary Cooper
Health Care Financing Administration
Bureau of Eligibility, Reimbursement
and Coverage
Room 1J2 East Low Rise Building
6325 Security Boulevard
Baltimore, Maryland 21207

Paul Cromwell
Office of the Assistant Secretary for
Management and Budget, OS
Room 532H, Hubert H. Humphrey
Building
200 Independence Avenue, SW
Washington, D.C. 20201

James Delozier
National Center for Health
Statistics, PHS
Room 2-43, Federal Center Building
3700 East-West Highway
Hyattsville, Maryland 20782

Irene Edmonds
Indian Health Service
Room 5-A-12, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

George Greenberg
Office of the Assistant Secretary for
Planning and Evaluation, OS
Room 432E, Hubert H. Humphrey
Building
200 Independence Avenue, SW
Washington, D.C. 20201

Marjorie S. Greenberg
National Center for Health
Statistics, PHS
Room 2-12, Federal Center Building
3700 East-West Highway
Hyattsville, Maryland 20782

Frank Kirby
Health Care Financing Administration
Bureau of Data Management and
Strategy
GD2, Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

Ronald Manderscheid
Alcohol, Drug Abuse, and Mental
Health Administration, PHS
Room 18C-07, Parklawn Building
5600 Fishers Lane
Rockville, Maryland 20857

Lon White
National Institute on Aging, PHS
Room 612, Federal Building
7550 Wisconsin Avenue
Bethesda, Maryland 20205

Janet Wise
Health Care Financing Administration
Bureau of Data Management and
Strategy
Office of Statistics and Data
Management
GD2, Meadows East Building
6325 Security Boulevard
Baltimore, Maryland 21207

