Uniform Hospital Discharge Data Set and Abstracting Patient Records

Speaker: Sarah Cottington

The Uniform Hospital Discharge Data Set, which is referred to as the 'UHDDS,' is the core data set for inpatient admissions. The data is collected on inpatient hospital discharges for Medicare and Medicaid programs. Much of the required information can be located on the patient's face sheet.

The goal of UHDDS is to obtain uniform comparable discharge data on all inpatients. The date elements can be categorized into four major categories: patient identification, provider information, clinical information of the patient episode of care, and financial information.

The official data set consists of the following information:

- Personal Identification/Unique Identifier – The primary identifier is used by the facility to identify the patient at admission (medical record number).
- Patient Name – This should be the patient legal name, including surname, given name, middle name or initial.
- Patient's Date of Birth – This should be in the format of year, month, and day of birth (entered as – YYYYMMDD).
- Gender – This should be noted as male, female, unknown, or undetermined.
- Race and Ethnicity – Race is a concept used to differentiate population groups largely on the basis of physical characteristics transmitted by descent. Races currently used by the government for statistical purposes are American Indian or Alaskan Native, Asian or Pacific Islander, Black, White, and Unknown. Ethnicity is a concept used to differentiate population groups on the basis of shared cultural characteristics or geographical origins. Ethnic designations currently used by the government for statistical purposes are Hispanic origin, not of Hispanic origin, and Unknown.
- Residence – This consists of the patient's address or location of residence. Components include the street address, city, state/province, zip or postal code, country, and type of address such as permanent or mailing.
- Health Care Facility Identification Number – This is a unique identification number of the facility where patients seek care. The Centers for Medicare and Medicaid (CMS) have developed a universal identifier system for all healthcare facilities.
- Admission Date and Type of Admission – A categorization of the encounter such as emergency, inpatient, outpatient, home care, or electronic which includes e-mail, Internet, or telemedicine.
- Discharge Date – The date the patient actually left the facility or died.
- Attending Physician Identification – The primary identifier is used by the facility to identify the Physician.
- Surgeon Identification – The primary identifier is used by the facility to identify the patient at surgeon.

- Principal Diagnosis – The principal diagnosis is defined as the condition established after study to be chiefly responsible for occasioning the admission of the patient to the hospital for care.
- Other Diagnosis – Other diagnosis consists of additional diagnosis for which the patient received treatment for and consists of complications and comorbidities.
- Principal Procedure and Dates – The principal procedure can be defined as a procedure that is performed for therapeutic reasons, rather than diagnostic purposes, or to treat a complication, or that procedure which is most closely related to the principal diagnosis.
- Other Procedures and Dates – Other procedures can be defined as additional procedures performed during the inpatient admission.
- Disposition of Patient at Discharge – This includes where the patient was discharged to. Examples include the following: discharged to home, to another acute care hospital, to a nursing facility, to home to be under the care of a home health service, other healthcare facility, or left against medical advice.
- Expected Payer of Most of This Bill – This would be who the facility will bill for the services that were provided to the patient.
- And finally, total charges for the services provided by the facility.

This information is then abstracted into the computer, which generates the main indexes (disease, procedure, and physician) that we have previously discussed in the *Essentials of Health Records* course.
