ABSTRACT

This material provides documentation for users of the Emergency Department public use micro-data file of the 2014 National Hospital Ambulatory Medical Care Survey (NHAMCS). NHAMCS is a national probability sample survey of visits to hospital outpatient and emergency departments, and hospital-based ambulatory surgery centers, conducted by the National Center for Health Statistics. The survey is a component of the National Health Care Surveys, which measure health care utilization across a variety of health care providers.

NOTE: This document contains complete information on emergency department records only, to accompany the release of the emergency department data file.

Section I of this documentation, "Description of the National Hospital Ambulatory Medical Care Survey," includes information on the scope of the survey, the sample, field activities, data collection procedures, medical coding procedures, and population estimates. Section II contains the codebook, which provides detailed descriptions of the contents of the file's data record by location. Section III contains marginal data for selected items on the file. The appendixes contain sampling errors, instructions and definitions for completing the Patient Record form, and lists of codes used in the survey.

SUMMARY OF CHANGES FOR 2014

The 2014 NHAMCS Emergency Department (ED) micro-data file is in general similar in layout to the 2013 file but there are some changes. These are described in more detail below.

Note that the questionnaire changes listed below only address items that are included on the public use data file and do not constitute a comprehensive list of all changes to the automated Patient Record form and automated Hospital Induction Interview forms.

A. Survey Items

1. New or Modified Items on the Automated Patient Record Form

NOTE: The headings and corresponding section locations reflected in the 2014 Emergency Department Patient Record Sample Card may not be identical to those in the automated electronic Patient Record Form. The Sample Card (available at the Ambulatory Health Care Data website) is a general representation of the automated instrument, using a more easily read format that is similar to the original paper forms used in earlier years.

a. Patient information: "Was patient transferred from another hospital or urgent care facility?" was added. It was only to be answered for visits where the patient arrived by ambulance (ARREMS=1).

b. "Expected source(s) of payment for this visit" – The response category of "Medicaid or CHIP" was modified to "Medicaid or CHIP or other state-based program."

Triage:
c. "Was patient seen in this ED within the last 72 hours and discharged" was moved to this section (in 2013, it was part of the "Reason for Visit" section).

d. In past years, up to 3 reasons for visit could be entered for each visit. In 2014, two additional fields were added to make a total of five. The item instruction was revised as follows: "List the first 5 reasons for visit (i.e., symptoms, problems, issues, concerns of the patient) in the order in which they appear, start with the chief complaint and then move to the patient history for additional reasons."

Injury:
e. For this item, "Is this visit related to an injury/trauma, overdose, poisoning, or adverse effect of medical treatment?", wording changes were made to include overdose (in 2013, the item was "Is this visit related to an injury, poisoning, or adverse effect of medical treatment").

f. New item: "Did the injury/trauma, overdose, or poisoning occur within 72 hours prior to the date and time of this visit?" This only displayed in the automated instrument if an injury or poisoning had been indicated.

g. For this item, "Is this injury/overdose/poisoning intentional?", wording changes were made to include overdose (in 2013, the item was "Is this injury/poisoning intentional?"). Also, the 2013 response category of "No, unintentional" was changed in 2014 to "No, unintentional (e.g., accidental).", and the "unknown" category in 2013 was changed to "intent unclear" in 2014.

h. The direction in the write-in field for cause of injury/trauma, overdose, poisoning or adverse effect was expanded to provide more detail: "Describe the place and circumstances that preceded the event. Examples: 1 – Injury (e.g., patient fell while walking down stairs at home and sprained her ankle; patient was bitten by a spider); 2 – Poisoning (e.g., 4 year old child was given adult cold/cough medication and became lethargic; child swallowed large amount of liquid cleanser and began vomiting); 3 – adverse effect (e.g., patient developed a rash on his arm 2 days after taking penicillin for an ear infection)."

Diagnosis:
i. In past years, up to three diagnoses could be recorded. For 2014, two additional "other" diagnosis fields were added to make a total of five.

j. In the section, "Does patient have –", new checkboxes were added for Alcohol abuse, Asthma, Chronic kidney disease (CKD), Depression, End-stage renal disease (ESRD), Hyperlipidemia, Hypertension, Obesity, Obstructive sleep apnea (OSA), Osteoporosis, and Substance abuse.

The category of Dementia used in 2013 was modified to Alzheimer's disease/Dementia. The Diabetes category was expanded into three separate checkboxes: Diabetes mellitus (DM) – Type I, Diabetes mellitus (DM) – Type II, and Diabetes mellitus (DM) – Type unspecified. The category of "History of heart attack" was expanded and modified as Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI). Minor wording changes were made to two categories: "Cerebrovascular disease/History of stroke or transient ischemic attack (TIA)" was changed to "Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA)". "Congestive heart failure" was changed to "Congestive heart failure (CHF)."

Diagnostic services:
k. In the Imaging section, a new item was added: "Was CT ordered/provided with intravenous (IV) contrast?". This only displayed in the automated instrument if a CT scan was reported as ordered or provided.
l. In the Imaging section, a new item was added: "Was MRI ordered/provided with intravenous (IV) contrast (*also written as "with gadolinium" or "with gado"?)"*. This only displayed in the automated instrument if an MRI was reported as ordered or provided.

Medications and Immunizations:
m. The number of medications that could be listed was increased from 12 to 30. (Note that the Sample Card online indicates 16 drugs; this was done to save space).

Vitals signs at ED discharge:
n. This is a new section that collects data on whether vital signs were taken at discharge ("Were vitals taken at discharge?"). If vitals were taken, information about temperature (Celsius or Fahrenheit), heart rate in beats per minute, respiratory rate in breaths per minute, and systolic and diastolic blood pressure measurements was collected.

From the Hospital Induction Interview, modifications were made to several items related to Electronic Medical Records (EMR)/Electronic Health Records (EHR) and several new items were added.

o. New item: Has your hospital made an assessment of the potential risks and vulnerabilities of your electronic health information within the last 12 months?
p. New item: Does your EHR have the capability to electronically send health information to another provider whose EHR system is different from your system?
q. New item: If you ED has the computerized capability for ordering prescriptions, are drug formulary checks performed?
r. New item: Does your ED have a computerized system for ordering radiology tests?

    s. New item: Does your ED have a computerized system for identifying patients due for preventive or follow-up care in order to send patients reminders?

    t. New item: Is the patient health information that you share electronically sent directly from your EHR system to another EHR system?

    u. New item: With what types of providers do you electronically share patient health information (e.g., lab results, imaging reports, problem lists, medication lists)? Ambulatory providers inside your hospital, ambulatory providers outside your hospital, hospitals with which you are affiliated, hospitals with which you are not affiliated, behavioral health providers, long-term care providers, or home health providers. Note that in 2013, this question was broken down into separate items for lab results, imaging reports, problem lists and medication lists and did not collect information on behavioral health, long-term care, or home health providers.

    v. The question: "Medicare and Medicaid offer incentives to practices [Editor's Note: This was an instrument error; the correct wording would have been 'hospitals'] that demonstrate, meaningful use of health IT. Are there plans to apply for these incentive payments?" was modified to: "Does your hospital have plans to apply for Stage 1 of these incentive payments?".

    w. New item: Are there plans to apply for Stage 2 incentive payments?

    x. New item: Does this hospital have an Emergency Medicine residence program? [Editor's Note: This was an instrument error; the correct wording would have been 'residency']

2. Deleted Items

    a. The "On oxygen on arrival" item in the Triage section was deleted.

    b. The chronic condition checkbox "Condition requiring dialysis" was deleted.

From the automated Hospital Induction Interview form, several EMR/EHR items were deleted:

    c. Does your ED have a computerized system for providing patients with an electronic copy of their health information?

    d. Please indicate whether your ED electronically (not fax) shares lab results with hospitals with which your hospital is affiliated, other departments inside your hospital, hospitals with which your hospital is not affiliated, or ambulatory providers outside your hospital?

    e. Please indicate whether your ED electronically (not fax) shares imaging reports with hospitals with which your hospital is affiliated, other departments inside your hospital, hospitals with which your hospital is not affiliated, or ambulatory providers outside your hospital?

    f. Please indicate whether your ED electronically (not fax) shares patient problem lists with hospitals with which your hospital is affiliated, other departments inside your hospital, hospitals with which your hospital is not affiliated, or ambulatory providers outside your hospital?

    g. Please indicate whether your ED electronically (not fax) shares medication lists with hospitals with which your hospital is affiliated, other departments inside your hospital, hospitals with which your hospital is not affiliated, or ambulatory providers outside your hospital?

B. Data Collection and Comparability of 2014 NHAMCS Estimates with 2013 NHAMCS Estimates

Because the 2012 survey year incorporated major changes to the mode of data collection, much research was conducted to assess the comparability of estimates from 2012 with previous years of data. Those results can be found in the 2012 NHAMCS-ED Public Use File Documentation. For 2014, the mode of data collection continued to be the automated laptop-assisted instrument first used in 2012, and additional research was conducted to assess any data anomalies between 2014 and 2013 data.

To accomplish this, more than 20 tables of 2014 estimates were compared with the same tables of 2013 estimates. The variables that were compared included most of those published in the annual survey web tables. Significant changes between the two years were noted and investigated. While many estimates were not statistically different in each year, some unexpected results were found. These may reflect

actual differences, or they may be related to the changes in item format, the new automated data collection system and/or the increase in Census abstraction. Data users are advised to take these factors into account when using these items or comparing them with previous years. Specific findings include the following:

Significant decreases in weighted percentage distributions were noted for some items compared with 2013 data. These include visits with "none of the above" checked for the "Does patient have—" item (from 79.0% in 2013 to 55.1% in 2014); and visits made by patients seen in the same ED within the last 72 hours and discharged (from 13.0% in 2013 to 7.7% in 2014). It should be noted that the number of chronic conditions checkboxes available in the "Does patient have—" item more than doubled for 2014, which likely contributed to the decrease noted above.

Significant increases in weighted percentage distributions were also noted for some items compared with 2013 data. These include visits to a teaching hospital (from 14.9% in 2013 to 18.2% in 2014); percent of visits made by Black of African Americans (from 22.3% in 2013 to 27.3% in 2014); percent of visits with Medicaid/CHIP or other state-based program (from 30.0% in 2013 to 34.9% in 2014)

NCHS staff will continue to monitor these and other changes with regard to 2014 data and beyond in an effort to better assess how much may be attributed to data collection and processing vs. real-world treatment patterns.

C. Sampling Strata and Variance Estimation Issues

NHAMCS currently comprises three components: hospital emergency departments, outpatient departments (OPDs), and ambulatory surgery centers/locations (ASLs). It is important to understand that the first stage of NHAMCS sampling occurs at the geographic level, but the second stage occurs at the hospital level. However, not all hospitals have all three components, and some may choose not to participate in all components, even if they have them. Therefore, it is often the case that not all hospitals participating in NHAMCS are included on the ED file, even though for variance estimation purposes all participating hospitals should be represented (that is, there should be sampling information on the ED public use file for each hospital participating in NHAMCS, in order to obtain the most accurate variance estimation).

In years from 1992-2009, when NHAMCS only included two components (emergency departments and outpatient departments), public use data file users were encouraged to combine the ED and OPD public use files for variance estimation purposes. That ensured that even if not all hospitals were represented on the ED file, the inclusion of records from the OPD file resulted in a complete set of participating hospitals and their sampling design variables.

Starting in 2010, when the ambulatory surgery component was added to NHAMCS, analysis was conducted within the Division of Health Care Statistics to ensure that the sampling design information was complete when combining the ED and OPD public use files, even though the ambulatory surgery file was not yet available (the 2010 ambulatory surgery public use file was released earlier this year). However, starting in 2012, changes to the mode of data collection in NHAMCS led to unforeseen problems in the sampling of OPD clinics and other related issues, which means that NCHS has not yet been able to release OPD public use files for 2012 through 2014.

For 2012 and 2013, internal research was conducted to study the effects of only using ED data, without the accompanying OPD data, on variance estimation. It was found that the effects on variance estimation were not problematic when compared with variance estimation using internal data and non-masked design variables. The effects did not warrant adding additional (dummy) records to the public use file to represent the missing hospitals with OPDs and/or ASLs but not EDs.

For 2014 data, internal research was again conducted, using the same methodology as in 2012 and 2013. The effects of the missing sampling design information were more pronounced in 2014 and may lead to more variances being understated compared with what was found in previous years. For most standard error estimates (approximately 75% of the approximately 400 estimates tested) the differences were small, but the possible understatement in variances for other estimates means a higher likelihood of a Type I error (finding a significant difference in the data that may not actually exist).

In order to decrease the possibility of a Type I error when analyzing the 2014 NHAMCS ED public use file, we recommend that researchers test for significant differences at the alpha=0.01 level, rather than the more commonly used 0.05 level. For questions, please contact the Ambulatory and Hospital Care Statistics Branch at 301-458-4600.

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Appendixes

NOTE: Appendix II and Appendix III are identical to those previously published in the 2014 National Ambulatory Medical Care Survey Public Use File Documentation and are not reprinted here; please use links to access.)

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List of Tables and Figures

I. DESCRIPTION OF THE NATIONAL HOSPITAL AMBULATORY MEDICAL CARE SURVEY

A. INTRODUCTION

The National Hospital Ambulatory Medical Care Survey (NHAMCS) was initiated to learn more about the ambulatory care rendered in hospital emergency and outpatient departments (EDs and OPDs) in the United States. NHAMCS is conducted by the Ambulatory and Hospital Care Statistics Branch of the Division of Health Care Statistics, National Center for Health Statistics (NCHS), Centers for Disease Control and Prevention (CDC). In 2009, hospital-based ambulatory surgery locations were included in the survey and, in 2010, freestanding ambulatory surgery centers were added. This documentation describes only the ED and OPD survey components. It should also be noted that only ED data are being released at this time (April 2017). As a result, much of the information contained in this documentation pertains only to the ED data file (for example, Codebook). Once the OPD data file is available, a new documentation including both ED and OPD components will replace this version.

Ambulatory medical care is the predominant method of providing health care services in the United States (1). Since 1973, data on ambulatory patient visits to physicians' offices have been collected through the National Ambulatory Medical Care Survey (NAMCS). However, visits to hospital emergency and outpatient departments, which represent a significant portion of total ambulatory medical care, are not included in NAMCS (2). Furthermore, hospital ambulatory patients are known to differ from office patients in their demographic and medical characteristics (3). NHAMCS was designed to fill this data gap. Together, NAMCS and NHAMCS provide a comprehensive look at ambulatory medical care.

NHAMCS is endorsed by the Emergency Nurses Association, the Society for Academic Emergency Medicine, the American College of Emergency Physicians, the American College of Osteopathic Emergency Physicians, the Society for Ambulatory Anesthesia, the American Health Information Management Association, and the American Academy of Ophthalmology. A complete description of NHAMCS is contained in the publication entitled, "Plan and Operation of the National Hospital Ambulatory Medical Care Survey" (4).

As noted above, only the ED data file is being released at this time. In 2014, there were 23,844 electronic Patient Record forms (PRFs) provided by EDs that participated in the survey.

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Please note the following important points concerning analysis of NHAMCS data on this micro-data file:

PATIENT VISIT WEIGHT
Micro-data file users should be fully aware of the importance of the "patient visit weight" and how it must be used. Information about the patient visit weight is presented on page 25. If more information is needed, the staff of the Ambulatory and Hospital Care Statistics Branch can be consulted by calling (301) 458-4600 during regular working hours.

RELIABILITY OF ESTIMATES
Users should also be aware of the reliability or unreliability of certain estimates, particularly smaller estimates. The National Center for Health Statistics considers an estimate to be reliable if it has a relative standard error of 30 percent or less (i.e., the standard error is no more than 30 percent of the estimate). Therefore, it is important to know the value of the lowest possible estimate in this survey that is considered reliable, so as not to present data in a journal article or paper that may be unreliable. Most data file users can obtain an adequate working knowledge of relative standard errors from the information presented in Appendix I. It should be noted that estimates based on fewer than 30 records are also considered unreliable, regardless of the magnitude of the relative standard error. If you would like more information, do not hesitate to consult the staff of the Ambulatory and Hospital Care Statistics Branch.
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B. SAMPLE DESIGN

The 2014 NHAMCS used a national probability sample of visits to the emergency and outpatient departments of noninstitutional general and short-stay hospitals, excluding Federal, military, and Veterans Administration hospitals, located in the 50 states and the District of Columbia. NHAMCS was designed to provide estimates for the following survey objectives listed in order of priority: United States; region; emergency and outpatient departments; and type of ownership. The national sample uses a four-stage probability design with samples of area primary sampling units (PSUs), hospitals within PSUs, clinics within outpatient departments, and patient visits within clinics/emergency service areas. Each stage of sampling is described below.

1. Primary Sampling Units (PSUs)

1. National sample

In the national sample, a PSU consists of a county, a group of counties, or county equivalents (such as parishes and independent cities), towns, townships, minor civil divisions (for some PSUs in New England), or a metropolitan statistical area (MSA). MSAs were defined by the U.S. Office of Management and Budget on the basis of the 1980 Census. The first-stage sample consisted of 112 PSUs that comprised a probability subsample of the PSUs used in the 1985-94 National Health Interview Survey (NHIS). The NHAMCS PSU sample included with certainty the 26 NHIS PSUs with the largest populations. In addition, the NHAMCS sample included one-half of the next 26 largest PSUs, and one PSU from each of the 73 PSU strata formed from the remaining PSUs for the NHIS sample.

The NHIS PSU sample was selected from approximately 1,900 geographically defined PSUs that covered the 50 States and the District of Columbia. The 1,900 PSUs were stratified by socioeconomic and demographic variables and then selected with a probability proportional to their size. Stratification was done within four geographical regions by MSA or non-MSA status. A detailed description of the 1985-94 NHIS PSU sample design is available (5).

2. Hospitals

The hospital universe and national sample were updated for the 2014 survey using hospital data from IMS Health's (now QuintilesIMS) annual data product "Healthcare Market Index." In that updated sample, 11 new hospitals were added (births) and 11 hospitals, no longer in existence, were deleted (deaths).

The original sampling frame was compiled as follows using the SMG Hospital Database. Hospitals with an average length of stay for all patients of less than 30 days (short-stay) or hospitals whose specialty was general (medical or surgical) or children's general were eligible for NHAMCS. Excluded were Federal hospitals, hospital units of institutions, and hospitals with less than six beds staffed for inpatient use. In 1991, the SMG Hospital Database contained 6,249 hospitals that met these eligibility criteria. Of the eligible hospitals, 5,582 (89 percent) had EDs and 5,654 (90 percent) had OPDs. Hospitals were defined to have an ED if the hospital file indicated the presence of such a unit or if the file indicated a non-zero number of visits to such a unit. A similar rule was used to define the presence of an OPD. Hospitals were classified into four groups: those with only an ED; those with an ED and an OPD; those with only an OPD; and those with neither an ED nor an OPD. Hospitals in the last class were considered as a separate stratum and a small sample (50 hospitals) was selected from this stratum to allow for estimation to the total universe of eligible hospitals and the opening and closing of EDs and OPDs in the sample hospitals.

All hospitals with EDs and/or OPDs in non-certainty sample PSUs with five or fewer hospitals were selected with certainty. There were 149 hospitals in 55 PSUs in this category. In non-certainty sample PSUs with more than five hospitals, hospitals were arrayed by hospital class; type of ownership (not-for-profit, non-Federal government, and for-profit); and hospital size. Hospital size was measured by the combined volume of ED and OPD visits. From the arrayed hospitals, five hospitals were selected

using systematic random sampling with probability proportional to hospital size. A total of 161 hospitals was selected from this group. In the certainty PSUs, hospitals were stratified by region, hospital class, ownership, and size. From the stratified hospital list, 240 hospitals were selected with probability proportional to size. A sample of 50 hospitals was selected from the 427 hospitals that had neither an ED nor an OPD in the sample PSUs.

The hospital selections were made so that each hospital would be chosen only once to avoid multiple inclusions of very large hospitals. A fixed panel of 600 hospitals was initially selected for the NHAMCS sample; 550 hospitals had an ED and/or an OPD and 50 hospitals had neither an ED nor an OPD. To preclude hospitals participating during the same time period each year, the sample of 600 hospitals was randomly divided into 16 subsets of approximately equal size. Each subset was assigned to 1 of the 16 4-week reporting periods, beginning December 2, 1991, which continues to rotate across each survey year. Therefore, the entire sample does not participate in a given year, and each hospital is inducted approximately once every 15 months.

The 2014 NHAMCS was conducted from December 23, 2013 through December 21, 2014, and used a sample of 449 hospitals. Of the sampled hospitals, 74 were found to be ineligible due to closing or other reasons. Of the 375 hospitals that were in scope (eligible) for the survey, 283 participated, for an unweighted hospital sampling response rate of 75.5 percent (73.9 percent weighted).

3. Outpatient Clinics and Emergency Service Areas (ESAs)

Within each hospital, outpatient clinics were sampled separately from emergency service areas (ESAs). Outpatient clinics were in scope if ambulatory medical care was provided under the supervision of a physician and under the auspices of the hospital. Clinics were required to be "organized" in the sense that services were offered at established locations and schedules. Clinics where only ancillary services were provided or other settings in which physician services were not typically provided were out of scope. In addition, freestanding clinics, which are physician practices located within hospitals but separate from OPDs, were out of scope because they are included in NAMCS, and ambulatory surgery centers/locations, whether in hospitals or freestanding, were out of scope through 2008. Ambulatory surgery centers/locations were included in the National Survey of Ambulatory Surgery which was conducted in 1994-96 and again in 2006. Beginning in 2009, and continuing to the present, data from hospital-based ambulatory surgery centers/locations are gathered as part of a separate NHAMCS ambulatory surgery component. Beginning in 2010, and continuing through 2012, data from freestanding ambulatory surgery centers were also gathered as part of this ambulatory surgery component.

A list of in scope and out of scope clinic types is provided in Appendix I (Definition of certain terms used in the survey). The OPD clinic definition excludes the "hospital as landlord" arrangement in which the hospital only rented space to a physician group and was not otherwise involved in the delivery of services. These physicians are considered office-based and are currently included in NAMCS.

Hospitals may define the term "separate clinic" differently, for example, by physical location within the hospital, by staff providing the services, by specialty or subspecialty, by schedules, or by patients' source of payment. Because of these differences, "separate clinics" in NHAMCS were defined as the smallest administrative units for which the hospital kept patient volume statistics.

During the visit by a field representative (FR) to induct a hospital into the survey, a list of all outpatient clinics was obtained from the sample hospital. Each outpatient department clinic's function, specialty, and expected number of visits during the assigned reporting period were also collected. If there were five or fewer clinics, then all were included in the sample. If an outpatient department had more than five clinics, a sample of clinics was selected based on probability proportion to size where size was defined as the number of patient visits the clinic expected to see during the hospital's assigned 4-week reporting period. For the sample, the clinics were assigned to one of six specialty groups: general medicine, surgery, pediatrics, obstetrics/gynecology, substance abuse, and other. Within these specialty groups, clinics

which expected fewer than 30 patient visits during the assigned reporting period were grouped to form clinic sampling units (SUs). If a grouped clinic SU was selected, all clinics included in that SU were included in the sample. Prior to 2001, a sample of generally five clinic SUs was selected per hospital based on probability proportional to SU size. Starting in 2001, stratified samples of SUs were selected from OPDs which had more than five SUs. Up to two SUs were selected from each of the specialty groups within each such OPD. The change was made to make it more likely that two SUs were sampled from each of an OPD's specialty groups having two or more SUs.

Emergency services provided under the "hospital as landlord" arrangement were also eligible for the study. An ED was in scope if it was staffed 24 hours a day. All ESAs within an in scope ED were selected with certainty, regardless of whether the individual ESA was open 24 hours a day. If an ED was not staffed 24 hours daily, the ED was out of scope and all of its ESAs were treated as outpatient clinics.

A total of 449 hospitals was selected for the 2014 NHAMCS, of which 375 were in scope and had eligible EDs. Of these, 283 participated, yielding an unweighted ED response rate of 75.5 percent (73.9 percent weighted). A sample of 397 ESAs were identified from the respondent EDs. Of these, 319 responded fully or adequately by providing forms for at least half of their expected visits based on the total number of visits during the reporting period, and 78 responded minimally (i.e. they provided fewer than half of their expected forms). In all, 23,844 electronic Patient Record Forms (PRFs) were completed. The resulting unweighted ESA sample response rate was 80.4 (85.1 percent weighted), and the overall unweighted response rate (ED rate times ESA rate) was 60.6 percent (62.9 percent weighted). Response rates have been adjusted to exclude minimal participants.

4. Visits

The basic sampling unit for the NHAMCS is the patient visit or encounter. Only visits made in the United States by patients to EDs and OPDs of non-Federal, short-stay, or general hospitals were included in the 2014 NHAMCS ED and OPD components. Within ESAs or OPD clinics, patient visits were systematically selected over a randomly assigned 4-week reporting period. A visit was defined as a direct, personal exchange between a patient and a physician, or a staff member acting under a physician's direction, for the purpose of seeking care and rendering health services. Visits solely for administrative purposes, such as payment of a bill, and visits in which no medical care was provided, such as visits to deliver a specimen, were out of scope.

The target numbers of PRFs to be completed for EDs and OPDs in each hospital were 100 and 150-200, respectively. In clinics with volumes higher than these desired figures, visits were sampled by a systematic procedure which selected every nth visit after a random start. Visit sampling rates were determined from the expected number of patients to be seen during the reporting period and the desired number of completed PRFs. During the 2014 NHAMCS, electronic PRFs were completed for 23,844 ED visits.

C. DATA COLLECTION PROCEDURES

1. Field Training

The U.S. Census Bureau was the data collection agent for the 2014 NHAMCS. Census Headquarters staff were responsible for overseeing the data collection process, training the Census Regional Office staff, and writing the field manual. Regional Office staff were responsible for training the Census Field Representatives (FRs) and monitoring hospital data collection activities. FR training included approximately eight hours of self-study and 8-9 hours of classroom training. FRs inducted the hospitals and trained the hospital staff on visit sampling and completion of the PRFs.

2. Hospital Induction

Approximately six weeks prior to the hospital's assigned reporting period, NCHS sent a personally signed introductory letter from the Director of NCHS to the hospital administrator or chief executive officer of each sampled hospital. The names of the hospital officials were obtained from the American Hospital Association (AHA) Guide to Health Care.

Approximately one week after this mailing, the Census FR called the hospital administrator to set up an appointment to further explain the study and to verify hospital eligibility for the survey. Earlier studies indicated that the 6-week lead time was necessary to obtain a meeting with the administrator, gain hospital and IRB approval, collect the required information about the hospital's ambulatory care services, develop the sampling plan, and train participating hospital staff (6, 7). At the appointment, the FR explained the survey to the hospital administrator and to any staff who were involved in abstracting the data. The decision was also made regarding who would perform the visit sampling and data abstraction.

3. Outpatient Clinic and Emergency Service Area Induction

After the initial visit and the development of the sampling plan, the FR contacted the hospital coordinator to arrange for induction of the sample ESAs and outpatient clinics and for training of any staff who were involved in abstracting the data on correct data collection procedures. At these visits, the FR described the purpose and use of the survey data, explained the data collection process, including the visit sampling procedures, and demonstrated how to use the automated Patient Record instrument.

4. Data Collection

In 2014, the mode of data collection for NHAMCS was through the use of an automated survey tool, which has been the data collection mode since 2012. This is described in more detail in the 2012 NHAMCS Public Use Data File Documentation. The adoption of computer-assisted data collection meant that most of the data collection and data processing systems developed over the years had to be redesigned. One of the first steps was the development of specifications, in conjunction with the Census Bureau, which detailed how each survey item would appear in the automated tool. This included wording, answer choices, variable length, skip patterns, and range checks. Numerous help screens were also created to provide field representatives with additional information to aid in data abstraction. Hard and soft edits were incorporated into the automated tool. Soft edits prompted field staff to double check a questionable entry but allowed them to proceed if the entry was thought to be correct, whereas hard edits resulted in strict range restrictions.

The automated survey tool was accessible either by Census laptop or by web portal. In past years, data collection for NHAMCS was expected to be carried out by hospital staff, but, over time, abstraction from medical charts by Census field representatives became the predominant mode. For 2014, Census FR abstraction using laptop computers and the automated instrument became the preferred mode of data collection. For hospitals who preferred to do their own data collection, a web portal containing a modified version of the automated tool was available, or a Census laptop could be left behind for hospital staff use. In 2014, 100 percent of ED records were completed by Census abstractors.

D. FIELD QUALITY CONTROL

Hospital staff were instructed to keep a daily listing of all patient visits during the assigned 4-week reporting period using an arrival log, optional worksheet, or similar method. The list was the sampling frame to indicate the visits for which data were to be recorded. It was to include both scheduled and unscheduled patients, but not cancellations or no-shows. Visits were selected from the list either by Census FRs or medical staff using a random start and a predetermined sampling interval based on the hospital's estimated visits for the week and the number of days the hospital department was expected to

see patients that week. In this way, a systematic random sample of visits was obtained. The sampling procedures were designed so that about 100 electronic Patient Records would be completed during the assigned reporting period. This was intended to minimize the data collection workload and maintain equal reporting levels among sample hospitals regardless of hospital size.

Data for sampled visits were recorded on laptops using the automated survey tool which emulated the traditional survey instrument, the paper-based ED Patient Record Forms (PRFs). The ED PRF was designed to reflect the type of care provided in the emergency department. You may view or download representations of the automated Patient Record Forms from these web addresses:

Link to Survey Instruments page: http://www.cdc.gov/nchs/ahcd/ahcd_survey_instruments.htm
Link to ED Patient Record Form:
http://www.cdc.gov/nchs/data/ahcd/2014_NHAMCS_ED_PRF_Sample_Card.pdf

Terms and definitions relating to the Patient Record forms are included in Appendix I.

The 2014 NHAMCS did not include any separate data supplements.

E. CONFIDENTIALITY

In April 2003, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) was implemented to establish minimum Federal standards for safeguarding the privacy of individually identifiable health information. No personally identifying information, such as patient's name or address or Social Security number, is collected in NHAMCS. Data collection is authorized by Section 306 of the Public Health Service Act (Title 42, U.S. Code, 242k). All information collected is held in the strictest confidence according to law [Section 308(d) of the Public Health Service Act (42, U.S. Code, 242m(d))] and the Confidential Information Protection and Statistical Efficiency Act (Title 5 of PL 107-347).

The NHAMCS protocol has been approved by the NCHS Research Ethics Review Board annually since February 2003. Waivers of the requirements to obtain informed consent of patients and patient authorization for release of patient medical record data by health care providers have been granted.

In the Spring of 2003, NHAMCS implemented additional data collection procedures to help providers assure patient confidentiality. Census Bureau FRs were trained on how the Privacy Rule allows hospitals to make disclosures of protected health information without patient authorization for public health purposes and for research that has been approved by a Research Ethics Review Board. Hospitals were encouraged to accept a data use agreement between themselves and NCHS/CDC, since the Privacy Rule allows hospitals to disclose limited data sets (i.e., data sets with no direct patient identifiers) for research and public health purposes if such an agreement exists. Such practices have been continued annually.

Assurance of confidentiality is provided to all hospitals according to Section 308 (d) of the Public Health Service Act (42 USC 242m). Strict procedures are utilized to prevent disclosure of NHAMCS data. All information which could identify the hospital or its facilities is confidential and seen only by persons engaged in NHAMCS, and is not disclosed or released to others for any other purpose. Names and other identifying information for individual patients are never removed from the hospital.

Prior to release of the public use data files, NCHS conducts extensive disclosure risk analysis to minimize the chance of any inadvertent disclosure. For some hospitals, selected characteristics may have been masked on the public use file to minimize the potential for disclosure. Furthermore, outlier values for certain variables such as age were top coded in accordance with NCHS confidentiality requirements. Masking was performed in such a way to cause minimal impact on the data; data users who wish to use unmasked data can apply to the NCHS Research Data Center.

F. DATA PROCESSING

1. Edits

Once electronic data were collected by the Census Bureau, a number of steps were required for data processing. Specifications for checking, configuring, and transmitting the data files were developed by NCHS and applied by the Census Bureau. Data files were transmitted either to NCHS for further processing, or to SRA International, Durham, North Carolina. At NCHS, the data underwent multiple consistency checks and review of verbatim entries. SRA edited and coded verbatim entries which required medical coding [patient's reason for visit, physician's diagnosis, cause of injury, and procedures (OPD only)]. Medication editing and coding were performed entirely at NCHS by the NHAMCS Drug Database Coordinator.

2. Quality control

All SRA medical coding and keying operations were subject to quality control procedures. The contractor randomly selected a 10 percent sample of records which were independently recoded and compared. Differences were adjudicated by SRA with error rates reported to NCHS. Coding error rates between coders or with illegible entries for the reason for visit, diagnosis, and E-code (cause of injury) were reviewed and adjudicated at NCHS. Coding error rates ranged between 0.42 and 0.95 percent for the 10 percent ED sample and between 0.35 and 0.94 percent for the 10 percent OPD sample. (It should be noted that the method of calculating error rates changed in 2012; in previous years, the error rate was calculated against the entire database rather than the 10 percent sample.)

3. Adjustment for item nonresponse

Unweighted item nonresponse rates were 5.0 percent or less for all ED items with the following exceptions (items are listed in order of their position on the file):

Variable	Variable Description	Denominator	Nonresponse %
WAITTIME	Waiting time to see MD/DO/PA/NP in minutes	All visits where MD/DO/PA/NP was seen	14.4
LOV	Length of visit in minutes	All visits	7.4
ETHUN	Unimputed ethnicity	All visits	23.9
RACEUN	Unimputed race	All visits	19.8
PAYTYPER	Recoded primary expected source of payment for visit (based on hierarchy)	All visits	8.3
TEMPF	Initial vital signs: Temperature (Fahrenheit)	All visits	5.2
PULSE	Initial vital signs: Heart rate per minute	All visits	5.9
BPSYS	Initial vital signs: Blood pressure – Systolic	All visits	11.3
BPDIAS	Initial vital signs: Blood pressure – Diastolic	All visits	11.5
POPCT	Initial vital signs: Pulse oximetry (percent)	All visits	7.9

IMMEDR	Immediacy with which patient should be seen (unimputed)	All visits	22.8
PAINSCALE	Pain scale (0-10)	All visits	30.7
EPISODE	Episode of care	All visits	6.2
INJURY	Is visit related to an injury/trauma, overdose, poisoning, or adverse effect of medical treatment? - Recoded from INJPOISAD	All visits	5.1
INJPOISAD	Is visit related to injury, poisoning or adverse effect of medical treatment?	All visits	5.1
INJURY72	Did the injury/trauma, overdose, or poisoning occur within 72 hours prior to the date and time of visit?	Injury- and poisoning-related visits	31.4
INTENT	Is this injury/overdose/poisoning intentional?	Injury- and poisoning-related visits	23.2
CAUSE1	Cause of injury, poisoning, adverse effect #1	Injury-, poisoning-, and adverse effect-related visits	16.5
SEEN72	Was patient seen in this ED within the last 72 hours and discharged?	All visits	10.1
CTCONTRAST	Was CT Scan ordered/provided with intravenous (IV) contrast?	All visits where CT scans were ordered or provided	18.1
MRICONTRAST	Was MRI ordered/provided with intravenous (IV) contrast?	All visits where MRIs were ordered or provided	35.4
GPMED14	Medication 14 given in ED or Rx at discharge	All visits where medication 14 was listed	5.1
TEMPDF	Vitals at discharge: Temperature in Fahrenheit	All visits where vitals were taken at discharge	44.7
PULSED	Vitals at discharge: Heart rate (beats per minute)	All visits where vitals were taken at discharge	7.0
RESPRD	Vitals at discharge: Respiratory rate (breaths per minute)	All visits where vitals were taken at discharge	8.0
BPDIASD	Vitals at discharge: Diastolic blood pressure	All visits where vitals were taken at discharge	10.9
BPSYSD	Vitals at discharge: Systolic blood pressure	All visits where vitals were taken at discharge	10.8
ADMIT	Admitted to:	Visits that resulted in hospital admission	11.5
ADMTPHYS	Admitting physician	Visits that resulted in hospital admission	35.8
BOARDED	Length of time boarded in ED in minutes	Visits that resulted in hospital admission	22.7

LOS	If admitted, length of stay in hospital (days)	Visits that resulted in hospital admission	11.3
HDDIAG1	Hospital discharge diagnosis #1	Visits that resulted in hospital admission	9.6
HDSTAT	Hospital discharge status	Visits that resulted in hospital admission	8.0
OBSSTAY	Length of stay in observation unit in minutes	Visits that resulted in observation unit admission and discharge	47.0
SECURCHCKE	Has your hospital made an assessment of the potential risks and vulnerabilities of your electronic health information within the last 12 months?	All visits where applicable	13.3
DIFFEHRE	Does your EHR have the capability to electronically send health information to another provider whose EHR system is different from your system?	All visits where applicable	15.6
EWARNE	Does your ED have a computerized system for providing warnings of drug interactions or contraindications?	All visits where applicable	7.6
EREMINDE	Does your ED have a computerized system for providing reminders for guideline-based interventions or screening tests?	All visits where applicable	8.2
EFORMULAE	Does your ED have the computerized capability for performing drug formulary checks?	All visits where applicable	18.1
EGRAPHE	Can the EHR/EMR automatically graph a specific patient's lab results over time?	All visits where applicable	14.8
EIDPTE	Does your ED have the computerized capability for identifying patients due for preventive or follow-up care in order to send patients reminders?	All visits where applicable	16.8
EPTEDUE	Does your ED have a computerized system for identifying educational resources for patients' specific conditions?	All visits where applicable	9.3
ECQME	Does your ED have a computerized system for reporting clinical quantity measures to federal or state agencies (such as CMS or Medicaid)?	All visits where applicable	8.7
EGENLISTE	Does your ED have a computerized system for generating list of patients with particular health conditions?	All visits where applicable	8.8
EIMMREGE	Does your ED have the computerized capability for electronic reporting to immunization registries?	All visits where applicable	15.3
EMSGE	Does your ED have a computerized system for exchanging secure messages with patients?	All visits where applicable	5.5
EHRTOEHRE	Is the patient health information that you share electronically sent directly	All visits where applicable	14.5

	from your EHR system to another EHR system?		
EDPRIM	When patients with identified primary care physicians (PCP) arrive at the ED, how often do you electronically send notifications to the patients' PCP?	All visits where applicable	8.3
EDINFO	When patients arrive at the ED, are you able to query for patients' healthcare information electronically from outside sources?	All visits where applicable	10.0
MUSTAGE2	Are there plans to apply for Stage 2 incentive payments?	All visits where applicable	10.9
BOARD	Are admitted ED patients ever "boarded" for more than 2 hours in the ED or observation unit while waiting for an inpatient bed?	All visits	5.4
AMBDIV	Did your ED go on ambulance diversion in 2013?	All visits	13.8
TOTHRDIVR	What is the total number of hours that your hospital's ED was on ambulance diversion in 2013?	All visits to EDs that went on ambulance diversion	32.8
REGDIV	Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?	All visits	7.2
ADMDIV	Does your hospital continue to admit elective or scheduled surgery cases when the ED is on ambulance diversion?	All visits	11.1
INCSHX	In the last two years, has your ED increased the number of standard treatment spaces?	All visits	6.5
EXPSPACE	Do you have plans to expand your your ED's physical space within the next two years?	All visits	10.5
ADVTRIAG	Does your ED use advanced triage (triage-based care) protocols?	All visits	11.1
CATRIAGE	Does your ED use computer-assisted triage?	All visits	5.9
IMBED	Does your ED use immediate bedding?	All visits	7.9
RFID	Does your ED use radio frequency identification tracking?	All visits	6.6
WIRELESS	Does your ED use wireless devices by providers?	All visits	5.6
ZONENURS	Does ED use zone nursing?	All visits	8.8
POOLNURS	Does your ED use pool nursing?	All visits	7.2
BEDCZAR	Does your hospital have a bed coordinator, sometimes known as a bed czar?	All visits	6.8

Denominators used to compute item nonresponse rates were adjusted to account for skip patterns on the PRFs. For example, if a hospital reported it did not go on ambulance diversion in 2013, those hospitals were omitted when computing item non-response for the total number of hours the hospital's ED was on ambulance diversion.

For some items, missing values were imputed as described below. In addition to imputing missing data, masking was required for a few records in some facilities for items such as race, ethnicity, and physician's diagnosis in order to protect respondent confidentiality.

On the ED file, four items were imputed: patient's age (0.03 percent), sex (0.3 percent), race (19.8 percent), and ethnicity (23.7 percent). Note that in years prior to 2013 triage level was also imputed. Age and sex were imputed using a hot deck based on 3-digit ICD-9-CM code for primary diagnosis, triage level, ED volume, and geographic region. Starting with 2010 data, the imputation of patient race and ethnicity was performed using a model-based single, sequential regression method. The decision to adopt this technique resulted from findings by an internal work group that studied imputation methods with NAMCS and NHAMCS data for nearly two years. The model used to impute race and ethnicity included the following variables: Census variables for ZIP code level race and ethnicity population estimates and an indicator for whether it was patient or hospital ZIP (used when patient ZIP was not available); patient age, sex, race, and ethnicity; triage level; log of ED wait time; primary expected source of payment derived from a hierarchical recode of the expected source of payment question; grouped 3-digit ICD-9-CM codes for primary diagnosis; who completed the Patient Record form; year of visit (2013 or 2014); type of ESA area; provider's MSA status; and ED weighting and volume variables.

4. Injury-Related Data

For 2014, injury data were edited using a program which reviewed codes for reason for visit, diagnosis, and cause of injury, and assigned injury and intentionality status accordingly. In this way, records which did not specifically state an injury but for which injury codes for reason, diagnosis, and/or cause of injury were present were recoded appropriately, while records which stated an injury but for which no corroborating data could be found were assigned to a 'questionable' injury status, allowing data users to make their own determination as desired.

The injury items are provided on the public use file using their current format. However, for trending and consistency-check purposes, we also provide recoded injury items using a format that is comparable with the injury variables used in 2010 and 2011. These variables are described in more detail in the Codebook section.

G. MEDICAL CODING

The electronic Patient Record form contains several medical items requiring three separate coding systems. The three coding systems are described briefly below. Quality control for the NHAMCS medical coding operations involved a 10-percent independent coding and verification procedure. A dependent verification procedure was used to review and adjudicate all records with coding discrepancies. Definitions of the medical items can be found in Appendix I.

1. Patient's Complaint(s), Symptoms(s) or Other Reason(s) for this Visit

Information collected in the Reason for Visit item was coded according to A Reason for Visit Classification for Ambulatory Care (RVC) (8). The updated classification is available (9), and the list of codes is shown in Appendix II. The classification was updated to incorporate several new codes as well as changes to existing codes. The system continues to utilize a modular structure. The digits 1 through 8 precede the 3-digit RVC codes to identify the various modules as follows:

Prefix   Module
"1" =   Symptom module
"2" =   Disease module
"3" =   Diagnostic, screening, and preventive module
"4" =   Treatment module
"5" =   Injuries and adverse effects module
"6" =   Test results module
"7" =   Administrative module
"8" =   Uncodable entries
"9" =   Special code = blank

Up to five reasons for visit were coded from the PRFs in sequence; coding instructions for this item are contained in the Reason for Visit Classification and Coding Manual (9).

2. Cause of Injury/Trauma, Overdose, Poisoning, or Adverse Effect

Up to three causes of injury/trauma, overdose, poisoning, or adverse effect were coded from responses to the "Cause of injury/trauma, overdose, poisoning, or adverse effect" section in the Injury item on the ED PRFs. Causes were coded using the Supplementary Classification of External Causes of Injury and Poisoning (E-codes), International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (10). In the classification, E-codes range from E000-E999, and many, but not all, codes have an additional fourth digit to provide greater specificity. For the NHAMCS ED public use file, the 'E' has been dropped.

There is an implied decimal between the third and fourth digits; inapplicable fourth digits have a dash inserted.

Examples: 895-   = E895 = Accident caused by controlled fire in private dwelling
               9056   = E905.6 = Venomous marine animals and plants as the cause of
                                  poisoning and toxic reactions

In addition to these character codes, we have also provided numeric recodes for the cause of injury fields at the end of the record format. Please see page 45 in the ED Codebook section for more information on using the numeric recodes.

3. Provider's Diagnosis

Diagnostic information in the Diagnosis item of the ED PRFs was coded according to the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM) (10).

For 2014, the ICD-9-CM codes are provided in two formats, the true ICD-9-CM code in character format, and a numeric recode found at the end of the record format. Please see page 47 in the ED Codebook section for information on the background, purpose, and appearance of the numeric recodes. The rest of this paragraph describes the format of the true ICD-9-CM codes.

The true ICD-9-CM codes are not prefixed or zerofilled on the public use file.
For example, 38100 = 381.00 = Acute nonsuppurative otitis media, unspecified.

There is an implied decimal between the third and fourth digits. For inapplicable fourth or fifth digits, a dash has been inserted. For example, 4011- = 401.1 = Essential hypertension, benign.

True supplementary classification codes are not prefixed or zerofilled.
For example, V700- = V70.0 = Routine general medical examination at a health care facility.

In addition to the diagnostic codes from the ICD-9-CM the following unique codes in the diagnostic fields were developed by NHAMCS staff:

    V990- = noncodable diagnosis, insufficient information for coding, illegible diagnosis
    V991- = left before being seen, patient walked out, not seen by doctor, left against
                 medical advice
    V992- = transferred to another facility, sent to see specialist
    V993- = HMO will not authorize treatment
    V997- = entry of "none," "no diagnosis," "no disease," "healthy"
    V998- = entry of "not applicable", "N/A", "not available" or "blank"
    -9   = field is blank (in contrast to an actual entry of "blank")

A maximum of five diagnoses were coded in sequence. Coding instructions concerning diagnoses are contained in the NHAMCS Coding Requirements Manual (11).

4. Medications & Immunizations

The NHAMCS drug data collected in the Medications & Immunizations items of the ED and OPD automated Patient Records have been classified and coded using the entry name (the entry made on the PRF) according to a unique classification scheme developed at NCHS (12). The medical classification system of drugs by entry name uses a five-digit coding scheme which is updated regularly to include new products. It includes the following special codes:

    -9   = blank
    99980   = unknown entry, other
    99999   = illegible entry

Up to 30 medications could be recorded for each visit on the ED automated Patient Record. A list of drug codes by entry name is included in Appendix III.

In addition to drugs coded by entry name, this file contains the following drug information:

a. Generic drug code: Drugs are coded in terms of their generic components and therapeutic classifications using Lexicon Plus®, a proprietary database of Cerner Multum, Inc., also used by the National Health and Nutrition Examination Survey, NCHS. The Lexicon Plus is a comprehensive database of all prescription and some nonprescription drug products available in the U.S. drug market. In accordance with the license agreement, NCHS publications, tabulations, and software applications should cite the Multum Lexicon as the source and basis for the coding and classification of NHAMCS drug data. For additional information on the Multum Lexicon Drug Database, please refer to the following Web site: http://www.cerner.com/cerner_multum/

All drug codes based on entry name (using NCHS' classification system as cited above) were also assigned a unique generic drug code from Multum's Lexicon Drug Database where possible. The structure of the Multum database is such that multiple ingredient drugs are assigned a single generic drug code encompassing all of a drug's ingredients rather than being assigned generic drug codes for each ingredient.

The generic drug code (DRUGID1-DRUGID30 for OPD and DRUGID1-DRUGID30 for ED) is 6 digits, beginning with the letters "a", "c", "d" or "n". All Multum codes begin with the letter "d", but there were some drug names reported by NHAMCS participants that were not found in the Lexicon Drug Database. These were assigned unique drug codes beginning with an "a" where a drug's ingredients could be determined, or a "c" (for 2006 and 2007 data only) or an "n" (2008 data forward) where a drug's ingredients could not be determined.

For a description of the method used to code drug data prior to 2006, please see page 20 of the 2009 NHAMCS Public Use File Documentation:
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS/doc09.pdf

b. Prescription status code: A code designed to identify the legal status (prescription or nonprescription) of the drug entry.

c. Controlled substance status code: A code used to denote the degree of potential abuse and federal control of a drug entry.

d. Composition status code: A code used to distinguish between single-ingredient and combination drugs.

e. Therapeutic category code: Multum's therapeutic classification system was first used in the 2006 NHAMCS public use files. Prior to that time, a 4-digit code was used to identify up to three therapeutic classes to which the drug entry might belong. (Prior to 2002 only a single therapeutic class was listed, but additional classes can be added for those years using tools available at the NHAMCS website.) These were based on the standard drug classifications used in the National Drug Code Directory, 1995 edition (13).

The Multum Lexicon provides a 3-level nested category system that assigns a therapeutic classification to each drug and each ingredient of the drug (e.g., for naproxen: the broadest category is central nervous system agents [level 1]; the more detailed category is analgesics [level 2]; and the most detailed category is nonsteroidal anti-inflammatory agents [level 3]). Not all drugs have three classification levels; some may only have two [e.g. for digoxin: cardiovascular agents [level 1]; inotropic agents [level 2]), others only have one. See Appendix III for the complete Multum category scheme.

Each drug may have up to four therapeutic categories on the public use file. The variables RX1CAT1 through RX30CAT4 reflect the unique Multum drug categories for a particular drug; these are character values with codes from '001' through '464'. This variable will always show the most detailed therapeutic level available of a particular drug. For example, psychotherapeutic agents in Multum are further classified into a second more detailed level as antidepressants or antipsychotics.

Antidepressants are further classified into seven subcategories (miscellaneous antidepressants, SSRI antidepressants, tricyclic antidepressants, monoamine oxidase inhibitors, phenylpiperazine antidepressants, tetracyclic antidepressants, and SSNRI antidepressants); antipsychotics are further classified into five subcategories. For a drug categorized as a tricyclic antidepressant, it would have a drug category code of '209', reflecting the Level 3 code.

Other drugs may have only two levels available, such as immunologic agents. There are seven level 2 categories of immunologic agents, and no further breakdowns into a third level in the Multum system. Therefore, RX1CAT1 would reflect only a second level code in that case. So, using RX1CAT1-RX30CAT4 will allow you to identify the most specific level of a drug, but will not, by itself, identify whether that code reflects the first, second, or third level.

In order to understand each level in terms of the Multum hierarchy, we have also placed on the file additional variables that show the full first, second, and third levels, if applicable, for each drug category for each drug. For example, in the case of the tricyclic antidepressant mentioned earlier, RX1CAT1='307'. But there are three additional variables corresponding to that drug's first therapeutic category. RX1V1C1 (meaning Drug 1, Level 1 of Therapeutic Category 1) would be '242' (psychotherapeutic agents), RX1V2C1 (Drug 1, Level 2 of Therapeutic Category 1) would be '249' (antidepressants), and RX1V3C1 (Drug 1, Level 3 of Therapeutic Category 1) would be '307' (tricyclic antidepressants). If there were no second or third level for a particular category, the entry would be blank (' '). This is repeated for each of the drug's maximum of four therapeutic categories. The three levels can easily be concatenated by data

users if they wish to obtain a complete code showing the full level structure applicable to each drug's therapeutic categories. An advantage of having separate levels is that it allows data users to aggregate drugs at any level desired. SAS code is provided at the website for micro-data users who wish to group therapeutic categories in various ways.

All drugs were coded using Multum drug categories, even those drugs that were not found in Multum's drug database. "Unspecified" drugs were assigned to their respective therapeutic category (e.g., hormones – unspecified: category id=97, category name=hormones). Drugs that could not be assigned to any drug entry name (MED1-MED30 = 99980, 99999) were not assigned a therapeutic drug category. In some cases, NCHS was able to categorize a drug's therapeutic class at the first or second Multum level, but not at the more detailed level. When this occurred, the undetermined levels are designated as '999' in the data.

Multum uses a "combination" category for some multiple ingredient drugs. These include antihypertensive combinations, antiasthmatic combinations, upper respiratory combinations, psychotherapeutic combinations, bronchodilator combinations, sex hormone combinations, skeletal muscle relaxant combinations, and narcotic analgesic combinations. This categorization may be sufficient for certain analyses but not for others because it lacks information about the therapeutic effect of the individual ingredients that make up the combination. For example, the drug HYDROCHLOROTHIAZIDE; LOSARTAN is identified as an antihypertensive combination. Therefore, we know that this drug has an antihypertensive drug effect. However, based on this combination category we do not know that the drug's single ingredients have the therapeutic effects of a diuretic and angiotensin II inhibitor, which is relevant for some analyses.

As a result, NCHS decided that, in addition to assigning therapeutic categories to each drug, a separate file would be provided listing the ingredients for each drug along with the therapeutic classes for each ingredient. In the case of single ingredient drugs, the ingredient therapeutic categories would be the same as the drug therapeutic categories. This separate downloadable file (DRUG_INGREDIENTS_2014) can be matched to the main file using the DRUGID code. For each DRUGID on the main file, the supplemental file contains up to 5 ingredients and up to 3 therapeutic category codes for each ingredient. In past years, codes used to identify the active generic ingredients of combination drugs were included on the public use file.

IMPORTANT: For the 2014 data, we have continued to update and revise the drug characteristics in our ambulatory care drug database, which underwent substantial revision beginning in 2002. For that year, we reviewed the ingredient lists for many drugs and removed non-active ingredients. Duplicate codes caused by misspellings or other variant entries were eliminated, and incorrect codes (for example, for non-medications) were removed. From 2002-2005, each drug entry had up to three therapeutic classes associated with it, compared with a single therapeutic class in prior years. These factors made trend analysis more problematic, and the solution was to provide researchers with our Drug Characteristics file, which was updated annually, at our Ambulatory Health Care Data website. The characteristics from this file could be applied by matching on drug codes to previous years of data in order to get the most accurate results when doing analysis of drug trends. A SAS program for applying drug characteristics from the current drug database to previous years of public use data was also available for downloading.

However, with the adoption of the Multum Lexicon for coding drugs according to generic ingredients and therapeutic categories, a new solution for trend analysis was necessary. Therefore, beginning with the 2006 data release, we also provided a separate downloadable mapping file (MEDCODE_DRUGID_MAP_2006), which allowed data users to match all of the drug codes used in previous years (for example, MED1-MED8 in 2005) with the corresponding Multum DRUGID code for generic composition of the drug and its corresponding therapeutic categories. Once that was accomplished, users could also match to the drug ingredient file as described above.

For each subsequent year of data, the mapping file has been updated and can be downloaded (for example, MEDCODE_DRUGID_MAP_2014) at
ftp://ftp.cdc.gov/pub/Health_Statistics/NCHS/Dataset_Documentation/NHAMCS/drugs/.

Researchers should keep in mind, however, that in cases where drug characteristics have legitimately changed over the years (e.g., moving from prescription to non-prescription status), using the current updated version of the drug characteristics will overwrite all of the previous characteristics with current ones.

Data users should also keep in mind that the Multum classification system can itself change over time, with new categories being added and some therapeutic categories being removed from an existing category and placed in a new one. In coding 2009 data, for example, therapeutic class was modified to reflect changes to the Multum Lexicon system regarding the therapeutic class of Genitourinary Tract Agents. This was previously a second-level category within the first-level category of Miscellaneous Agents. It was changed to a first-level category of Genitourinary Tract Agents. All of the previous third-level classes within the original scheme were changed to second-level categories in the new scheme.

For users who are interested in analyzing drug data, one method involves the isolation of those records with drugs, or drug mentions, and the creation of a separate data file of drug mentions. Each Patient Record for 2014 can have up to thirty (ED) drug mentions recorded, so whatever file is created would need to include all of them. This method can be used for obtaining estimates of drug mentions, but is not recommended for variance estimation. Rather, the structure of the visit file should be kept intact when estimating variance. In order to do this, estimates of drug mentions can be obtained by creating a new weight variable (called DRUGWT in this example). This variable is created by multiplying PATWT (the patient visit weight) by NUMMED (the number of medications recorded at the sampled visit) or DRUGWT=PATWT*NUMMED. DRUGWT can then be used in place of PATWT to weight one's data; it produces the estimated number of drug mentions rather than visits. (See Codebook for more on PATWT and NUMMED.)

This documentation contains some marginal data for drug mentions. Should the data user need additional assistance in analyzing data on drug mentions, the staff of the Ambulatory and Hospital Care Statistics Branch is available by calling (301) 458-4600. Our website can be accessed at:
http://www.cdc.gov/nchs/ahcd.htm

H. ESTIMATION PROCEDURES

Statistics from NHAMCS were derived by a multistage estimation procedure that produces essentially unbiased estimates. The estimation procedure has three basic components: 1) inflation by reciprocals of the sampling selection probabilities; 2) adjustment for nonresponse; and 3) a population weighting ratio adjustment.

1. Inflation by reciprocals of selection probabilities

There is one probability for each sampling stage: a) the probability of selecting the PSU; b) the probability of selecting the hospital; c) the probability of selecting the OPD clinic from within the hospital; and d) the probability of selecting the visit within the ESA or clinic. The last probability is calculated to be the sample size from the ESA or clinic divided by the total number of visits occurring in that unit during that unit's data collection period. The overall probability of selection is the product of the probabilities at each stage. The inverse of the overall selection probability is the basic inflation weight. Beginning in 1997, the overall selection probabilities of some OPDs were permanently trimmed to prevent individual OPDs from contributing too much of their region's total for OPD visit estimates.

2. Adjustment for nonresponse

NHAMCS data were adjusted to account for two types of nonresponse. The first type of nonresponse occurs when a sample hospital refuses to provide information about its ESA(s) and/or OPD clinic(s) which are publicly known to exist. In this case, the weights of visits to hospitals similar to the nonrespondent hospitals were inflated to account for visits represented by the nonrespondent hospitals where hospitals were judged to be similar if they were in the same region, had the same department size, and had the same metropolitan statistical area (MSA) status (that is, whether they were located in an MSA or not in an MSA). This adjustment was made separately by department type.

The second type of nonresponse occurs when an ESA or a sample OPD clinic within a respondent hospital fails to provide completed PRFs for a sample of its patient visits. In this case, the weights for visits to ESAs/OPD clinics similar to nonrespondent ESAs/OPD clinics were inflated to account for visits represented by nonrespondent ESAs/OPD clinics where ESAs/OPD clinics were judged to be similar if they were in the same region, MSA status group, and ESA/OPD clinic group. For this purpose, there were six OPD clinic groups: general medicine, pediatrics, surgery, OB/GYN, alcohol and/or substance abuse, and "other."

Beginning in 2004, changes were made to the nonresponse adjustment factor to account for the seasonality of the reporting period. Extra weights for nonresponding hospital OPDs and EDs were shifted to responding outpatient and emergency departments in reporting periods within the same quarter of the year. The shift in nonresponse adjustment did not significantly affect any of the overall annual estimates. However, adjustment for non-response within season was not feasible for the 2014 ED visit estimates due to uneven ED response across seasons.

3. Ratio adjustments

Adjustments were made within hospital strata defined by region. Within the Northeast, the Midwest and the South, the adjustment strata were further defined by MSA status. These adjustments were made separately for emergency and outpatient departments. For EDs, the adjustment was a multiplicative factor that had as its numerator the sum of annual visit volumes reported for EDs in sampling frame hospitals in the stratum and as its denominator the estimated number of those visits for that stratum.

Beginning in 1997, the adjustment for OPD estimates was replaced by a ratio which had as its numerator the weighted OPD visit volumes of hospitals in the full NHAMCS sample (16 hospital panels) and as its denominator the weighted OPD visit volumes of hospitals in the 13 hospital panels included in the sample for the survey year. (The full NHAMCS hospital sample is partitioned into 16 panels which are rotated into the sample over 16 periods of four weeks each so that only 13 panels are used in each year.) This adjustment used visit volumes that were based on the most recent survey data collected from hospitals that had participated in NHAMCS at least once. For hospitals which had never participated, visit volumes were obtained by phone, from frame data, or by using the average of visit volumes for refusal hospitals which had converted to respondent status.

I. PATIENT VISIT WEIGHT

The "patient visit weight" is a vital component in the process of producing national estimates from sample data and its use should be clearly understood by all data file users. The statistics contained on the micro-data file reflect only a sample of patient visits-- not a complete count of all such visits that occurred in the United States. Each record on the ED file represents one visit in the sample of 23,844 visits. In order to obtain national estimates from the sample, each record is assigned an inflation factor called the "patient visit weight."

By aggregating the "patient visit weights" contained in the PATWT variable on the 23,844 sample records for 2014, the user can obtain the estimated total of 141,420,460vED visits made in the United States.

IMPORTANT: Estimates produced from the 2014 ED public use file may differ somewhat from estimates produced from NCHS in-house files. This is because of adjustments required for the public use data as part of the disclosure avoidance process. Certain variables, including race, ethnicity, physician's diagnosis, and hospital discharge diagnosis, were masked on some records for confidentiality purposes.

The marginal tables in Section III contain data on numbers of records for selected variables as well as the corresponding national estimated number of visits and drug mentions obtained by aggregating the "patient visit weights" on those records. Note that there are no estimates for OPD settings because the OPD data file is not part of this product and should be released at a later time.

J. HOSPITAL CODE and PATIENT CODE

The purpose of these codes is to allow for greater analytical depth by permitting the user to link individual PRFs on the public use file with individual hospitals. This linkage will enable users to conduct more comprehensive analysis without violating the confidentiality of patients or hospitals. Hospital codes are randomly assigned each year and may be different on the OPD and ED files.

To uniquely identify a record, both the hospital code and the patient code must be used. Patient codes are merely a sequential numbering of the visits recorded by the hospital and alone will not uniquely identify visit records. In order to do so, both the unique 3-digit hospital code and the 3-digit patient code must be used.

K. USE OF THE ED WEIGHT

An emergency department weight (EDWT) was first added to the 2005 ED public use file. These weights enable data users to calculate department-level estimates. There is generally one weight for each emergency department which appears on the first visit record only for that department.

IMPORTANT: The initial (April 2017) release of the NHAMCS ED Public Use Data File does not include the EDWT variable. This should be added to a subsequent release.

When running an analysis of facility-level characteristics using EDWT, it is recommended to select only those records where EDWT is greater than 0. This will result in correct sample counts of variables, which is useful for assessing reliability. Weighted estimates will be correct either way, because of the one weight per department format.

Estimates at the ED level generated using EDWT reflect only facilities which participated in the survey. Therefore, estimates made with EDWT could be biased if nonresponding facilities had different characteristics than those which responded.

In addition to producing estimates of department-level characteristics, it is possible to compute means of visit characteristics at the department level, for example, caseload percentages across emergency departments for expected source of payment. This type of analysis is somewhat complicated and is described with sample SAS code at the Ambulatory Health Care Data website (www.cdc.gov/nchs/nhamcs.htm). For more information, contact the Ambulatory and Hospital Care Statistics Branch at 301-458-4600.

L. POPULATION FIGURES

The base population used in computing annual visit rates is presented in tables I-II. The estimates of age, sex, race, ethnicity, and geographic region for the civilian noninstitutionalized population of the U.S. are from special tabulations developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Population estimates for race groups in the 2014 NHAMCS are based on data from the 2010 U.S. Census in which respondents were able to indicate more than one race category. Specific race denominators reflect persons with a single race identification, and a separate denominator is available for persons with more than one race designation. For a description of differences in the collection of race data as well as population denominators used for producing visit rates by race prior to 2002, please see the 2009 NHAMCS Public Use File Documentation.

Data indicate that multiple races are recorded for a patient less frequently in medical records compared to their numbers in the general population. The 2014 population estimates indicate that 2.5 percent of the total population identify themselves as being of multiple races. In contrast, multiple race patients account for 0.1 percent of weighted ED visits (based on known race data only). (REMINDER: Since 2009, NHAMCS data only include imputed values for the race categories White, Black, and Other; see 2009-2014 NHAMCS Public Use File Documentation Summary of Changes for more information.) Differences may exist because hospital staff are less likely to know and record multiple race preferences for patients, and not because, after age-adjusting, persons with multiple races make fewer visits to EDs. This implies that the ED visit rates by race populations calculated for 2014 are probably slight overestimates for the single race categories and underestimates for the multiple race category.

Table I. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by age, race, and sex: July 1, 2014

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All races	313,672,860	3,946,554	15,924,807	41,151,725	43,010,105	42,263,007
Male	153,217,332	2,016,979	8,135,994	21,003,624	21,695,646	20,873,938
Female	160,455,528	1,929,575	7,788,813	20,148,101	21,314,459	21,389,069
White Only	243,106,418	2,824,567	11,433,014	30,106,255	31,814,990	31,820,096
Male	119,804,751	1,444,646	5,851,055	15,408,939	16,148,750	15,979,899
Female	123,301,667	1,379,921	5,581,959	14,697,316	15,666,240	15,840,197
Black Only	40,780,688	602,520	2,422,331	6,169,122	6,623,649	5,779,908
Male	19,033,518	306,764	1,229,510	3,126,132	3,251,645	2,653,265
Female	21,747,170	295,756	1,192,821	3,042,990	3,372,004	3,126,643
AIAN* Only	3,887,259	64,517	257,048	652,673	646,336	590,447
Male	1,939,567	32,915	130,619	331,527	327,199	301,086
Female	1,947,692	31,602	126,429	321,146	319,137	289,361
Asian Only	17,249,610	201,860	819,590	2,076,946	2,297,612	2,920,453
Male	8,189,145	103,368	418,069	1,048,350	1,157,816	1,389,346
Female	9,060,465	98,492	401,521	1,028,596	1,139,796	1,531,107
NHOPI* Only	720,831	12,435	48,636	117,070	116,194	127,601
Male	361,042	6,364	24,911	59,486	58,406	65,200
Female	359,789	6,071	23,725	57,584	57,788	62,401
Multiple Races	7,928,054	240,655	944,188	2,029,659	1,511,324	1,024,502
Male	3,889,309	122,922	481,830	1,029,190	751,830	485,142
Female	4,038,745	117,733	462,358	1,000,469	759,494	539,360

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

Geographic Region totals		Metropolitan Statistical Area totals	
Northeast	55,403,548	MSA	272,914,209
Midwest	66,752,759	Non-MSA	40,758,651
South	117,451,370		
West	74,065,183		

Table I. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by age, race, and sex: July 1, 2014 - con.

Race and sex	35-44	45-54	55-64	65-74	75+
All races	39,679,478	42,931,040	39,819,836	26,171,532	18,774,776
Male	19,426,863	20,973,687	19,134,318	12,234,461	7,721,822
Female	20,252,615	21,957,353	20,685,518	13,937,071	11,052,954
White Only	30,300,416	33,995,070	32,469,770	22,099,590	16,242,650
Male	15,116,213	16,844,510	15,796,922	10,454,925	6,758,892
Female	15,184,203	17,150,560	16,672,848	11,644,665	9,483,758
Black Only	5,194,565	5,401,570	4,579,522	2,472,723	1,534,778
Male	2,333,194	2,461,298	2,064,116	1,055,614	551,980
Female	2,861,371	2,940,272	2,515,406	1,417,109	982,798
AIAN* Only	515,750	487,965	374,343	194,451	103,729
Male	260,150	241,409	179,797	91,949	42,916
Female	255,600	246,556	194,546	102,502	60,813
Asian Only	2,810,017	2,357,291	1,887,187	1,137,992	740,662
Male	1,308,811	1,098,034	851,551	508,427	305,373
Female	1,501,206	1,259,257	1,035,636	629,565	435,289
NHOPI* Only	101,747	86,449	61,904	32,084	16,711
Male	51,168	42,759	30,178	15,506	7,064
Female	50,579	43,690	31,726	16,578	9,647
Multiple Races	756,983	602,695	447,110	234,692	136,246
Male	357,327	285,677	211,754	108,040	55,597
Female	399,656	317,018	235,356	126,652	80,649

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Bureau of the Census postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2014. The estimates of age, sex, race and region are from special tabulations developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table II. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2014

HISPANIC

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All races	54,729,821	1,012,818	4,117,083	10,021,482	9,253,934	8,667,496
Male	27,458,961	516,614	2,096,724	5,103,271	4,724,529	4,473,653
Female	27,270,860	496,204	2,020,359	4,918,211	4,529,405	4,193,843
White Only	48,212,636	857,750	3,506,291	8,660,744	8,090,397	7,611,265
Male	24,217,119	437,531	1,785,954	4,411,406	4,135,806	3,942,286
Female	23,995,517	420,219	1,720,337	4,249,338	3,954,591	3,668,979
Black Only	2,587,902	59,051	230,772	517,592	461,681	425,573
Male	1,253,784	30,125	117,353	263,391	232,715	203,816
Female	1,334,118	28,926	113,419	254,201	228,966	221,757
AIAN* Only	1,595,417	30,992	122,380	299,333	277,472	271,679
Male	827,794	15,824	62,192	152,249	143,103	147,519
Female	767,623	15,168	60,188	147,084	134,369	124,160
Asian Only	546,570	12,404	48,115	106,938	95,374	89,851
Male	270,581	6,293	24,550	54,878	47,595	44,834
Female	275,989	6,111	23,565	52,060	47,779	45,017
NHOPI* Only	193,504	4,222	16,483	36,945	33,380	36,572
Male	99,691	2,144	8,359	18,710	17,162	20,167
Female	93,813	2,078	8,124	18,235	16,218	16,405
Multiple Races	1,593,792	48,399	193,042	399,930	295,630	232,556
Male	789,992	24,697	98,316	202,637	148,148	115,031
Female	803,800	23,702	94,726	197,293	147,482	117,525

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Bureau of the Census postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2014. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table II. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2014 - con.

HISPANIC

Race and sex	35-44	45-54	55-64	65-74	75+
All races	7,862,297	6,266,272	4,030,066	2,115,445	1,382,928
Male	3,963,793	3,136,446	1,935,336	954,924	553,671
Female	3,898,504	3,129,826	2,094,730	1,160,521	829,257
White Only	7,007,043	5,628,758	3,636,547	1,933,296	1,280,545
Male	3,543,784	2,825,613	1,748,102	872,889	513,748
Female	3,463,259	2,803,145	1,888,445	1,060,407	766,797
Black Only	338,681	258,293	166,113	81,538	48,608
Male	156,045	119,816	76,646	35,483	18,394
Female	182,636	138,477	89,467	46,055	30,214
AIAN* Only	235,772	180,261	107,653	45,974	23,901
Male	125,392	94,638	54,747	22,208	9,922
Female	110,380	85,623	52,906	23,766	13,979
Asian Only	76,410	56,695	35,054	16,465	9,264
Male	37,749	27,472	16,340	7,307	3,563
Female	38,661	29,223	18,714	9,158	5,701
NHOPI* Only	28,063	19,737	10,837	4,738	2,527
Male	14,718	9,962	5,277	2,172	1,020
Female	13,345	9,775	5,560	2,566	1,507
Multiple Races	176,328	122,528	73,862	33,434	18,083
Male	86,105	58,945	34,224	14,865	7,024
Female	90,223	63,583	39,638	18,569	11,059

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.
SOURCE: These are U.S. Bureau of the Census postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2014. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table II. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2014 – con.

NON-HISPANIC

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All races	258,943,039	2,933,736	11,807,724	31,130,243	33,756,171	33,595,511
Male	125,758,371	1,500,365	6,039,270	15,900,353	16,971,117	16,400,285
Female	133,184,668	1,433,371	5,768,454	15,229,890	16,785,054	17,195,226
White Only	194,893,782	1,966,817	7,926,723	21,445,511	23,724,593	24,208,831
Male	95,587,632	1,007,115	4,065,101	10,997,533	12,012,944	12,037,613
Female	99,306,150	959,702	3,861,622	10,447,978	11,711,649	12,171,218
Black Only	38,192,786	543,469	2,191,559	5,651,530	6,161,968	5,354,335
Male	17,779,734	276,639	1,112,157	2,862,741	3,018,930	2,449,449
Female	20,413,052	266,830	1,079,402	2,788,789	3,143,038	2,904,886
AIAN* Only	2,291,842	33,525	134,668	353,340	368,864	318,768
Male	1,111,773	17,091	68,427	179,278	184,096	153,567
Female	1,180,069	16,434	66,241	174,062	184,768	165,201
Asian Only	16,703,040	189,456	771,475	1,970,008	2,202,238	2,830,602
Male	7,918,564	97,075	393,519	993,472	1,110,221	1,344,512
Female	8,784,476	92,381	377,956	976,536	1,092,017	1,486,090
NHOPI* Only	527,327	8,213	32,153	80,125	82,814	91,029
Male	261,351	4,220	16,552	40,776	41,244	45,033
Female	265,976	3,993	15,601	39,349	41,570	45,996
Multiple Races	6,334,262	192,256	751,146	1,629,729	1,215,694	791,946
Male	3,099,317	98,225	383,514	826,553	603,682	370,111
Female	3,234,945	94,031	367,632	803,176	612,012	421,835

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Bureau of the Census postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2014. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

Table II. U.S. population estimates used in computing annual visit rates for the National Hospital Ambulatory Medical Care Survey, by ethnicity, age, race, and sex: July 1, 2014 - con.

NON-HISPANIC

Race and sex	35-44	45-54	55-64	65-74	75+
All races	31,817,181	36,664,768	35,789,770	24,056,087	17,391,848
Male	15,463,070	17,837,241	17,198,982	11,279,537	7,168,151
Female	16,354,111	18,827,527	18,590,788	12,776,550	10,223,697
White Only	23,293,373	28,366,312	28,833,223	20,166,294	14,962,105
Male	11,572,429	14,018,897	14,048,820	9,582,036	6,245,144
Female	11,720,944	14,347,415	14,784,403	10,584,258	8,716,961
Black Only	4,855,884	5,143,277	4,413,409	2,391,185	1,486,170
Male	2,177,149	2,341,482	1,987,470	1,020,131	533,586
Female	2,678,735	2,801,795	2,425,939	1,371,054	952,584
AIAN* Only	279,978	307,704	266,690	148,477	79,828
Male	134,758	146,771	125,050	69,741	32,994
Female	145,220	160,933	141,640	78,736	46,834
Asian Only	2,733,607	2,300,596	1,852,133	1,121,527	731,398
Male	1,271,062	1,070,562	835,211	501,120	301,810
Female	1,462,545	1,230,034	1,016,922	620,407	429,588
NHOPI* Only	73,684	66,712	51,067	27,346	14,184
Male	36,450	32,797	24,901	13,334	6,044
Female	37,234	33,915	26,166	14,012	8,140
Multiple Races	580,655	480,167	373,248	201,258	118,163
Male	271,222	226,732	177,530	93,175	48,573
Female	309,433	253,435	195,718	108,083	69,590

*NHOPI is Native Hawaiian/Other Pacific Islander. AIAN is American Indian/Alaska Native.

SOURCE: These are U.S. Bureau of the Census postcensal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2014. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2014 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

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Information concerning additional reports using NHAMCS data that have been published or are scheduled for publication through NCHS may be obtained from the Ambulatory and Hospital Care Statistics Branch.

II. A. CODEBOOK OF EMERGENCY DEPARTMENT MICRO-DATA FILE

Number of records = 23,844

This section consists of a detailed breakdown of each data record. For each item on the record, the user is provided with a sequential item number, field length, file location, and brief description of the item, along with valid codes. Unless otherwise stated in the "item description" column, the data are derived from the Emergency Department automated Patient Record form. The hospital induction interview is another source of information, and some data are derived by recoding selected items.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
			DATE OF VISIT
1	2	1-2	[VMONTH] MONTH OF VISIT 01-12: January-December
2	1	3	[VDAYR] DAY OF WEEK OF VISIT 1 = Sunday 2 = Monday 3 = Tuesday 4 = Wednesday 5 = Thursday 6 = Friday 7 = Saturday
3	2	4-7	[ARRTIME] ARRIVAL TIME (military time) -9 = Blank 0000-2359
4	4	8-11	[WAITTIME] WAITING TIME TO SEE MD/DO/PA/NP (minutes) (Note: MD/DO/PA/NP is Doctor of Medicine, Doctor of Osteopathy, Physician Assistant, and Nurse Practitioner) Calculated from date and time of ED arrival, and time seen by MD/DO/PA/NP -9 = Blank -7 = Not applicable (Not seen by MD/DO/PA/NP) 0-1356 (reported range)
5	4	12-15	[LOV] LENGTH OF VISIT (minutes) Calculated from date and time of ED arrival and discharge -9 = Blank 0-5740 (reported range)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
6	3	16-18	[AGE] PATIENT AGE (IN YEARS; DERIVED FROM DATE OF VISIT AND DATE OF BIRTH) Note: Outlier values were top coded in accordance with NCHS confidentiality requirements. 0 = Under 1 year 1-92 93 = 93 years or older
7	1	19	[AGER] AGE RECODE 1 = Under 15 years 2 = 15-24 years 3 = 25-44 years 4 = 45-64 years 5 = 65-74 years 6 = 75 years and over
8	3	20-22	[AGEDAYS] AGE IN DAYS FOR PATIENTS LESS THAN ONE YEAR OF AGE 001-365 = 001-365 days -7 = Not applicable
9	2	23-24	[RESIDNCE] PATIENT RESIDENCE -9 = Blank -8 = Unknown 1 = Private residence 2 = Nursing home 3 = Homeless 4 = Other
10	1	25	[SEX] SEX 1 = Female 2 = Male
11	2	26-27	[ETHUN] ETHNICITY (UNIMPUTED) This variable is NOT imputed. Ethnicity data were missing on 23.7 ED records. An imputed ethnicity variable can be found in column 28. -9= Blank 1 = Hispanic or Latino 2 = Not Hispanic or Latino
12	1	28	[ETHIM] ETHNICITY (WITH MISSING DATA IMPUTED) 1 = Hispanic or Latino 2 = Not Hispanic or Latino

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

13   2   29-30   [RACEUN] RACE (UNIMPUTED)
This variable is NOT imputed. Race data were missing
on 19.8 of ED records. An imputed race variable can
be found in column 31.
-9 = Blank
1 = White
2 = Black/African American
3 = Asian
4 = Native Hawaiian/Other Pacific Islander
5 = American Indian/Alaska Native
6 = More than one race reported

14   1   31   [RACER] RACE (WITH MISSING DATA IMPUTED)
1 = White
2 = Black
3 = Other

15   1   32   [RACERETH] RACE/ETHNICITY (WITH MISSING DATA IMPUTED)
1 = Non-Hispanic White
2 = Non-Hispanic Black
3 = Hispanic
4 = Non-Hispanic Other

16   2   33-34   [ARREMS] Arrival by ambulance
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

17   2   35-36   [AMBTRANSFER] If "Yes" to Arrival by Ambulance, was the patient
transferred from another hospital or urgent care facility?
-9 = Blank
-8 = Unknown
-7 = Not applicable
1 = Yes
2 = No

18   1   37   [NOPAY] No answer to expected source of payment item
0 = At least one source of payment is recorded
1 = All sources of payments are blank

19   1   38   [PAYPRIV] EXPECTED SOURCE OF PAYMENT:
PRIVATE INSURANCE
0 = No
1 = Yes

20   1   39   [PAYMCARE] EXPECTED SOURCE OF PAYMENT:
MEDICARE
0 = No
1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
21	1	40	[PAYMCAID] EXPECTED SOURCE OF PAYMENT: MEDICAID or CHIP OR OTHER STATE-BASED PROGRAM 0 = No 1 = Yes
22	1	41	[PAYWKCMP] EXPECTED SOURCE OF PAYMENT: WORKER'S COMPENSATION 0 = No 1 = Yes
23	1	42	[PAYSELF] EXPECTED SOURCE OF PAYMENT: SELF PAY 0 = No 1 = Yes
24	1	43	[PAYNOCHG] EXPECTED SOURCE OF PAYMENT: NO CHARGE 0 = No 1 = Yes
25	1	44	[PAYOTH] EXPECTED SOURCE OF PAYMENT: OTHER 0 = No 1 = Yes
26	1	45	[PAYDK] EXPECTED SOURCE OF PAYMENT: UNKNOWN 0 = No 1 = Yes
27	2	46-47	[PAYTYPER] RECODED PRIMARY EXPECTED SOURCE OF PAYMENT FOR THIS VISIT (Using this hierarchy of payment categories: Medicare, Medicaid or CHIP, Private Insurance, Worker's Compensation, Self-Pay, No Charge/Charity, Other, Unknown) NOTE change in hierarchy starting in 2008 relative to previous years. In 2005-2007, dual-eligible Medicare and Medicaid recipients had been grouped under Medicaid; this was changed to Medicare starting in 2008. See page 2 of the 2009 NHAMCS Public Use Data File Documentation for more information. Researchers can also create their own hierarchy as desired. -9 = Blank -8 = Unknown 1 = Private insurance 2 = Medicare 3 = Medicaid or CHIP 4 = Worker's compensation 5 = Self-pay 6 = No charge/Charity 7 = Other

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

INITIAL VITAL SIGNS

28	4	48-51	[TEMPF] TEMPERATURE. There is an implied decimal between the third and fourth digits. -9 = Blank 0880-1090 = 88.0 – 109.0 Fahrenheit (reported range)
29	3	52-54	[PULSE] HEART RATE -9 = Blank 0-225 (reported range) 998 = DOP, DOPPLER
30	3	55-57	[RESPR] RESPIRATORY RATE -9 = Blank 0-150 (reported range)
31	3	58-60	[BPSYS] SYSTOLIC BLOOD PRESSURE -9 = Blank 0-280 (reported range)
32	3	61-63	[BPDIAS] DIASTOLIC BLOOD PRESSURE -9 = Blank 0-172 (reported range) 998 = P, Palp, DOP, or DOPPLER
33	3	64-66	[POPCT] PULSE OXIMETRY (percent) -9 = Blank 0-100 (reported range)
34	2	67-68	[IMMEDR] IMMEDIACY WITH WHICH PATIENT SHOULD BE SEEN (Based on PRF Item Triage Level)

NOTE: The collection and processing of this item changed starting in 2009, as described in the 2009 Public Use Data File Documentation.   Unlike in 2005-08 when response categories were checkboxes for each level of immediacy, the PRFs for 2009-2013 requested responses using a 1-5 scale. PRF responses were evaluated with reference to responses on the Ambulatory Unit Form, completed during induction, to the question, "How many levels are in this ESA's triage system?" After initial reconciliation between forms was completed, rescaling of responses was conducted. ESAs using 3 or 4 level triage systems had their responses rescaled to fit the 5 level system, such that, for 3-level hospitals, responses of 1, 2, and 3 were recoded to 2, 3, and 4. For ESAs using a 4-level system, responses were recoded from 1-4 to 2-5. The rescaling method was determined in consultation with subject matter experts and based on record analysis. For 2014, rescaling was required for about 3 percent of records overall, or 5 percent of records where triage was conducted.

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

Also, in 2009-2011, missing responses were imputed to levels 1-5 using the method described in Section 1. This is unlike years 2005-08 when "no triage" and "unknown", checkboxes used on the PRF in those years, were also valid imputation categories. For 2012-2014, this item is NOT imputed. Because of the difference in collection and processing of this item across the years, data users are advised to be careful when combining data across years for trending.

                                    -9 = Blank
                                    -8 = Unknown
                                     0 = 'No triage' reported for this visit but ESA does conduct nursing
                                          triage
                                    1 = Immediate
                                    2 = Emergent
                                    3 = Urgent
                                    4 = Semi-urgent
                                    5 = Nonurgent
                                    7 = Visit occurred in ESA that does not conduct nursing triage

35   2   69-70   [PAINSCALE] PAIN SCALE
                                    NOTE: This item was collected using checkbox categories of none, mild, moderate, severe, and unknown prior to 2009. Since 2009, a numerical 0-10 scale has been used.
                                    -9 = Blank
                                    -8 = Unknown
                                    0-10

36   2   71-72   [SEEN72] HAS PATIENT BEEN SEEN IN THIS ED WITHIN THE LAST 72 HOURS AND DISCHARGED? (The wording for this item changed in 2012. In 2011, the question was "Has patient been seen in this ED within the last 72 hours?)
                                    -9 = Blank
                                    -8 = Unknown
                                    1 = Yes
                                    2 = No

                                    PATIENT'S REASON(S) FOR VISIT (See page 19 in Section I and Code List in Appendix II.)

37   5   73-77   [RFV1] REASON # 1
                                    -9 = Blank
                                    10050-89990 = 1005.0-8999.0

38   5   78-82   [RFV2] REASON # 2
                                    -9 = Blank
                                    10050-89990 = 1005.0-8999.0

39   5   83-87   [RFV3] REASON # 3
                                    -9 = Blank
                                    10050-89990 = 1005.0-8999.0

40   5   88-92   [RFV4] REASON # 4
                                    -9 = Blank
                                    10050-89990 = 1005.0-8999.0

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

41   5   93-97   [RFV5] REASON # 5
                                    -9 = Blank
                                    10050-89990 = 1005.0-8999.0

42   2   98-99   [EPISODE] EPISODE OF CARE
                                      -9 = Blank
                                      -8 = Unknown
                                       1 = Initial visit to this ED
                                       2 = Follow-up visit to this ED

INJURY VARIABLES

43   2   100-101   [INJURY] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE, POISONING, OR ADVERSE EFFECT OF MEDICAL TREATMENT?

This is a summary variable provided for trending with previous years of data, although the format has changed slightly from previous years to better reflect uncertainties and nuances in the injury data. It has been recoded from the INJPOISAD variable below.

This item reflects the broad definition of injury traditionally used in NHAMCS. In addition to injury, poisoning, and adverse effects and complications codes from the NCHS Reason for Visit Classification (RVC) and the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM), a selection of other reason and diagnosis codes relating to various conditions (for example, carpal tunnel syndrome, allergic reactions, alcohol and drug abuse, birth trauma, and others) was used to indicate an injury-related visit. This broader definition of injury is used in the INJURY, INJPOISAD, and INJDETR variables.

                                     -9 = Blank
                                     -8 = Unknown
                                     0 = No
                                     1 = Yes
                                     2 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, and cause of injury)

44   1   102-102   [INJR1] IS THIS VISIT RELATED TO AN INJURY OR POISONING? Recoded version # 1

This variable uses a definition of injury developed in conjunction with NCHS' Office of Analysis and Epidemiology and is based on first-listed reason for visit, first-listed cause of injury, and first-listed diagnosis only. Note that adverse effects of medicinal drugs and adverse effects or complications of medical and surgical care are not included in this definition.

                                     0 = No
                                     1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

45   1   103-103   [INJR2] IS THIS VISIT RELATED TO AN INJURY OR POISONING? Recoded version # 2

This variable uses a definition of injury developed in conjunction with NCHS' Office of Analysis and Epidemiology and is based on any-listed reason for visit, any-listed cause of injury, and any-listed diagnosis. Note that adverse effects of medicinal drugs and adverse effects or complications of medical and surgical care are not included in this definition.

                               0 = No
                               1 = Yes

46   2   104-105   [INJPOISAD] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE, POISONING OR ADVERSE EFFECT OF MEDICAL TREATMENT?

                               This variable reflects the new injury item format used since 2012. INJPOISAD was created directly from reason for visit, diagnosis, and cause of injury codes first, followed by consideration of unedited data which indicated an injury but where no concrete evidence of injury existed.

                               -9 = Blank
                               -8 = Unknown
                               1 = Yes, injury/trauma
                               2 = Yes, poisoning
                               3 = Yes, adverse effect of medical treatment
                               4 = No, visit is not related to injury, poisoning, or adverse effect of medical treatment
                               5 = Questionable injury status ((visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

47   2   106-107   [INJPOISADR1] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE, POISONING OR ADVERSE EFFECT OF MEDICAL TREATMENT? – Recode #1

                               This variable is a recode of INJPOISAD which uses the INJR1 definition of injury described above, for categories 1 and 2 below.

                               -9 = Blank
                               -8 = Unknown
                               1 = Yes, injury/trauma
                               2 = Yes, poisoning
                               3 = Yes, adverse effect of medical treatment
                               4 = No, visit is not related to injury, poisoning, or adverse effect of medical treatment
                               5 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

48   2   108-109   **[INJPOISADR2] IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE, POISONING OR ADVERSE EFFECT OF MEDICAL TREATMENT? – Recode #2**

This variable is a recode of INJPOISAD which uses the INJR2 definition of injury described above, for categories 1 and 2 below.

-9 = Blank
-8 = Unknown
1 = Yes, injury/trauma
2 = Yes, poisoning
3 = Yes, adverse effect of medical treatment
4 = No, visit is not related to injury, poisoning, or adverse effect of medical treatment
5 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

49   2   110-111   **[INJURY72] Did the injury/trauma, overdose, or poisoning occur within 72 hours prior to the date and time of visit?**

-9 = Blank
-8 = Unknown
-7 = Not applicable
1 = Yes
2 = No

50   2   112-113   **[INTENT] IS THIS INJURY/OVERDOSE/POISONING INTENTIONAL?**
-9 = Blank
-8 = Unknown/intent unclear
1 = Yes, self-inflicted
2 = Yes, assault
3 = No, unintentional (e.g. accidental)
4 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

51   2   114-115   **[INJDETR] IS VISIT RELATED TO ANY OF THE FOLLOWING?**

This item reflects the injury format used prior to 2012 and has been included for trending purposes.

-9 = Blank
-8 = Unknown
-5 = Intentionality does not apply
1 = Unintentional injury/poisoning
2 = Intentional injury/poisoning
3 = Injury/poisoning of undetermined intent
4 = Adverse effect of medical treatment
5 = Visit is not related to injury, poisoning, or adverse effect of medical treatment
6 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

52   2   116-117   [INJDETR1] IS VISIT RELATED TO ANY OF THE FOLLOWING? – RECODE #1

This item reflects the injury format used prior to 2012 and has been included for trending purposes. It uses the INJR1 definition of injury above, for categories 1, 2, and 3 below.

-9 = Blank
-8 = Unknown
1 = Unintentional injury/poisoning
2 = Intentional injury/poisoning
3 = Injury/poisoning of undetermined intent
4 = Adverse effect of medical treatment
5 = Visit is not related to injury, poisoning, or adverse effect of medical treatment
6 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

53   2   118-119   [INJDETR2] IS VISIT RELATED TO ANY OF THE FOLLOWING? – RECODE #2

This item reflects the injury format used prior to 2012 and has been included for trending purposes. It uses the INJR2 definition of injury above, for categories 1, 2, and 3 below.

-9 = Blank
-8 = Unknown
1 = Unintentional injury/poisoning
2 = Intentional injury/poisoning
3 = Injury/poisoning of undetermined intent
4 = Adverse effect of medical treatment
5 = Visit is not related to injury, poisoning, or adverse effect of medical treatment
6 = Questionable injury status (visit was reported as injury related but lacked an injury reason for visit, diagnosis, or cause of injury)

CAUSE OF INJURY (See page 20 in Section I for explanation of codes.)

54   4   120-123   [CAUSE1] CAUSE #1 (ICD-9-CM, E-Codes)
There is an implied decimal between the third and fourth digits; for inapplicable fourth digits, a dash is inserted.
A prefix 'E' is implied. Codes in the 700- series were developed by the Ambulatory and Hospital Care Statistics Branch.

-9 = Not applicable/Blank
700- = Drug use/abuse
710- = Alcohol use/abuse
8000-999[-] = E800.0-E999

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

55   4   124-127   [CAUSE2] CAUSE #2 (ICD-9-CM, E-Codes)
There is an implied decimal between the third and fourth
digits; for inapplicable fourth digits, a dash is inserted.
A prefix 'E' is implied.

NOTE : CAUSE2 and CAUSE3 include additional activity codes
(E000.0-E030.0) that can be used to indicate the activity of the patient
seeking health care for an injury or health condition.

-9 = Not applicable/Blank
700- = Drug use/abuse
710- = Alcohol use/abuse
0000-999[-] = E000.0-E999

56   4   128-131   [CAUSE3] CAUSE #3 (ICD-9-CM, E-Codes)
There is an implied decimal between the third and fourth
digits; for inapplicable fourth digits, a dash is inserted.
A prefix 'E' is implied. See CAUSE #2 for details.

NUMERIC RECODES FOR CAUSE OF INJURY

The following recodes are included on the public use file to facilitate analysis of visits using ICD-9-CM E-codes. It had come to our attention in the past that some users of NHAMCS data find it preferable to use the numeric field recodes rather than the alphanumeric fields in certain data applications. Users can make their own choice about which format best suits their needs (more information can be found on page 20).

57   4   132-135   [CAUSE1R] CAUSE OF INJURY #1
(Recode to Numeric Field)
-9 = Blank
7000 = Drug use/abuse
7100 = Alcohol use/abuse
8000-9999 = E800.0 - E999.[9]

58   4   136-139   [CAUSE2R] CAUSE OF INJURY #2
(Recode to Numeric Field)

NOTE : CAUSE2R and CAUSE3R include additional activity codes
(E000.0-E030.0) that can be used to indicate the activity of the
patient seeking health care for an injury or health condition.

-9 = Blank
7000 = Drug use/abuse
7100 = Alcohol use/abuse
0000-9999 = E000.0 - E999.[9]

59   4   140-143   [CAUSE3R] CAUSE OF INJURY #3
(Recode to Numeric Field)
-9 = Blank
7000 = Drug use/abuse
7100 = Alcohol use/abuse
0000-9999 = E000.0 - E999.[9]

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

PROVIDER'S DIAGNOSIS (See page 20, Section 1 for explanation of coding.)

60   5   144-148   [DIAG1] DIAGNOSIS #1 (ICD-9-CM) There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted.

-9 = Blank (no entry made)
0010[-] – V9199 = 001.0[0]-V91.9[9]
V990- = Non-codable, insufficient information for coding, illegible
V991- = Left before being seen; patient walked out; not seen by doctor; left against medical advice
V992- = Transferred to another facility; sent to see specialist
V993- = HMO will not authorize treatment
V997- = Entry of "none," "no diagnosis," "no disease," or "healthy"
V998- = Entry of "Not applicable", "Not Available", "NA" or "Blank"

61   5   149-153   [DIAG2] DIAGNOSIS # 2 (ICD-9-CM) There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted. See DIAGNOSIS #1 for details.

62   5   154-158   [DIAG3] DIAGNOSIS # 3 (ICD-9-CM) There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted. See DIAGNOSIS #1 for details.

63   5   159-163   [DIAG4] DIAGNOSIS # 4 (ICD-9-CM) There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted. See DIAGNOSIS #1 for details.

64   5   164-168   [DIAG5] DIAGNOSIS # 5 (ICD-9-CM) There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted. See DIAGNOSIS #1 for details.

PROBABLE, QUESTIONABLE, AND RULE OUT DIAGNOSES

65   2   169-170   [PRDIAG1] IS DIAGNOSIS #1 PROBABLE, QUESTIONABLE, OR RULE OUT?
-7 = Not applicable
0 = No
1 = Yes

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

66   2   171-172   [PRDIAG2] IS DIAGNOSIS #2 PROBABLE, QUESTIONABLE, OR RULE OUT?
                                         -7 = Not applicable
                                         0 = No
                                         1 = Yes

67   2   173-174   [PRDIAG3] IS DIAGNOSIS #3 PROBABLE, QUESTIONABLE, OR RULE OUT?
                                         -7 = Not applicable
                                         0 = No
                                         1 = Yes

68   2   175-176   [PRDIAG4] IS DIAGNOSIS #4 PROBABLE, QUESTIONABLE, OR RULE OUT?
                                         -7 = Not applicable
                                         0 = No
                                         1 = Yes

69   2   177-178   [PRDIAG5] IS DIAGNOSIS #5 PROBABLE, QUESTIONABLE, OR RULE OUT?
                                         -7 = Not applicable
                                         0 = No
                                         1 = Yes

NUMERIC RECODES FOR DIAGNOSES

The following items were included on the public use file to facilitate analysis of visits using ICD-9-CM codes. Prior to the 1995 public use file, all ICD-9-CM diagnosis codes on the NHAMCS micro-data file were converted from alphanumeric to numeric fields according to the following coding conventions: A prefix of '1' was added to ICD-9-CM codes in the range of 001.0[-] through 999.9[-]. A prefix of '20' was substituted for the letter 'V' for codes in the range of V01.0[-] through V91.9[9]. Inapplicable fourth or fifth digits were zerofilled. This conversion was done to facilitate analysis of ICD-9-CM data using Ambulatory Care Statistics software systems. Specific coding conventions are discussed in the public use documentation for each data year.

In 1995, however, the decision was made to use actual ICD-9-CM codes on the public use data file. Codes were not prefixed, and a dash was inserted for inapplicable fourth or fifth digits. This had the advantage of preserving actual codes and avoiding possible confusion over the creation of some artificial codes due to zerofilling.

It had come to our attention in the past that some users of NHAMCS data find it preferable to use the numeric field recodes rather than the alphanumeric fields in certain data applications. Therefore, since data year 1997, we have included numeric recodes for ICD-9-CM diagnosis codes on our datasets. These are in addition to the actual codes for these diagnoses which appear earlier on the public use file. Users can make their own choice about which format best suits their needs.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
70	6	179-184	[DIAG1R] DIAGNOSIS #1 (Recode to Numeric Field) 100100-209199 = 001.0[0]-V91.9[9] 209900 = Noncodable, insufficient information for coding, illegible 209910 = Left before being seen; patient walked out; not seen by doctor; left against medical advice 209920 = Transferred to another facility; sent to see specialist 209930 = HMO will not authorize treatment 209970 = Entry of "none," "no diagnosis," "no disease," or "healthy" 209980 = Entry of "Not Applicable", "NA", or "Blank" -9 = Blank
71	6	185-190	[DIAG2R] DIAGNOSIS #2 (Recode to Numeric Field) See DIAGNOSIS #1 for details.
72	6	191-196	[DIAG3R] DIAGNOSIS #3 (Recode to Numeric Field) See DIAGNOSIS #1 for details.
73	6	197-202	[DIAG4R] DIAGNOSIS #4 (Recode to Numeric Field) See DIAGNOSIS #1 for details.
74	6	203-208	[DIAG5R] DIAGNOSIS #5 (Recode to Numeric Field) See DIAGNOSIS #1 for details. DOES PATIENT HAVE: 0 = No 1 = Yes
75	1	209	[CANCER] Cancer
76	1	210	[ETOHAB] Alcohol abuse
77	1	211	[ALZHD] Alzheimer's disease/dementia
78	1	212	[ASTHMA] Asthma
79	1	213	[CEBVD] Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA)
80	1	214	[CKD] Chronic kidney disease (CKD)
81	1	215	[COPD] Chronic obstructive pulmonary disease (COPD)
82	1	216	[CHF] Congestive heart failure
83	1	217	[CAD] Coronary artery disease (CAD), ischemic heart disease (IHD), or history of myocardial infarction (MI)
84	1	218	[DEPRN] Depression
85	1	219	[DIABTYP1] Diabetes mellitus (DM) – Type I
86	1	220	[DIABTYP2] Diabetes mellitus (DM) – Type II
87	1	221	[DIABTYP0] Diabetes mellitus (DM) – Type unspecified
88	1	222	[ESRD] End-stage renal disease (ESRD)
89	1	223	[HPE] History of pulmonary embolism (PE) or deep vein thrombosis (DVT)
90	1	224	[EDHIV] HIV infection/AIDS
91	1	225	[HYPLIPID] Hyperlipidemia
92	1	226	[HTN] Hypertension
93	1	227	[OBESITY] Obesity
94	1	228	[OSA] Obstructive sleep apnea (OSA)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

95	1	229	[OSTPRSIS] Osteoporosis
96	1	230	[SUBSTAB] Substance abuse
97	1	231	[NOCHRON] None of the above

0 = No
1 = Yes
2 = Entire item blank including "None" box

| 98 | 2 | 232-233 | [TOTCHRON] Total number of chronic conditions |

-9 = "None" box and all item fields are blank
0-12 (reported range)

| 99 | 1 | 234 | [DIAGSCRN] Were diagnostic services ordered or provided at this visit? |

0 = No
1 = Yes
2 = Entire item blank, including "None" box

DIAGNOSTIC SERVICES

0 = No, 1 = Yes

Blood tests:

100	1	235	[ABG] Arterial blood gases
101	1	236	[BAC] BAC (blood alcohol concentration)
102	1	237	[BLOODCX] Blood culture
103	1	238	[BNP] BNP (Brain natriuretic peptide)
104	1	239	[BUNCREAT] BUN (Blood urea nitrogen)/Creatinine
105	1	240	[CARDENZ] Cardiac enzymes
106	1	241	[CBC] CBC (Complete blood count)
107	1	242	[DDIMER] D-dimer
108	1	243	[ELECTROL] Electrolytes
109	1	244	[GLUCOSE] Glucose
110	1	245	[LACTATE] Lactate
111	1	246	[LFT] Liver function tests
112	1	247	[PTTINR] Prothrombin time/INR
113	1	248	[OTHERBLD] Other blood test

Other tests:

114	1	249	[CARDMON] Cardiac monitor
115	1	250	[EKG] EKG/ECG
116	1	251	[HIVTEST] HIV test
117	1	252	[FLUTEST] Influenza test
118	1	253	[PREGTEST] Pregnancy/HCG test
119	1	254	[TOXSCREN] Toxicology screen
120	1	255	[URINE] Urinalysis (UA)
121	1	256	[WOUNDCX] Wound culture
122	1	257	[URINECX] Urine culture

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
123	1	258	[OTHRTEST] Other test/service
			Imaging:
124	1	259	[ANYIMAGE] Any imaging
125	1	260	[XRAY] X-ray
126	1	261	[CATSCAN] CT scan (any)
127	1	262	[CTAB] CT scan – abdomen/pelvis
128	1	263	[CTCHEST] CT scan – chest
129	1	264	[CTHEAD] CT scan - head
130	1	265	[CTOTHER] CT scan – other
131	1	266	[CTUNK] CT scan – site not specified
132	2	267-268	[CTCONTRAST] Was CT scan ordered/provided with intravenous (IV) contrast?
133	1	269	[MRI] MRI
134	2	270-271	[MRICONTRAST] Was MRI ordered/provided with intravenous (IV) contrast?
135	1	272	[ULTRASND] Ultrasound
136	1	273	[OTHIMAGE] Other imaging
137	2	274-275	[TOTDIAG] TOTAL NUMBER OF DIAGNOSTIC SERVICES ORDERED OR PROVIDED -9 = "None" box and all item fields are blank 0-22 (reported range)
138	1	276	[PROC] Were procedures provided at this visit? 0 = No 1 = Yes 2 = Entire item blank, including "None" box
			PROCEDURES
			0 = No, 1 = Yes
139	1	277	[BPAP] BPAP/CPAP
140	1	278	[BLADCATH] Bladder catheter
141	1	279	[CASTSPLINT] Cast, splint, wrap
142	1	280	[CENTLINE] Central line
143	1	281	[CPR] CPR
144	1	282	[ENDOINT] Endotracheal intubation
145	1	283	[INCDRAIN] Incision & drainage (I&D)
146	1	284	[IVFLUIDS] IV fluids
147	1	285	[LUMBAR] Lumbar puncture
148	1	286	[NEBUTHER] Nebulizer therapy
149	1	287	[PELVIC] Pelvic exam
150	1	288	[SKINADH] Skin adhesives
151	1	289	[SUTURE] Suturing/staples
152	1	290	[OTHPROC] Other procedure
153	2	291-292	[TOTPROC] TOTAL NUMBER OF PROCEDURES PROVIDED -9 = "None" box and all item fields are blank 0-6 (reported range)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

MEDICATIONS & IMMUNIZATIONS
(See page 21 for more information. See Appendix III for codes.)

154   1   293   [MED] WERE MEDICATIONS OR IMMUNIZATIONS GIVEN AT THIS VISIT OR PRESCRIBED AT ED DISCHARGE?
0 = No
1 = Yes
2 = Entire item blank, including "None" box

155   5   294-298   [MED1] MEDICATION #1
-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

156   5   299-303   [MED2] MEDICATION #2
See MED1.

157   5   304-308   [MED3] MEDICATION #3
See MED1.

158   5   309-313   [MED4] MEDICATION #4
See MED1.

159   5   314-318   [MED5] MEDICATION #5
See MED1.

160   5   319-323   [MED6] MEDICATION #6
See MED1.

161   5   324-328   [MED7] MEDICATION #7
See MED1.

162   5   329-333   [MED8] MEDICATION #8
See MED1.

163   5   334-338   [MED9] MEDICATION #9
See MED1.

164   5   339-343   [MED10] MEDICATION #10
See MED1.

165   5   344-348   [MED11] MEDICATION #11
See MED1.

166   5   349-353   [MED12] MEDICATION #12
See MED1.

167   5   354-358   [MED13] MEDICATION #13
See MED1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
168	5	359-363	[MED14] MEDICATION #14 See MED1.
169	5	364-368	[MED15] MEDICATION #15 See MED1.
170	5	369-373	[MED16] MEDICATION #16 See MED1.
171	5	374-378	[MED17] MEDICATION #17 See MED1.
172	5	379-383	[MED18] MEDICATION #18 See MED1.
173	5	384-388	[MED19] MEDICATION #19 See MED1.
174	5	389-393	[MED20] MEDICATION #20 See MED1.
175	5	394-398	[MED21] MEDICATION #21 See MED1.
176	5	399-403	[MED22] MEDICATION #22 See MED1.
177	5	404-408	[MED23] MEDICATION #23 See MED1.
178	5	409-413	[MED24] MEDICATION #24 See MED1.
179	5	414-418	[MED25] MEDICATION #25 See MED1.
180	5	419-423	[MED26] MEDICATION #26 See MED1.
181	5	424-428	[MED27] MEDICATION #27 See MED1.
182	5	429-433	[MED28] MEDICATION #28 See MED1.
183	5	434-438	[MED29] MEDICATION #29 See MED1.
184	5	439-443	[MED30] MEDICATION #30 See MED1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
185	2	444-445	[GPMED1] Was medication #1 given in ED or Rx at discharge? -9= Blank -7 = Not applicable 1 = Given in ED 2 = Rx at discharge 3 = Both given and Rx marked
186	2	446-447	[GPMED2] Was medication #2 given in ED or Rx at discharge? See GPMED1.
187	2	448-449	[GPMED3] Was medication #3 given in ED or Rx at discharge? See GPMED1.
188	2	450-451	[GPMED4] Was medication #4 given in ED or Rx at discharge? See GPMED1.
189	2	452-453	[GPMED5] Was medication #5 given in ED or Rx at discharge? See GPMED1.
190	2	454-455	[GPMED6] Was medication #6 given in ED or Rx at discharge? See GPMED1.
191	2	456-457	[GPMED7] Was medication #7 given in ED or Rx at discharge? See GPMED1.
192	2	458-459	[GPMED8] Was medication #8 given in ED or Rx at discharge? See GPMED1.
193	2	460-461	[GPMED9] Was medication #9 given in ED or Rx at discharge? See GPMED1.
194	2	462-463	[GPMED10] Was medication #10 given in ED or Rx at discharge? See GPMED1.
195	2	464-465	[GPMED11] Was medication #11 given in ED or Rx at discharge? See GPMED1.
196	2	466-467	[GPMED12] Was medication #12 given in ED or Rx at discharge? See GPMED1.
197	2	468-469	[GPMED13] Was medication #13 given in ED or Rx at discharge? See GPMED1.
198	2	470-471	[GPMED14] Was medication #14 given in ED or Rx at discharge? See GPMED1.
199	2	472-473	[GPMED15] Was medication #15 given in ED or Rx at discharge? See GPMED1.
200	2	474-475	[GPMED16] Was medication #16 given in ED or Rx at discharge? See GPMED1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
201	2	476-477	[GPMED17] Was medication #17 given in ED or Rx at discharge? See GPMED1.
202	2	478-479	[GPMED18] Was medication #18 given in ED or Rx at discharge? See GPMED1.
203	2	480-481	[GPMED19] Was medication #19 given in ED or Rx at discharge? See GPMED1.
204	2	482-483	[GPMED20] Was medication #20 given in ED or Rx at discharge? See GPMED1.
205	2	484-485	[GPMED21] Was medication #21 given in ED or Rx at discharge? See GPMED1.
206	2	486-487	[GPMED22] Was medication #22 given in ED or Rx at discharge? See GPMED1.
207	2	488-489	[GPMED23] Was medication #23 given in ED or Rx at discharge? See GPMED1.
208	2	490-491	[GPMED24] Was medication #24 given in ED or Rx at discharge? See GPMED1.
209	2	492-493	[GPMED25] Was medication #25 given in ED or Rx at discharge? See GPMED1.
210	2	494-495	[GPMED26] Was medication #26 given in ED or Rx at discharge? See GPMED1.
211	2	496-497	[GPMED27] Was medication #27 given in ED or Rx at discharge? See GPMED1.
212	2	498-499	[GPMED28] Was medication #28 given in ED or Rx at discharge? See GPMED1.
213	2	500-501	[GPMED29] Was medication #29 given in ED or Rx at discharge? See GPMED1.
214	2	502-503	[GPMED30] Was medication #30 given in ED or Rx at discharge? See GPMED1.
215	2	504-505	[NUMGIV] NUMBER OF MEDICATIONS GIVEN IN ED 0 – 30

NOTE: For this variable, the value '0' can reflect the following situations: a) no drug listed; b) drug listed but only Rx at discharge; and c) drug listed but unknown whether given in ED or Rx at discharge.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

216 2 506-507 **[NUMDIS] NUMBER OF MEDICATIONS PRESCRIBED AT DISCHARGE**
0 - 30
NOTE: For this variable, the value '0' can reflect the following situations: a) no drug listed; b) drug listed but only given in ED; and c) drug listed but unknown whether given in ED or prescribed at discharge.

217 2 508-509 **[NUMMED] NUMBER OF MEDICATIONS CODED**
0 – 30

218 2 510-511 **[VITALSD] Were vitals taken at discharge?**
-9= Blank
1 = Yes
2 = No

219 4 512-515 **[TEMPDF] Vitals at discharge: Temperature in Farenheit**
-9= Blank
880-1050 = 88.0 - 105.0 Fahrenheit (reported range)

220 3 516-518 **[PULSED] Vitals at discharge: Heart rate (beats per minute)**
-9 = Blank
0-247 (reported range)
998 = DOP, DOPPLER

221 3 519-521 **[RESPRD] Vitals at discharge: Respiratory rate (breaths per minute)**
-9 = Blank
0-148 (reported range)

222 3 522-524 **[BPSYSD] Vitals at discharge: Systolic blood pressure**
-9 = Blank
59-261 (reported range)
998 = DOP, DOPPLER

223 3 525-527 **[BPDIASD] Vitals at discharge: Diastolic blood pressure**
-9 = Blank
21-139 (reported range)
998 = P, PALP, DOP, or DOPPLER

PROVIDERS SEEN

0 = No, 1 = Yes

224	1	528	[NOPROVID] No answer to item
225	1	529	[ATTPHYS] ED attending physician
226	1	530	[RESINT] ED resident/intern
227	1	531	[CONSULT] Consulting physician
228	1	532	[RNLPN] RN/LPN [Registered nurse/Licensed practical nurse]
229	1	533	[NURSEPR] Nurse practitioner
230	1	534	[PHYSASST] Physician assistant
231	1	535	[EMT] EMT [Emergency medicine technician]
232	1	536	[MHPROV] Other mental health provider

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
233	1	537	[OTHPROV] Other provider

VISIT DISPOSITION

0 = No, 1 = Yes

234	1	538	[NODISP] No answer to item
235	1	539	[NOFU] No follow-up planned
236	1	540	[RETRNED] Return to ED
237	1	541	[RETREFFU] Return/Refer to physician/clinic for FU [followup]
238	1	542	[LEFTBTRI] Left before triage
239	1	543	[LEFTATRI] Left after triage
240	1	544	[LEFTAMA] Left AMA [against medical advice]
241	1	545	[DOA] DOA [Dead on arrival]
242	1	546	[DIEDED] Died in ED
243	1	547	[TRANNH] Return/transfer to nursing home
244	1	548	[TRANPSYC] Transfer to psychiatric hospital
245	1	549	[TRANOTH] Transfer to other hospital
246	1	550	[ADMITHOS] Admit to this hospital
247	1	551	[OBSHOS] Admit to observation unit, then hospitalized
248	1	552	[OBSDIS] Admit to observation unit, then discharged
249	1	553	[OTHDISP] Other visit disposition

The next 4 items were completed only if the patient was admitted to the hospital at the current visit.

250	2	554-555	[ADMIT] Admitted to:

NOTE: The order of categories 4 and 5 was switched on the Patient Record Form starting in 2009 relative to 2007-08. Please take note if combining data across years.
-9 = Blank
-8 = Data not available (Unknown)
-7 = Not applicable (not admitted to hospital)
1 = Critical care unit
2 = Stepdown unit
3 = Operating room
4 = Mental health or detox unit
5 = Cardiac catheterization lab
6 = Other bed/unit

251	2	556-557	[ADMTPHYS] Admitting physician

-9 = Blank
-7 = Not applicable (not admitted to hospital)
1 = Hospitalist
2 = Not hospitalist
3 = Unknown

252	4	558-561	[BOARDED] Length of time boarded in the ED in minutes

Calculated from date/time bed was requested for hospital admission or transfer and date/time patient actually left the ED or observation unit
-9 = Missing data
-7 = Not applicable
0000-3615 (reported range)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

253   4   562-565   [LOS] Length of stay in hospital (days)
Calculated from date patient actually left the ED or observation unit to hospital discharge date
-9 = Missing data
-7 = Not applicable
1-67 (reported range)

254   5   556-570   [HDDIAG1] HOSPITAL DISCHARGE DIAGNOSIS #1 (ICD-9-CM)
There is an implied decimal between the third and fourth digits; for inapplicable fourth or fifth digits, a dash is inserted.
   -9 = Blank
   -7 = Not applicable (not admitted to hospital)
0010[-] – V9199 = 001.0[0]-V91.9[9]
V990- = Non-codable, insufficient information for coding, illegible
V991- = Left before being seen; patient walked out; not seen by doctor; left against medical advice
V992- = Transferred to another facility; sent to see specialist
V993- = HMO will not authorize treatment
V997- = Entry of "none," "no diagnosis," "no disease," or "healthy"
V998- = Entry of "Not Available", "NA" or "Blank"

255   5   571-575   [HDDIAG2] HOSPITAL DISCHARGE DIAGNOSIS #2 (ICD-9-CM)
See HDDIAG1.

256   5   576-580   [HDDIAG3] HOSPITAL DISCHARGE DIAGNOSIS #3 (ICD-9-CM)
See HDDIAG1.

257   5   581-585   [HDDIAG4] HOSPITAL DISCHARGE DIAGNOSIS #4 (ICD-9-CM)
See HDDIAG1.

258   5   586-590   [HDDIAG5] HOSPITAL DISCHARGE DIAGNOSIS #5 (ICD-9-CM)
See HDDIAG1.

NUMERIC RECODES FOR HOSPITAL DISCHARGE DIAGNOSIS

259   6   591-596   [HDDIAG1R] HOSPITAL DISCHARGE DIAGNOSIS #1
(Recode to Numeric Field)
100100-209199 = 001.0[0]-V91.9[9]
209900 = Noncodable, insufficient information for coding, illegible
209910 = Left before being seen; patient walked out; not seen by doctor; left against medical advice
209920 = Transferred to another facility; sent to see specialist
209930 = HMO will not authorize treatment
209970 = Entry of "none," "no diagnosis," "no disease," or "healthy"
209980 = Entry of "Not Applicable", "NA", or "Blank"
-9 = Blank

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
260	6	597-602	[HDDIAG2R] HOSPITAL DISCHARGE DIAGNOSIS #2 (Recode to Numeric Field) See HDDIAG1R.
261	6	603-608	[HDDIAG3R] HOSPITAL DISCHARGE DIAGNOSIS #3 See HDDIAG1R.
262	6	609-614	[HDDIAG4R] HOSPITAL DISCHARGE DIAGNOSIS #3 See HDDIAG1R.
263	6	615-620	[HDDIAG5R] HOSPITAL DISCHARGE DIAGNOSIS #3 See HDDIAG1R.
264	2	621-622	[HDSTAT] Hospital discharge status -9 = Blank -8 = Data not available (Unknown) -7 = Not applicable (not admitted to hospital) 1 = Alive 2 = Dead
265	2	623-624	[ADISP] Disposition of live discharges -9 = Blank -8 = Data not available (Unknown) -7 = Not applicable (not admitted/admitted, but not a live discharge) 1 = Home/Residence 2 = Return/Transfer to nursing home 3 = Transfer to another facility (not usual place of residence) 4 = Other
266	4	625-628	[OBSSTAY] Length of stay in observation unit (for those patients who were admitted to observation unit and then discharged) Calculated from date and time patient was discharged from the ED and date and time of observation unit discharge -9 = Missing data -7 = Not admitted to observation unit and then discharged 1 -5290 minutes (reported range)
267	1	629	[STAY24] ED discharge greater than 24 hours 1 = Patient was discharged from ED in more than 24 hours 2 = Patient was discharged from ED in 24 hours or less 3 = Missing data for ED discharge date and/or time

**** THE FOLLOWING FIELDS SHOW WHETHER DATA WERE IMPUTED TO REPLACE BLANKS ****

268	2	630-631	[AGEFL] Was patient age imputed, calculated or reported? -9 = Age derived by NCHS using imputed birth date 0 = Age calculated by NCHS based on reported birth date 1 = Age reported in survey instrument without birth date

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

IMPUTED FIELDS
0 = Not imputed
1 = Imputed

269	1	632	[BDATEFL] Was patient birth date imputed?
270	1	633	[SEXFL] Was patient sex imputed?
271	1	634	[ETHNICFL] Was patient ethnicity imputed?
272	1	635	[RACERFL] Was patient race imputed?

****************** END OF IMPUTED DATA FIELDS ********************

| 273 | 3 | 636-638 | [HOSPCODE] HOSPITAL CODE |

A unique code assigned to all the records from a particular hospital. For a number of hospitals, additional masking was required to minimize risks of disclosure. For this reason, the number of hospital codes is different than the number of responding facilities.
1-266

| 274 | 3 | 639-641 | [PATCODE] PATIENT CODE - A number assigned to identify each |

individual record from a particular hospital.
1-266

| 275 | 2 | 642-643 | [EBILLANYE] DOES YOUR ED SUBMIT CLAIMS |

ELECTRONICALLY (ELECTRONIC BILLING)?
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No

| 276 | 2 | 644-645 | [EMRED] DOES YOUR ED USE ELECTRONIC MEDICAL OR |

HEALTH RECORDS (EMR/EHR)? (DO NOT INCLUDE BILLING SYSTEMS)
-9 = Blank
-8 = Unknown
1 = Yes, all electronic
2 = Yes, part paper and part electronic
3 = No

(If response of '1' or '2' to EMRED, the next 3 questions were asked.)

| 277 | 2 | 646-647 | [HHSMUE] DOES YOUR CURRENT SYSTEM MEET MEANINGFUL |

USE CRITERIA AS DEFINED BY THE DEPARTMENT OF HEALTH AND HUMAN SERVICES?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

278   2   648-649   [SECURCHCKE] HAS YOUR HOSPITAL MADE AN ASSESSMENT OF THE POTENTIAL RISKS AND VULNERABILITIES OF YOUR ELECTRONIC HEALTH INFORMATION WITHIN THE LAST 12 MONTHS?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No

279   2   650-651   [DIFFEHRE] DOES YOUR EHR HAVE THE CAPABILITY TO ELECTRONICALLY SEND HEALTH INFORMATION TO ANOTHER PROVIDER WHOSE EHR SYSTEM IS DIFFERENT FROM YOUR SYSTEM?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No

280   2   652-653   [EHRINSE] DOES YOUR ED HAVE PLANS FOR INSTALLING A NEW EMR/EHR SYSTEM WITHIN THE NEXT 18 MONTHS?
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
3 = Maybe

IMPORTANT NOTE: Questions on features of a hospital's computerized capabilities have changed over the years. In the following section, items with an "R" suffix have been recoded in each year since 2010 to be consistent with the format used in the 2009 Physician Induction Interview, to make trending easier. Items without the "R" suffix reflect the current format.

PLEASE INDICATE WHETHER YOUR ED HAS EACH OF THE FOLLOWING COMPUTERIZED CAPABILITIES AND HOW OFTEN THESE CAPABILITIES ARE USED
(APPLIES TO ITEMS 281-332)

281   2   654-655   [EDEMOGE] REPORTING PATIENT HISTORY AND DEMOGRAPHIC INFORMATION
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

282   2   656-657   [EDEMOGER] REPORTING PATIENT HISTORY AND
DEMOGRAPHIC INFORMATION (recoded for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

283   2   658-659   [EPROLSTE] IF YES TO RECORDING PATIENT HISTORY AND
DEMOGRAPHIC INFORMATION, DOES THIS INCLUDE A
PATIENT PROBLEM LIST?
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

284   2   660-661   [EPROLSTER] IF YES TO RECORDING PATIENT HISTORY AND
DEMOGRAPHIC INFORMATION, DOES THIS INCLUDE A
PATIENT PROBLEM LIST? (recoded for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

285   2   662-663   [EVITALE] RECORDING AND CHARTING VITAL SIGNS
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

286   2   664-665   [EVITALER] RECORDING AND CHARTING VITAL SIGNS (recoded
for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
287	2	666-667	[ESMOKEE] RECORDING PATIENT SMOKING STATUS -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
288	2	668-669	[ESMOKEER] RECORDING PATIENT SMOKING STATUS (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
289	2	670-671	[EPNOTESE] RECORDING CLINICAL NOTES -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
290	2	672-673	[EPNOTESER] RECORDING CLINICAL NOTES (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
291	2	674-675	[EMEDALGE] RECORDING PATIENT'S MEDICATIONS AND ALLERGIES? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
292	2	676-677	[EMEDALGER] RECORDING PATIENT'S MEDICATIONS AND ALLERGIES? (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

293   2   678-679   **[EMEDIDE] RECONCILING LISTS OF PATIENTS' MEDICATIONS TO IDENTIFY THE MOST ACCURATE LIST**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

294   2   680-681   **[EMEDIDER] RECONCILING LISTS OF PATIENTS' MEDICATIONS TO IDENTIFY THE MOST ACCURATE LIST (recoded for trending)**
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

295   2   682-683   **[EREMINDE] REMINDERS FOR GUIDELINE-BASED INTERVENTIONS AND/OR SCREENING TESTS**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

296   2   684-685   **[EREMINDER] REMINDERS FOR GUIDELINE-BASED INTERVENTIONS AND/OR SCREENING TESTS (recoded for trending)**
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

297   2   686-687   **[ECPOEE] ORDERS FOR PRESCRIPTIONS**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

298   2   688-689   [ECPOEER] ORDERS FOR PRESCRIPTIONS (recoded for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

299   2   690-691   [ESCRIPE] IF YES TO ORDERING PRESCRIPTIONS, ARE PRESCRIPTIONS SENT ELECTRONICALLY TO THE PHARMACY?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

300   2   692-693   [ESCRIPER] IF YES TO ORDERING PRESCRIPTIONS, ARE PRESCRIPTIONS SENT ELECTRONICALLY TO THE PHARMACY? (recoded for trending)
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

301   2   694-695   [EWARNE] IF YES TO ORDERING PRESCRIPTIONS, ARE WARNINGS OF DRUG INTERACTIONS OR CONTRAINDICATIONS PROVIDED?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

302   2   696-697   [EWARNER] IF YES TO ORDERING PRESCRIPTIONS, ARE WARNINGS OF DRUG INTERACTIONS OR CONTRAINDICATIONS PROVIDED? (recoded for trending)
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

303   2   698-699   [EFORMULAE] IF YES TO ORDERING PRESCRIPTIONS, DOES YOUR ED HAVE A COMPUTERIZED SYSTEM FOR PERFORMING DRUG FORMULARY CHECKS?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

304   2   700-701   [EFORMULAER] IF YES TO ORDERING PRESCRIPTIONS, DOES YOUR ED HAVE A COMPUTERIZED SYSTEM FOR PERFORMING DRUG FORMULARY CHECKS? (recoded for trending)
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

305   2   702-703   [ECTOEE] ORDERING LAB TESTS
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

306   2   704-705   [ECTOEER] ORDERING LAB TESTS (recoded for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

307   2   706-707   [EORDERE] IF YES TO ORDERING LAB TESTS, ARE ORDERS SENT ELECTRONICALLY?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

308   2   708-709   [EORDERER] IF YES TO ORDERING LAB TESTS, ARE ORDERS SENT ELECTRONICALLY? (recoded for trending)
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

309   2   710-711   [ERESULTE] VIEWING LAB RESULTS
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

310   2   712-713   [ERESULTER] VIEWING LAB RESULTS (recoded for trending)
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

311   2   714-715   [EGRAPHE] IF YES TO VIEWING LAB RESULTS, CAN THE EHR/EMR AUTOMATICALLY GRAPH A SPECIFIC PATIENT'S LAB RESULTS OVER TIME?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

312   2   716-717   [EGRAPHER] IF YES TO VIEWING LAB RESULTS, CAN THE EHR/EMR AUTOMATICALLY GRAPH A SPECIFIC PATIENT'S LAB RESULTS OVER TIME? (recoded for trending)
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

313   2   718-719   **[ERADIE] ORDERING RADIOLOGY TESTS**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

314   2   720-721   **[ERADIER] ORDERING RADIOLOGY TESTS (recoded for trending)**
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

315   2   722-723   **[EIMGRESE] VIEWING IMAGING RESULTS**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

316   2   724-725   **[EIMGRESER] VIEWING IMAGING RESULTS (recoded for trending)**
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes
2 = No
4 = Yes, but turned off/not used

317   2   726-727   **[EPTEDUE] IDENTIFYING EDUCATIONAL RESOURCES FOR PATIENTS' SPECIFIC CONDITIONS**
-9 = Blank
-8 = Unknown
-6 = Refused to answer question
1 = Yes, used routinely
2 = Yes, but not used routinely
3 = Yes, but turned off or not used
4 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
318	2	728-729	[EPTEDUER] VIEWING IDENTIFYING EDUCATIONAL RESOURCES FOR PATIENTS' SPECIFIC CONDITIONS (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
319	2	730-731	[ECQME] REPORTING CLINICAL QUANTITY MEASURES TO FEDERAL OR STATE AGENCIES (SUCH AS CMS OR MEDICAID) -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
320	2	732-733	[ECQMER] REPORTING CLINICAL QUANTITY MEASURES TO FEDERAL OR STATE AGENCIES (SUCH AS CMS OR MEDICAID) (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
321	2	734-735	[EIDPTE] IDENTIFYING PATIENTS DUE FOR PREVENTIVE OR FOLLOW-UP CARE IN ORDER TO SEND PATIENTS REMINDERS? -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
322	2	736-737	[EIDPTER] IDENTIFYING PATIENTS DUE FOR PREVENTIVE OR FOLLOW-UP CARE IN ORDER TO SEND PATIENTS REMINDERS? (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
323	2	738-739	[EGENLISTE] GENERATING LIST OF PATIENTS WITH PARTICULAR HEALTH CONDITIONS -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
324	2	740-741	[EGENLISTER] GENERATING LIST OF PATIENTS WITH PARTICULAR HEALTH CONDITIONS (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
325	2	742-743	[EIMMREGE] ELECTRONIC REPORTING TO IMMUNIZATION REGISTRIES -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
326	2	744-745	[EIMMREGER] ELECTRONIC REPORTING TO IMMUNIZATION REGISTRIES (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
327	2	746-747	[ESUME] PROVIDING PATIENTS WITH CLINICAL SUMMARIES FOR EACH VISIT -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
328	2	748-749	[ESUMER] PROVIDING PATIENTS WITH CLINICAL SUMMARIES FOR EACH VISIT (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
329	2	750-751	[EMSGE] EXCHANGING SECURE MESSAGES WITH PATIENTS -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
330	2	752-753	[EMSGER] EXCHANGING SECURE MESSAGES WITH PATIENTS (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used
331	2	754-755	[EPTRECE] PROVIDING PATIENTS THE ABILITY TO VIEW ONLINE, DOWNLOAD OR TRANSMIT INFORMATION FROM THEIR MEDICAL RECORD -9 = Blank -8 = Unknown -6 = Refused to answer question 1 = Yes, used routinely 2 = Yes, but not used routinely 3 = Yes, but turned off or not used 4 = No
332	2	756-757	[EPTRECER] PROVIDING PATIENTS THE ABILITY TO VIEW ONLINE, DOWNLOAD OR TRANSMIT INFORMATION FROM THEIR MEDICAL RECORD (recoded for trending) -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No 4 = Yes, but turned off/not used

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
333	2	758-759	[ESHAREE] DOES YOUR ED SHARE ANY PATIENT HEALTH INFORMATION ELECTRONICALLY (NOT FAX) WITH OTHER PROVIDERS, INCLUDING HOSPITALS, AMBULATORY PROVIDERS, OR LABS? -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No

HOW DOES YOUR ED ELECTRONICALLY SHARE PATIENT HEALTH INFORMATION?

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
334	2	760-761	[ESHAREEHRE] EHR/EMR
335	2	762-763	[ESHAREWEBE] Web portal (separate from EHR/EMR)
336	2	764-765	[ESHAREOTHE] Other electronic methods
337	2	766-767	[ESHAREUNKE] Unknown
338	2	768-769	[ESHAREREFE] Refused to answer

-9 = Blank
-7 = Not applicable
0 = Box is not marked
1 = Box is marked

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
339	2	770-771	[EHRTOEHRE] IF ED SHARES PATIENT INFORMATION ELECTRONICALLY (NOT FAX) WITH OTHER PROVIDERS, IS THE PATIENT HEALTH INFORMATION THAT YOU SHARE ELECTRONICALLY SENT DIRECTLY FROM YOUR EHR SYSTEM TO ANOTHER EHR SYSTEM? -9 = Blank -8 = Unknown -7 = Not applicable -6 = Refused to answer question 1 = Yes, routinely 2 = Yes, but not routinely 3 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

WITH WHAT TYPES OF PROVIDERS DO YOU ELECTRONICALLY SHARE PATIENT HEALTH INFORMATION:

340	2	772-773	[ESHAREPROVE1] Ambulatory providers inside your hospital
341	2	774-775	[ESHAREPROVE2] Ambulatory providers outside your hospital
342	2	776-777	[ESHAREPROVE3] Hospitals with which you are affiliated
343	2	778-779	[ESHAREPROVE4] Hospitals with which you are not affiliated
344	2	780-781	[ESHAREPROVE5] Behavioral health providers
345	2	782-783	[ESHAREPROVE6] Long-term care providers
346	2	784-785	[ESHAREPROVE7] Home health providers
347	2	786-787	[ESHAREPROVEREF] Refused to answer
348	2	788-789	[ESHAREPROVEUNK] Unknown

-9 = Blank
-7 = Not applicable
0 = Box is not marked
1 = Box is marked

349   2   790-791   [EDPRIM] WHEN PATIENTS WITH IDENTIFIED PRIMARY CARE PHYSICIANS (PCP) ARRIVE AT THE ED, HOW OFTEN DO YOU ELECTRONICALLY SEND NOTIFICATIONS TO THE PATIENTS' PCP?
-9 = Blank
-8 = Unknown
-7 = Not applicable
-6 = Refused to answer
1 = Always
2 = Sometimes
3 = Rarely
4 = Never

350   2   792-793   [EDINFO] WHEN PATIENTS ARRIVE AT THE ED, ARE YOU ABLE TO QUERY FOR PATIENTS' HEALTHCARE INFORMATION ELECTRONICALLY FROM OUTSIDE SOURCES?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

351   2   794-795   [MUSTAGE1] DOES YOUR HOSPITAL HAVE PLANS TO APPLY FOR STAGE 1 MEANINGFUL USE OF HEALTH IT INCENTIVE PAYMENTS?
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes, we already applied
2 = Yes, we intend to apply
3 = Uncertain if we will apply
4 = No, we will not apply

If response of '1' or '2' to MUSTAGE1, then MUSTAGE2 was asked.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

352   2   796-797   **[MUSTAGE2] ARE THERE PLANS TO APPLY FOR STAGE 2 INCENTIVE PAYMENTS?**
-9 = Blank
-8 = Unknown
-7 = Not applicable
1 = Yes
2 = No
3 = Maybe

353   2   798-799   **[OBSCLIN] DOES YOUR ED HAVE AN OBSERVATION OR CLINICAL DECISION UNIT?**
Note that there were related items in 2009 and 2010 called OBSUNIT, OBSED, and OBSDEC. In 2013-2014, OBSCLIN and OBSSEP replaced the OBSUNITS item from 2012.
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

354   2   800-801   **[OBSSEP] IS THIS OBSERVATION OR CLINICAL DECISION UNIT SEPARATE FROM THE ED?**
-9 = Blank
-8 = Unknown
-7 = Not applicable
1 = Yes
2 = No

IF YOUR ED HAS A PHYSICALLY SEPARATE OBSERVATION OR CLINICAL DECISION UNIT, WHAT TYPE OF PHYSICIAN MAKES DECISIONS FOR PATIENTS IN THIS OBSERVATION UNIT?

355	2	802-803	[OBSPHYSED] ED physicians
356	2	804-805	[OBSHOSP] Hospitalists
357	2	806-807	[OBSPHYSOT] Other physicians
358	2	808-809	[OBSPHYSUN] Unknown

-7 = Not applicable
0 = Box is not marked
1 = Box is marked

359   2   810-811   **[BOARD] ARE ADMITTED ED PATIENTS EVER "BOARDED" FOR MORE THAN 2 HOURS IN THE ED OR OBSERVATION UNIT WHILE WAITING FOR AN INPATIENT BED?**
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
360	2	812-813	[BOARDHOS] DOES YOUR ED ALLOW SOME PATIENTS TO MOVE FROM THE ED TO INPATIENT CORRIDORS WHILE AWAITING A BED ("BOARDING) – SOMETIMES CALLED A "FULL CAPACITY PROTOCOL"? -9 = Blank -8 = Unknown 1 = Yes 2 = No
361	2	814-815	[AMBDIV] DID YOUR ED GO ON AMBULANCE DIVERSION IN 2013? -9 = Blank -8 = Unknown 1 = Yes 2 = No
362	2	816-817	[TOTHRDIVR] TOTAL NUMBER OF HOURS YOUR HOSPITAL'S ED WAS ON AMBULANCE DIVERSION IN 2013 (Recoded) -9='Blank' -7='Not applicable' 2 = 1-99 3 = 100-499 4 = 500 or more 5 = Diversion data not available
363	2	818-819	[REGDIV] IS AMBULANCE DIVERSION ACTIVELY MANAGED ON A REGIONAL LEVEL VERSUS EACH HOSPITAL ADOPTING DIVERSION IF AND WHEN IT CHOOSES? -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
364	2	820-821	[ADMDIV] DOES YOUR HOSPITAL CONTINUE TO ADMIT ELECTIVE OR SCHEDULED SURGERY CASES WHEN THE ED IS ON AMBULANCE DIVERSION? -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
365	2	822-823	[INCSHX] IN THE LAST TWO YEARS, HAS YOUR ED INCREASED THE NUMBER OF STANDARD TREATMENT SPACES? -9 = Blank -8 = Unknown 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
366	2	824-825	[INCPHYS] IN THE LAST TWO YEARS, HAS YOUR ED'S PHYSICAL SPACE BEEN EXPANDED? -9 = Blank -8 = Unknown 1 = Yes 2 = No
367	2	826-827	[EXPSPACE] DO YOU HAVE PLANS TO EXPAND YOUR ED'S PHYSICAL SPACE WITHIN THE NEXT TWO YEARS? -9 = Blank -8 = Unknown 1 = Yes 2 = No DOES YOUR ED USE: (Note change in item format since 2009.) -9 = Blank -8 = Unknown 1 = Yes 2 = No
368	2	828-829	[BEDREG] Bedside registration
369	2	830-831	[KIOSELCHK] Kiosk self check-in
370	2	832-833	[CATRIAGE] Computer-assisted triage
371	2	834-835	[IMBED] Immediate bedding
372	2	836-837	[ADVTRIAG] Advanced triage (triage-based care) protocols
373	2	838-839	[PHYSPRACTRIA] Physician/practitioner at triage
374	2	840-841	[FASTTRAK] Separate fast track unit for nonurgent care
375	2	842-843	[EDPTOR] Separate operating room dedicated to ED patients
376	2	844-845	[DASHBORD] Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources
377	2	846-847	[RFID] Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)
378	2	848-849	[WIRELESS] Wireless devices by providers
379	2	850-851	[ZONENURS] Zone nursing (i.e., all of a nurse's patients are located in one area)
380	2	852-853	[POOLNURS] "Pool" nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)
381	2	854-855	[SURGDAY] HOW MANY DAYS IN A WEEK ARE INPATIENT ELECTIVE SURGERIES SCHEDULED? -9 = Blank -8 = Unknown 0-7
382	2	856-857	[BEDCZAR] DOES YOUR HOSPITAL HAVE A BED COORDINATOR, SOMETIMES REFERRED TO AS A BED CZAR? -9 = Blank -8 = Unknown 1 = Yes 2 = No

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
383	2	858-859	[BEDDATA] HOW OFTEN ARE HOSPITAL BED CENSUS DATA AVAILABLE? -9 = Blank -8 = Unknown 1 = Instantaneously 2 = Every 4 hours 3 = Every 8 hours 4 = Every 12 hours 5 = Every 24 hours 6 = Other
384	2	860-861	[HLIST] DOES YOUR HOSPITAL HAVE HOSPITALISTS ON STAFF? -9 = Blank -8 = Unknown 1 = Yes 2 = No
385	2	862-863	[HLISTED] DO THE HOSPITALISTS ON STAFF AT YOUR HOSIPTAL ADMIT PATIENTS FROM YOUR ED? -9 = Blank -8 = Unknown -7 = Not applicable 1 = Yes 2 = No
386	2	864-865	[EMEDRES] DOES YOUR HOSPITAL HAVE AN EMERGENCY MEDICINE RESIDENCY PROGRAM? -9 = Blank -8 = Unknown 1 = Yes 2 = No
387	1	866	[REGION] GEOGRAPHIC REGION (Based on actual location of the hospital.) 1 = Northeast 2 = Midwest 3 = South 4 = West
388	1	867	[MSA] METROPOLITAN STATISTICAL AREA STATUS (Based on actual location of the hospital in conjunction with the definition of the Bureau of the Census and the U.S. Office of Management and Budget.) 1 = MSA (Metropolitan Statistical Area) 2 = Non-MSA (includes micropolitan statistical areas)

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #1

NOTE: Starting with the 2006 data release, all drug codes based on entry name (using NCHS' standard classification system) were also assigned a unique generic drug code from Multum's Lexicon Drug Database, where possible. The structure of the Multum database is such that multiple ingredient drugs are assigned a single generic drug code encompassing all of a drug's ingredients rather than being assigned generic drug codes for each ingredient, as in past years of NHAMCS drug data. All Multum codes start with the letter "d" but there were some drugs reported in NHAMCS that could not be assigned a code in Multum. These received a prefix of either "a" (when ingredients could be determined) or "c" (when ingredients could not be determined). For more on the structure of the drug data (including information on therapeutic class and drug ingredients, please see page 21.)

389   6   868-873   [DRUGID1] DRUG ID (See p. 144 for more information.)
a07001-a92507 = NCHS code (for drugs not found in Multum but for which ingredients could be determined)
c00001-c00898, c00900-c92511 = NCHS code (for drugs not found in Multum and with undetermined ingredients)
d00001-d08200 = Multum code
n00001-n12023 = NCHS code (for drugs not found in Multum that were added to the database beginning with survey year 2008)

390   1   874   [PRESCR1] PRESCRIPTION STATUS CODE
1 = Prescription Drug   4 = Illicit (no longer used in NHAMCS)
2 = Nonprescription Drug   5 = Both Prescription and
3 = Undetermined   Over-the-Counter

391   1   875   [CONTSUB1] CONTROLLED SUBSTANCE STATUS CODE
1 = Schedule I (Research Only)
2 = Schedule II   5 = Schedule V   8 = Multiple Schedules
3 = Schedule III   6 = No Control
4 = Schedule IV   7 = Undetermined

392   1   876   [COMSTAT1] COMPOSITION STATUS CODE
1 = Single Entity Drug
2 = Combination Drug
3 = Undetermined

393   3   877-879   [RX1CAT1] MULTUM DRUG CATEGORY # 1

Reflects the most detailed therapeutic level to which the drug can be classified. For some drugs, Multum Level 1 (broadest level) is the most detailed, while others can be coded to Level 2, but the majority can be coded to Level 3 (most detailed level). For more on the Multum classification system, please see page 21. The complete Multum classification is shown in Appendix III.

"   " = Blank/Not applicable
001 - 899 = Drug category
999 = Undetermined category

394   3   880-882   [RX1CAT2] MULTUM DRUG CATEGORY # 2
See RX1CAT1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
395	3	883-885	[RX1CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
396	3	886-888	[RX1CAT4] MULTUM DRUG CATEGORY # 4 See RX1CAT1.

DRUG CATEGORY LEVELS

See RX1CAT1 for general coding conventions that apply to all Multum drug categories. Complete Multum classification scheme is shown in Appendix III.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
397	3	889-891	[RX1V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
398	3	892-894	[RX1V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
399	3	895-897	[RX1V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
400	3	898-900	[RX1V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
401	3	901-903	[RX1V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
402	3	904-906	[RX1V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
403	3	907-909	[RX1V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
404	3	910-912	[RX1V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
405	3	913-915	[RX1V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
406	3	916-918	[RX1V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
407	3	919-921	[RX1V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
408	3	922-924	[RX1V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #2

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

409	6	925-930	[DRUGID2] Drug ID
410	1	931	[PRESCR2] PRESCRIPTION STATUS CODE
411	1	932	[CONTSUB2] CONTROLLED SUBSTANCE STATUS CODE
412	1	933	[COMSTAT2] COMPOSITION STATUS CODE
413	3	934-936	[RX2CAT1] MULTUM DRUG CATEGORY # 1
414	3	937-939	[RX2CAT2] MULTUM DRUG CATEGORY # 2 See RX2CAT1.
415	3	940-942	[RX2CAT3] MULTUM DRUG CATEGORY # 3 See RX2CAT1.
416	3	943-945	[RX2CAT4] MULTUM DRUG CATEGORY # 4 See RX2CAT1.

DRUG CATEGORY LEVELS

417	3	946-948	[RX2V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
418	3	949-951	[RX2V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
419	3	952-954	[RX2V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
420	3	955-957	[RX2V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
421	3	958-960	[RX2V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
422	3	961-963	[RX2V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
423	3	964-966	[RX2V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
424	3	967-969	[RX2V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
425	3	970-972	[RX2V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
426	3	973-975	[RX2V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
427	3	976-978	[RX2V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
428	3	979-981	[RX2V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #3

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

429	6	982-987	[DRUGID3] Drug ID
430	1	988	[PRESCR3] PRESCRIPTION STATUS CODE
431	1	989	[CONTSUB3] CONTROLLED SUBSTANCE STATUS CODE
432	1	990	[COMSTAT3] COMPOSITION STATUS CODE
433	3	991-993	[RX3CAT1] MULTUM DRUG CATEGORY # 1
434	3	994-996	[RX3CAT2] MULTUM DRUG CATEGORY # 2 See RX3CAT1.
435	3	997-999	[RX3CAT3] MULTUM DRUG CATEGORY # 3 See RX3CAT1.
436	3	1000-1002	[RX3CAT4] MULTUM DRUG CATEGORY # 4 See RX3CAT1.

DRUG CATEGORY LEVELS

437	3	1003-1005	[RX3V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
438	3	1006-1008	[RX3V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
439	3	1009-1011	[RX3V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
440	3	1012-1014	[RX3V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
441	3	1015-1017	[RX3V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
442	3	1018-1020	[RX3V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
443	3	1021-1023	[RX3V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
444	3	1024-1026	[RX3V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
445	3	1027-1029	[RX3V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
446	3	1030-1032	[RX3V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
447	3	1033-1035	[RX3V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
448	3	1036-1038	[RX3V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #4

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

| 449 | 6 | 1039-1044 | [DRUGID4] Drug ID |

| 450 | 1 | 1045 | [PRESCR4] PRESCRIPTION STATUS CODE |

| 451 | 1 | 1046 | [CONTSUB4] CONTROLLED SUBSTANCE STATUS CODE |

| 452 | 1 | 1047 | [COMSTAT4] COMPOSITION STATUS CODE |

| 453 | 3 | 1048-1050 | [RX4CAT1] MULTUM DRUG CATEGORY # 1 |

454   3   1051-1053   [RX4CAT2] MULTUM DRUG CATEGORY # 2
                               See RX4CAT1.

455   3   1054-1056   [RX4CAT3] MULTUM DRUG CATEGORY # 3
                               See RX4CAT1.

456   3   1057-1059   [RX4CAT4] MULTUM DRUG CATEGORY # 4
                               See RX4CAT1.

DRUG CATEGORY LEVELS

457	3	1060-1062	[RX4V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
458	3	1063-1065	[RX4V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
459	3	1066-1068	[RX4V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
460	3	1069-1071	[RX4V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

461	3	1072-1074	[RX4V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
462	3	1075-1077	[RX4V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
463	3	1078-1080	[RX4V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
464	3	1081-1083	[RX4V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

465	3	1084-1086	[RX4V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
466	3	1087-1089	[RX4V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
467	3	1090-1092	[RX4V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
468	3	1093-1095	[RX4V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #5

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

469   6   1096-1101 [DRUGID5] Drug ID

470   1   1102   [PRESCR5] PRESCRIPTION STATUS CODE

471   1   1103   [CONTSUB5] CONTROLLED SUBSTANCE STATUS CODE

472   1   1104   [COMSTAT5] COMPOSITION STATUS CODE

473   3   1105-1107 [RX5CAT1] MULTUM DRUG CATEGORY # 1

474   3   1108-1110 [RX5CAT2] MULTUM DRUG CATEGORY # 2
                               See RX3CAT1.

475   3   1111-1113 [RX5CAT3] MULTUM DRUG CATEGORY # 3
                               See RX3CAT1.

476   3   1114-1116 [RX5CAT4] MULTUM DRUG CATEGORY # 4
                               See RX3CAT1.

                               DRUG CATEGORY LEVELS

477   3   1117-1119 [RX5V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
478   3   1120-1122 [RX5V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
479   3   1123-1125 [RX5V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
480   3   1126-1128 [RX5V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

481   3   1129-1131 [RX5V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
482   3   1132-1134 [RX5V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
483   3   1135-1137 [RX5V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
484   3   1138-1140 [RX5V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

485   3   1141-1143 [RX5V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
486   3   1144-1146 [RX5V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
487   3   1147-1149 [RX5V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
488   3   1150-1152 [RX5V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #6

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

489	6	1153-1158	[DRUGID6] Drug ID
490	1	1159	[PRESCR6] PRESCRIPTION STATUS CODE
491	1	1160	[CONTSUB6] CONTROLLED SUBSTANCE STATUS CODE
492	1	1161	[COMSTAT6] COMPOSITION STATUS CODE
493	3	1162-1164	[RX6CAT1] MULTUM DRUG CATEGORY # 1
494	3	1165-1167	[RX6CAT2] MULTUM DRUG CATEGORY # 2 See RX6CAT1.
495	3	1168-1170	[RX6CAT3] MULTUM DRUG CATEGORY # 3 See RX6CAT1.
496	3	1171-1173	[RX6CAT4] MULTUM DRUG CATEGORY # 4 See RX6CAT1.

DRUG CATEGORY LEVELS

497	3	1174-1176	[RX6V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
498	3	1177-1179	[RX6V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
499	3	1180-1182	[RX6V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
500	3	1183-1185	[RX6V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
501	3	1186-1188	[RX6V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
502	3	1189-1191	[RX6V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
503	3	1192-1194	[RX6V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
504	3	1195-1197	[RX6V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
505	3	1198-1200	[RX6V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
506	3	1201-1203	[RX6V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
507	3	1204-1206	[RX6V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
508	3	1207-1209	[RX6V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #7

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

509	6	1210-1215	[DRUGID7] Drug ID
510	1	1216	[PRESCR7] PRESCRIPTION STATUS CODE
511	1	1217	[CONTSUB7] CONTROLLED SUBSTANCE STATUS CODE
512	1	1218	[COMSTAT7] COMPOSITION STATUS CODE
513	3	1219-1221	[RX7CAT1] MULTUM DRUG CATEGORY # 1
514	3	1222-1224	[RX7CAT2] MULTUM DRUG CATEGORY # 2 See RX7CAT1.
515	3	1225-1227	[RX7CAT3] MULTUM DRUG CATEGORY # 3 See RX7CAT1.
516	3	1228-1230	[RX7CAT4] MULTUM DRUG CATEGORY # 4 See RX7CAT1.

DRUG CATEGORY LEVELS

517	3	1231-1233	[RX7V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
518	3	1234-1236	[RX7V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
519	3	1237-1239	[RX7V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
520	3	1240-1242	[RX7V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
521	3	1243-1245	[RX7V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
522	3	1246-1248	[RX7V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
523	3	1249-1251	[RX7V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
524	3	1252-1254	[RX7V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
525	3	1255-1257	[RX7V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
526	3	1258-1260	[RX7V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
527	3	1261-1263	[RX7V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
528	3	1264-1266	[RX7V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #8

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

529   6   1267-1272   [DRUGID8] Drug ID

530   1   1273   [PRESCR8] PRESCRIPTION STATUS CODE

531   1   1274   [CONTSUB8] CONTROLLED SUBSTANCE STATUS CODE

532   1   1275   [COMSTAT8] COMPOSITION STATUS CODE

533   3   1276-1278   [RX8CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

534   3   1279-1281   [RX8CAT2] MULTUM DRUG CATEGORY # 2
                                  See RX8CAT1.

535   3   1282-1284   [RX8CAT3] MULTUM DRUG CATEGORY # 3
                                  See RX8CAT1.

536   3   1285-1287   [RX8CAT4] MULTUM DRUG CATEGORY # 4
                                  See RX8CAT1.

DRUG CATEGORY LEVELS

537   3   1288-1290   [RX8V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
538   3   1291-1293   [RX8V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
539   3   1294-1296   [RX8V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
540   3   1297-1299   [RX8V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

541   3   1300-1302   [RX8V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
542   3   1303-1305   [RX8V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
543   3   1306-1308   [RX8V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
544   3   1309-1311   [RX8V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

545   3   1312-1314   [RX8V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
546   3   1315-1317   [RX8V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
547   3   1318-1320   [RX8V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
548   3   1321-1323   [RX8V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #9

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

549   6   1324-1329 [DRUGID9] Drug ID

550   1   1330   [PRESCR9] PRESCRIPTION STATUS CODE

551   1   1331   [CONTSUB9] CONTROLLED SUBSTANCE STATUS CODE

552   1   1332   [COMSTAT9] COMPOSITION STATUS CODE

553   3   1333-1335 [RX9CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

554   3   1336-1338 [RX9CAT2] MULTUM DRUG CATEGORY # 2
                                   See RX9CAT1.

555   3   1339-1341 [RX9CAT3] MULTUM DRUG CATEGORY # 3
                                   See RX9CAT1.

556   3   1342-1344 [RX9CAT4] MULTUM DRUG CATEGORY # 4
                                   See RX9CAT1.

DRUG CATEGORY LEVELS

557   3   1345-1347 [RX9V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
558   3   1348-1350 [RX9V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
559   3   1351-1353 [RX9V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
560   3   1354-1356 [RX9V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

561   3   1357-1359 [RX9V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
562   3   1360-1362 [RX9V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
563   3   1363-1365 [RX9V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
564   3   1366-1368 [RX9V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

565   3   1369-1371 [RX9V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
566   3   1372-1374 [RX9V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
567   3   1375-1377 [RX9V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
568   3   1378-1380 [RX9V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #10

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

569	6	1381-1386	[DRUGID10] Drug ID

570   1   1387   [PRESCR10] PRESCRIPTION STATUS CODE

571   1   1388   [CONTSUB10] CONTROLLED SUBSTANCE STATUS CODE

572   1   1389   [COMSTAT10] COMPOSITION STATUS CODE

573   3   1390-1392   [RX10CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

574   3   1393-1395   [RX10CAT2] MULTUM DRUG CATEGORY # 2
                      See RX10CAT1.

575   3   1396-1398   [RX10CAT3] MULTUM DRUG CATEGORY # 3
                      See RX10CAT1.

576   3   1399-1401   [RX10CAT4] MULTUM DRUG CATEGORY # 4
                      See RX10CAT1.

DRUG CATEGORY LEVELS

577   3   1402-1404   [RX10V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
578   3   1405-1407   [RX10V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
579   3   1408-1410   [RX10V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
580   3   1411-1413   [RX10V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

581   3   1414-1416   [RX10V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
582   3   1417-1419   [RX10V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
583   3   1420-1422   [RX10V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
584   3   1423-1425   [RX10V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

585   3   1426-1428   [RX10V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
586   3   1429-1431   [RX10V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
587   3   1432-1434   [RX10V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
588   3   1435-1437   [RX10V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #11

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

589   6   1438-1443 [DRUGID11] Drug ID

590   1   1444   [PRESCR11] PRESCRIPTION STATUS CODE

591   1   1445   [CONTSUB11] CONTROLLED SUBSTANCE STATUS CODE

592   1   1446   [COMSTAT11] COMPOSITION STATUS CODE

593   3   1447-1449 [RX11CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

594   3   1450-1452 [RX11CAT2] MULTUM DRUG CATEGORY # 2
                                   See RX11CAT1.

595   3   1453-1455 [RX11CAT3] MULTUM DRUG CATEGORY # 3
                                   See RX11CAT1.

596   3   1456-1458 [RX11CAT4] MULTUM DRUG CATEGORY # 4
                                   See RX11CAT1.

DRUG CATEGORY LEVELS

597   3   1459-1461 [RX11V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
598   3   1462-1464 [RX11V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
599   3   1465-1467 [RX11V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
600   3   1468-1470 [RX11V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

601   3   1471-1473 [RX11V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
602   3   1474-1476 [RX11V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
603   3   1477-1479 [RX11V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
604   3   1480-1482 [RX11V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

605   3   1483-1485 [RX11V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
606   3   1486-1488 [RX11V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
607   3   1489-1491 [RX11V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
608   3   1492-1494 [RX11V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES
_____

DRUG-RELATED INFO FOR MEDICATION #12

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

609   6   1495-1500   [DRUGID12] Drug ID

610   1   1501   [PRESCR12] PRESCRIPTION STATUS CODE

611   1   1502   [CONTSUB12] CONTROLLED SUBSTANCE STATUS CODE

612   1   1503   [COMSTAT12] COMPOSITION STATUS CODE

613   3   1504-1506   [RX12CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

614   3   1507-1509   [RX12CAT2] MULTUM DRUG CATEGORY # 2
                                    See RX12CAT1.

615   3   1510-1512   [RX12CAT3] MULTUM DRUG CATEGORY # 3
                                    See RX12CAT1.

616   3   1513-1515   [RX12CAT4] MULTUM DRUG CATEGORY # 4
                                    See RX12CAT1.

                                    DRUG CATEGORY LEVELS

617   3   1516-1518   [RX12V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
618   3   1519-1521   [RX12V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
619   3   1522-1524   [RX12V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
620   3   1525-1527   [RX12V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

621   3   1528-1530   [RX12V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
622   3   1531-1533   [RX12V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
623   3   1534-1536   [RX12V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
624   3   1537-1539   [RX12V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

625   3   1540-1542   [RX12V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
626   3   1543-1545   [RX12V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
627   3   1546-1548   [RX12V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
628   3   1549-1551   [RX12V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #13

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

629	6	1552-1557	[DRUGID13] Drug ID
630	1	1558	[PRESCR13] PRESCRIPTION STATUS CODE
631	1	1559	[CONTSUB13] CONTROLLED SUBSTANCE STATUS CODE
632	1	1560	[COMSTAT13] COMPOSITION STATUS CODE
633	3	1561-1563	[RX13CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
634	3	1564-1566	[RX13CAT2] MULTUM DRUG CATEGORY # 2 See RX13CAT1.
635	3	1567-1569	[RX13CAT3] MULTUM DRUG CATEGORY # 3 See RX13CAT1.
636	3	1570-1572	[RX13CAT4] MULTUM DRUG CATEGORY # 4 See RX13CAT1.

DRUG CATEGORY LEVELS

637	3	1573-1575	[RX13V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
638	3	1576-1578	[RX13V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
639	3	1579-1581	[RX13V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
640	3	1582-1584	[RX13V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
641	3	1585-1587	[RX13V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
642	3	1588-1590	[RX13V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
643	3	1591-1593	[RX13V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
644	3	1594-1596	[RX13V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
645	3	1597-1599	[RX13V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
646	3	1600-1602	[RX13V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
647	3	1603-1605	[RX13V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
648	3	1606-1608	[RX13V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #14

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

649   6   1609-1614 [DRUGID14] Drug ID

650   1   1615   [PRESCR14] PRESCRIPTION STATUS CODE

651   1   1616   [CONTSUB14] CONTROLLED SUBSTANCE STATUS CODE

652   1   1617   [COMSTAT14] COMPOSITION STATUS CODE

653   3   1618-1620 [RX14CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

654   3   1621-1623 [RX14CAT2] MULTUM DRUG CATEGORY # 2
                                 See RX14CAT1.

655   3   1624-1626 [RX14CAT3] MULTUM DRUG CATEGORY # 3
                                 See RX14CAT1.

656   3   1627-1629 [RX14CAT4] MULTUM DRUG CATEGORY # 4
                                 See RX14CAT1.

DRUG CATEGORY LEVELS

657   3   1630-1632 [RX14V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
658   3   1633-1635 [RX14V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
659   3   1636-1638 [RX14V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
660   3   1639-1641 [RX14V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

661   3   1642-1644 [RX14V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
662   3   1645-1647 [RX14V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
663   3   1648-1650 [RX14V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
664   3   1651-1653 [RX14V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

665   3   1654-1656 [RX14V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
666   3   1657-1659 [RX14V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
667   3   1660-1662 [RX14V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
668   3   1663-1665 [RX14V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #15

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

669   6   1666-1671   [DRUGID15] Drug ID

670   1   1672   [PRESCR15] PRESCRIPTION STATUS CODE

671   1   1673   [CONTSUB15] CONTROLLED SUBSTANCE STATUS CODE

672   1   1674   [COMSTAT15] COMPOSITION STATUS CODE

673   3   1675-1677   [RX15CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

674   3   1678-1680   [RX15CAT2] MULTUM DRUG CATEGORY # 2
                                 See RX15CAT1.

675   3   1681-1683   [RX15CAT3] MULTUM DRUG CATEGORY # 3
                                 See RX15CAT1.

676   3   1684-1686   [RX15CAT4] MULTUM DRUG CATEGORY # 4
                                 See RX15CAT1.

                                 DRUG CATEGORY LEVELS

677   3   1687-1689   [RX15V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
678   3   1690-1692   [RX15V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
679   3   1693-1695   [RX15V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
680   3   1696-1698   [RX15V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

681   3   1699-1701   [RX15V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
682   3   1702-1704   [RX15V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
683   3   1705-1707   [RX15V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
684   3   1708-1710   [RX15V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

685   3   1711-1713   [RX15V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
686   3   1714-1716   [RX15V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
687   3   1717-1719   [RX15V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
688   3   1720-1722   [RX15V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #16

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

| 689 | 6 | 1723-1728 | [DRUGID16] Drug ID |

| 690 | 1 | 1729 | [PRESCR16] PRESCRIPTION STATUS CODE |

| 691 | 1 | 1730 | [CONTSUB16] CONTROLLED SUBSTANCE STATUS CODE |

| 692 | 1 | 1731 | [COMSTAT16] COMPOSITION STATUS CODE |

| 693 | 3 | 1732-1734 | [RX16CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

694   3   1735-1737 [RX16CAT2] MULTUM DRUG CATEGORY # 2
                           See RX16CAT1.

695   3   1738-1740 [RX16CAT3] MULTUM DRUG CATEGORY # 3
                           See RX16CAT1.

696   3   1741-1743 [RX16CAT4] MULTUM DRUG CATEGORY # 4
                           See RX16CAT1.

DRUG CATEGORY LEVELS

697	3	1744-1746	[RX16V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
698	3	1747-1749	[RX16V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
699	3	1750-1752	[RX16V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
700	3	1753-1755	[RX16V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

701	3	1756-1758	[RX16V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
702	3	1759-1761	[RX16V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
703	3	1762-1764	[RX16V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
704	3	1765-1767	[RX16V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

705	3	1768-1770	[RX16V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
706	3	1771-1773	[RX16V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
707	3	1774-1776	[RX16V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
708	3	1777-1779	[RX16V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #17

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

| 709 | 6 | 1780-1785 | [DRUGID17] Drug ID |

| 710 | 1 | 1786 | [PRESCR17] PRESCRIPTION STATUS CODE |

| 711 | 1 | 1787 | [CONTSUB17] CONTROLLED SUBSTANCE STATUS CODE |

| 712 | 1 | 1788 | [COMSTAT17] COMPOSITION STATUS CODE |

| 713 | 3 | 1789-1791 | [RX17CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

714   3   1792-1794   [RX17CAT2] MULTUM DRUG CATEGORY # 2
                               See RX17CAT1.

715   3   1795-1797   [RX17CAT3] MULTUM DRUG CATEGORY # 3
                               See RX17CAT1.

716   3   1798-1800   [RX17CAT4] MULTUM DRUG CATEGORY # 4
                               See RX17CAT1.

DRUG CATEGORY LEVELS

717	3	1801-1803	[RX17V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
718	3	1804-1806	[RX17V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
719	3	1807-1809	[RX17V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
720	3	1810-1812	[RX17V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

721	3	1813-1815	[RX17V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
722	3	1816-1818	[RX17V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
723	3	1819-1821	[RX17V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
724	3	1822-1824	[RX17V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

725	3	1825-1827	[RX17V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
726	3	1828-1830	[RX17V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
727	3	1831-1833	[RX17V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
728	3	1834-1836	[RX17V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #18

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

729	6	1837-1842	[DRUGID18] Drug ID
730	1	1843	[PRESCR18] PRESCRIPTION STATUS CODE
731	1	1844	[CONTSUB18] CONTROLLED SUBSTANCE STATUS CODE
732	1	1845	[COMSTAT18] COMPOSITION STATUS CODE
733	3	1846-1848	[RX18CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
734	3	1849-1851	[RX18CAT2] MULTUM DRUG CATEGORY # 2 See RX18CAT1.
735	3	1852-1854	[RX18CAT3] MULTUM DRUG CATEGORY # 3 See RX18CAT1.
736	3	1855-1857	[RX18CAT4] MULTUM DRUG CATEGORY # 4 See RX18CAT1.

DRUG CATEGORY LEVELS

737	3	1858-1860	[RX18V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
738	3	1861-1863	[RX18V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
739	3	1864-1866	[RX18V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
740	3	1867-1869	[RX18V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
741	3	1870-1872	[RX18V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
742	3	1873-1875	[RX18V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
743	3	1876-1878	[RX18V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
744	3	1879-1881	[RX18V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
745	3	1882-1884	[RX18V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
746	3	1885-1887	[RX18V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
747	3	1888-1890	[RX18V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
748	3	1891-1893	[RX18V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #19

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

749	6	1894-1899	[DRUGID19] Drug ID
750	1	1900	[PRESCR19] PRESCRIPTION STATUS CODE
751	1	1901	[CONTSUB19] CONTROLLED SUBSTANCE STATUS CODE
752	1	1902	[COMSTAT19] COMPOSITION STATUS CODE
753	3	1903-1905	[RX19CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
754	3	1906-1908	[RX19CAT2] MULTUM DRUG CATEGORY # 2 See RX19CAT1.
755	3	1909-1911	[RX19CAT3] MULTUM DRUG CATEGORY # 3 See RX19CAT1.
756	3	1912-1914	[RX19CAT4] MULTUM DRUG CATEGORY # 4 See RX19CAT1.

DRUG CATEGORY LEVELS

757	3	1915-1917	[RX19V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
758	3	1918-1920	[RX19V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
759	3	1921-1923	[RX19V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
760	3	1924-1926	[RX19V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
761	3	1927-1929	[RX19V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
762	3	1930-1932	[RX19V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
763	3	1933-1935	[RX19V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
764	3	1936-1938	[RX19V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
765	3	1939-1941	[RX19V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
766	3	1942-1944	[RX19V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
767	3	1945-1947	[RX19V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
768	3	1948-1950	[RX19V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #20

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

| 769 | 6 | 1951-1956 | [DRUGID20] Drug ID |

| 770 | 1 | 1957 | [PRESCR20] PRESCRIPTION STATUS CODE |

| 771 | 1 | 1958 | [CONTSUB20] CONTROLLED SUBSTANCE STATUS CODE |

| 772 | 1 | 1959 | [COMSTAT20] COMPOSITION STATUS CODE |

| 773 | 3 | 1960-1962 | [RX20CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

| 774 | 3 | 1963-1965 | [RX20CAT2] MULTUM DRUG CATEGORY # 2 |
| | | | See RX20CAT1. |

| 775 | 3 | 1966-1968 | [RX20CAT3] MULTUM DRUG CATEGORY # 3 |
| | | | See RX20CAT1. |

| 776 | 3 | 1969-1971 | [RX20CAT4] MULTUM DRUG CATEGORY # 4 |
| | | | See RX20CAT1. |

DRUG CATEGORY LEVELS

777	3	1972-1974	[RX20V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
778	3	1975-1977	[RX20V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
779	3	1978-1980	[RX20V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
780	3	1981-1983	[RX20V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

781	3	1984-1986	[RX20V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
782	3	1987-1989	[RX20V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
783	3	1990-1992	[RX20V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
784	3	1993-1995	[RX20V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

785	3	1996-1998	[RX20V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
786	3	1999-2001	[RX20V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
787	3	2002-2004	[RX20V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
788	3	2005-2007	[RX20V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #21

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

789	6	2008-2013	[DRUGID21] Drug ID
790	1	2014	[PRESCR21] PRESCRIPTION STATUS CODE
791	1	2015	[CONTSUB21] CONTROLLED SUBSTANCE STATUS CODE
792	1	2016	[COMSTAT21] COMPOSITION STATUS CODE
793	3	2017-2019	[RX21CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
794	3	2020-2022	[RX21CAT2] MULTUM DRUG CATEGORY # 2 See RX21CAT1.
795	3	2023-2025	[RX21CAT3] MULTUM DRUG CATEGORY # 3 See RX21CAT1.
796	3	2026-2028	[RX21CAT4] MULTUM DRUG CATEGORY # 4 See RX21CAT1.

DRUG CATEGORY LEVELS

797	3	2029-2031	[RX21V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
798	3	2032-2034	[RX21V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
799	3	2035-2037	[RX21V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
800	3	2038-2040	[RX21V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
801	3	2041-2043	[RX21V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
802	3	2044-2046	[RX21V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
803	3	2047-2049	[RX21V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
804	3	2050-2052	[RX21V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
805	3	2053-2055	[RX21V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
806	3	2056-2058	[RX21V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
807	3	2059-2061	[RX21V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
808	3	2062-2064	[RX21V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #22

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

809	6	2065-2070	[DRUGID22] Drug ID
810	1	2071	[PRESCR22] PRESCRIPTION STATUS CODE
811	1	2072	[CONTSUB22] CONTROLLED SUBSTANCE STATUS CODE
812	1	2073	[COMSTAT22] COMPOSITION STATUS CODE
813	3	2074-2076	[RX22CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
814	3	2077-2079	[RX22CAT2] MULTUM DRUG CATEGORY # 2 See RX22CAT1.
815	3	2080-2082	[RX22CAT3] MULTUM DRUG CATEGORY # 3 See RX22CAT1.
816	3	2083-2085	[RX22CAT4] MULTUM DRUG CATEGORY # 4 See RX22CAT1.

DRUG CATEGORY LEVELS

817	3	2086-2088	[RX22V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
818	3	2089-2091	[RX22V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
819	3	2092-2094	[RX22V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
820	3	2095-2097	[RX22V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
821	3	2098-2100	[RX22V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
822	3	2101-2103	[RX22V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
823	3	2104-2106	[RX22V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
824	3	2107-2109	[RX22V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
825	3	2110-2112	[RX22V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
826	3	2113-2115	[RX22V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
827	3	2116-2118	[RX22V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
828	3	2119-2121	[RX22V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #23

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

829	6	2122-2127	[DRUGID23] Drug ID
830	1	2128	[PRESCR23] PRESCRIPTION STATUS CODE
831	1	2129	[CONTSUB23] CONTROLLED SUBSTANCE STATUS CODE
832	1	2130	[COMSTAT23] COMPOSITION STATUS CODE
833	3	2131-2133	[RX23CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
834	3	2134-2136	[RX23CAT2] MULTUM DRUG CATEGORY # 2 See RX23CAT1.
835	3	2137-2139	[RX23CAT3] MULTUM DRUG CATEGORY # 3 See RX23CAT1.
836	3	2140-2142	[RX23CAT4] MULTUM DRUG CATEGORY # 4 See RX23CAT1.

DRUG CATEGORY LEVELS

837	3	2143-2145	[RX23V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
838	3	2146-2148	[RX23V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
839	3	2149-2151	[RX23V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
840	3	2152-2154	[RX23V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
841	3	2155-2157	[RX23V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
842	3	2158-2160	[RX23V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
843	3	2161-2163	[RX23V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
844	3	2164-2166	[RX23V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
845	3	2167-2169	[RX23V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
846	3	2170-2172	[RX23V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
847	3	2173-2175	[RX23V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
848	3	2176-2178	[RX23V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #24

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

849	6	2179-2184	[DRUGID24] Drug ID
850	1	2185	[PRESCR24] PRESCRIPTION STATUS CODE
851	1	2186	[CONTSUB24] CONTROLLED SUBSTANCE STATUS CODE
852	1	2187	[COMSTAT24] COMPOSITION STATUS CODE
853	3	2188-2190	[RX24CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
854	3	2191-2193	[RX24CAT2] MULTUM DRUG CATEGORY # 2 See RX24CAT1.
855	3	2194-2196	[RX24CAT3] MULTUM DRUG CATEGORY # 3 See RX24CAT1.
856	3	2197-2199	[RX24CAT4] MULTUM DRUG CATEGORY # 4 See RX24CAT1.

DRUG CATEGORY LEVELS

857	3	2200-2202	[RX24V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
858	3	2203-2205	[RX24V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
859	3	2206-2208	[RX24V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
860	3	2209-2211	[RX24V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
861	3	2212-2214	[RX24V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
862	3	2215-2217	[RX24V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
863	3	2218-2220	[RX24V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
864	3	2221-2223	[RX24V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
865	3	2224-2226	[RX24V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
866	3	2227-2229	[RX24V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
867	3	2230-2232	[RX24V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
868	3	2233-2235	[RX24V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #25

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

869	6	2236-2241	[DRUGID25] Drug ID
870	1	2242	[PRESCR25] PRESCRIPTION STATUS CODE
871	1	2243	[CONTSUB25] CONTROLLED SUBSTANCE STATUS CODE
872	1	2244	[COMSTAT25] COMPOSITION STATUS CODE
873	3	2245-2247	[RX25CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
874	3	2248-2250	[RX25CAT2] MULTUM DRUG CATEGORY # 2 See RX25CAT1.
875	3	2251-2253	[RX25CAT3] MULTUM DRUG CATEGORY # 3 See RX25CAT1.
876	3	2254-2256	[RX25CAT4] MULTUM DRUG CATEGORY # 4 See RX25CAT1.

DRUG CATEGORY LEVELS

877	3	2257-2259	[RX25V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
878	3	2260-2262	[RX25V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
879	3	2263-2265	[RX25V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
880	3	2266-2268	[RX25V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
881	3	2269-2271	[RX25V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
882	3	2272-2274	[RX25V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
883	3	2275-2277	[RX25V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
884	3	2278-2280	[RX25V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
885	3	2281-2283	[RX25V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
886	3	2284-2286	[RX25V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
887	3	2287-2289	[RX25V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
888	3	2290-2292	[RX25V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES
_____

DRUG-RELATED INFO FOR MEDICATION #26

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

| 889 | 6 | 2293-2298 | [DRUGID26] Drug ID |

| 890 | 1 | 2299 | [PRESCR26] PRESCRIPTION STATUS CODE |

| 891 | 1 | 2300 | [CONTSUB26] CONTROLLED SUBSTANCE STATUS CODE |

| 892 | 1 | 2301 | [COMSTAT26] COMPOSITION STATUS CODE |

| 893 | 3 | 2302-2304 | [RX26CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

| 894 | 3 | 2305-2307 | [RX26CAT2] MULTUM DRUG CATEGORY # 2
See RX26CAT1. |

| 895 | 3 | 2308-2310 | [RX26CAT3] MULTUM DRUG CATEGORY # 3
See RX26CAT1. |

| 896 | 3 | 2311-2313 | [RX26CAT4] MULTUM DRUG CATEGORY # 4
See RX26CAT1. |

DRUG CATEGORY LEVELS

897	3	2314-2316	[RX26V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
898	3	2317-2319	[RX26V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
899	3	2320-2322	[RX26V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
900	3	2323-2325	[RX26V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

901	3	2326-2328	[RX26V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
902	3	2329-2331	[RX26V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
903	3	2332-2334	[RX26V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
904	3	2335-2337	[RX26V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

905	3	2338-2340	[RX26V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
906	3	2341-2343	[RX26V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
907	3	2344-2346	[RX26V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
908	3	2347-2349	[RX26V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #27

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

909	6	2350-2355	[DRUGID27] Drug ID
910	1	2356	[PRESCR27] PRESCRIPTION STATUS CODE
911	1	2357	[CONTSUB27] CONTROLLED SUBSTANCE STATUS CODE
912	1	2358	[COMSTAT27] COMPOSITION STATUS CODE
913	3	2359-2361	[RX27CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
914	3	2362-2364	[RX27CAT2] MULTUM DRUG CATEGORY # 2 See RX27CAT1.
915	3	2365-2367	[RX27CAT3] MULTUM DRUG CATEGORY # 3 See RX27CAT1.
916	3	2368-2370	[RX27CAT4] MULTUM DRUG CATEGORY # 4 See RX27CAT1.

DRUG CATEGORY LEVELS

917	3	2371-2373	[RX27V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
918	3	2374-2376	[RX27V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
919	3	2377-2379	[RX27V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
920	3	2380-2382	[RX27V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
921	3	2383-2385	[RX27V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
922	3	2386-2388	[RX27V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
923	3	2389-2391	[RX27V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
924	3	2392-2394	[RX27V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
925	3	2395-2397	[RX27V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
926	3	2398-2400	[RX27V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
927	3	2401-2403	[RX27V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
928	3	2404-2406	[RX27V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM   FIELD   FILE
 NO.   LENGTH   LOCATION   [ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #28

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

929   6   2407-2412 [DRUGID28] Drug ID

930   1   2413   [PRESCR28] PRESCRIPTION STATUS CODE

931   1   2414   [CONTSUB28] CONTROLLED SUBSTANCE STATUS CODE

932   1   2415   [COMSTAT28] COMPOSITION STATUS CODE

933   3   2416-2418 [RX28CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

934   3   2419-2421 [RX28CAT2] MULTUM DRUG CATEGORY # 2
                               See RX28CAT1.

935   3   2422-2424 [RX28CAT3] MULTUM DRUG CATEGORY # 3
                               See RX28CAT1.

936   3   2425-2427 [RX28CAT4] MULTUM DRUG CATEGORY # 4
                               See RX28CAT1.

DRUG CATEGORY LEVELS

937   3   2428-2430 [RX28V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
938   3   2431-2433 [RX28V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
939   3   2434-2436 [RX28V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
940   3   2437-2439 [RX28V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

941   3   2440-2442 [RX28V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
942   3   2443-2445 [RX28V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
943   3   2446-2448 [RX28V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
944   3   2449-2451 [RX28V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

945   3   2452-2454 [RX28V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
946   3   2455-2457 [RX28V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
947   3   2458-2460 [RX28V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
948   3   2461-2463 [RX28V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #29

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

949	6	2464-2469	[DRUGID29] Drug ID
950	1	2470	[PRESCR29] PRESCRIPTION STATUS CODE
951	1	2471	[CONTSUB29] CONTROLLED SUBSTANCE STATUS CODE
952	1	2472	[COMSTAT29] COMPOSITION STATUS CODE
953	3	2473-2475	[RX29CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
954	3	2476-2478	[RX29CAT2] MULTUM DRUG CATEGORY # 2 See RX29CAT1.
955	3	2479-2481	[RX29CAT3] MULTUM DRUG CATEGORY # 3 See RX29CAT1.
956	3	2482-2484	[RX29CAT4] MULTUM DRUG CATEGORY # 4 See RX29CAT1.

DRUG CATEGORY LEVELS

957	3	2485-2487	[RX29V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
958	3	2488-2490	[RX29V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
959	3	2491-2493	[RX29V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
960	3	2494-2496	[RX29V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
961	3	2497-2499	[RX29V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
962	3	2500-2502	[RX29V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
963	3	2503-2505	[RX29V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
964	3	2506-2508	[RX29V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
965	3	2509-2511	[RX29V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
966	3	2512-2514	[RX29V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
967	3	2515-2517	[RX29V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
968	3	2518-2520	[RX29V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

DRUG-RELATED INFO FOR MEDICATION #30

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 77) for coding information.

969	6	2521-2526	[DRUGID30] Drug ID
970	1	2527	[PRESCR30] PRESCRIPTION STATUS CODE
971	1	2528	[CONTSUB30] CONTROLLED SUBSTANCE STATUS CODE
972	1	2529	[COMSTAT30] COMPOSITION STATUS CODE
973	3	2530-2532	[RX30CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
974	3	2533-2535	[RX30CAT2] MULTUM DRUG CATEGORY # 2 See RX30CAT1.
975	3	2536-2538	[RX30CAT3] MULTUM DRUG CATEGORY # 3 See RX30CAT1.
976	3	2539-2541	[RX30CAT4] MULTUM DRUG CATEGORY # 4 See RX30CAT1.

DRUG CATEGORY LEVELS

977	3	2542-2544	[RX30V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
978	3	2545-2547	[RX30V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
979	3	2548-2550	[RX30V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
980	3	2551-2553	[RX30V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
981	3	2554-2556	[RX30V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
982	3	2557-2559	[RX30V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
983	3	2560-2562	[RX30V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
984	3	2563-2565	[RX30V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
985	3	2566-2568	[RX30V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
986	3	2569-2571	[RX30V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
987	3	2572-2574	[RX30V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
988	3	2575-2577	[RX30V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES

989   1   2578   [SETTYPE] SETTING TYPE
This item is intended for use when combining data from the
NAMCS or NHAMCS-OPD public use files with ED data.
1 = Physician Office (NAMCS) (only on NAMCS file)
2 = Outpatient Department (NHAMCS-OPD) (only on OPD file)
3 = Emergency Department (NHAMCS-ED)

990   4   2579-2582   [YEAR] SURVEY YEAR (2014)

NHAMCS DESIGN VARIABLES

Masked design variables were first released on the 2000 NHAMCS (and NAMCS) public use files, and were subsequently added to the 1993-1999 public use files. These variables reflected the multi-stage sampling design of the surveys, and were for use with statistical software like SUDAAN that takes such information into account. However, these variables could not be used in other statistical software packages, such as SAS and Stata, which employ an ultimate cluster model to estimate variance, without substantial modification. Therefore, two new variables were created and first added to the 2002 file, CSTRATM and CPSUM. They can be used to estimate variance with SUDAAN's with-replacement (WR) option, as well as with Stata, SPSS, SAS, and other statistical software packages utilizing an ultimate cluster model for variance estimation. These variables and their use are described more fully in the "Relative Standard Errors" section of the public use file documentation. The decision was made to include only these new variables, CSTRATM and CPSUM, and not the multi-stage design variables, beginning with the 2003 data release. For those who wish to combine data from 2003 forward with survey data from years prior to 2002 which do not contain CSTRATM and CPSUM, please see the technical paper, *Using Ultimate Cluster Models with NAMCS and NHAMCS Public Use Files,* at http://www.cdc.gov/nchs/nhamcs.htm.

991   8   2583-2590   [CSTRATM] CLUSTERED PSU STRATUM MARKER (masked)
                              20114201-40400000

992   6   2591-2596   [CPSUM] CLUSTERED PSU MARKER (masked)
                              1-100261

** WEIGHTING VARIABLES **

993   6   2597-2602   [PATWT] PATIENT VISIT WEIGHT (See page 25 in Section I.)
A right-justified integer developed by NCHS staff for the purpose of
producing national estimates from sample data.
22-72062

*************PLEASE NOTE THAT EDWT IS NOT AVAILABLE ON THE FIRST RELEASE OF THE 2014 ED PUBLIC USE FILE. IT WILL BE ADDED TO A SUBSEQUENT RELEASE.******************************

994   6   2603-2608   [EDWT] EMERGENCY DEPARTMENT WEIGHT
EDWT enables data users to make emergency-department-level
estimates. Please see page 26 for more information

III. MARGINAL DATA

A. EMERGENCY DEPARTMENT PATIENT VISITS

PATIENT AGE

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
1 - Under 15 years	4,818	27,739,115	19.615
2 - 15-24 years	3,383	21,341,177	15.091
3 - 25-44 years	6,622	40,208,378	28.432
4 - 45-64 years	5,261	30,353,829	21.464
5 - 65-74 years	1,710	9,689,466	6.852
6 - 75 years and over	2,050	12,088,495	8.548

PATIENT SEX

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
1 - Female	13,065	77,416,201	54.742
2 - Male	10,779	64,004,259	45.258

PATIENT RACE (UNIMPUTED)

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
-9 - Blank	4,720	29,429,871	20.810
1 - White Only	13,747	76,859,570	54.348
2 - Black/African American Only	4,701	31,443,849	22.234
3 - Asian Only	389	2,230,524	1.577
4 - Native Hawaiian/Oth Pac Isl Only	95	278,985	0.197
5 - American Indian/Alaska Native Only	146	987,504	0.698
6 - More than one race reported	46	190,157	0.136

PATIENT ETHNICITY (WITH MISSING DATA IMPUTED)

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
1 - Hispanic or Latino	3,834	21,549,730	15.238
2 - Not Hispanic or Latino	20,010	119,870,730	84.762

RECODED EXPECTED PRIMARY SOURCE OF PAYMENT FOR THIS VISIT

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
-9 - All sources of payment are blank	97	646,142	0.457
-8 - Unknown	1,880	10,394,363	7.350
1 - Private insurance	6,762	39,858,536	28.184
2 - Medicare	4,312	24,731,263	17.488
3 - Medicaid or CHIP	7,574	44,988,024	31.812
4 - Worker's compensation	160	945,423	0.669
5 - Self-pay	2,439	16,873,773	11.932
6 - No charge/Charity	53	154,539	0.109
7 - Other	567	2,828,397	2.000

RECODED IMMEDIACY WITH WHICH PATIENT SHOULD BE SEEN (TRIAGE LEVEL)

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
-9 - Blank	773	7,095,734	5.017
-8 - Unknown	4,658	33,331,279	23.569
0 - 'No triage' for this visit but ESA does conduct nursing triage	797	3,301,051	2.334
1 - Immediate	112	633,163	0.448
2 - Emergent	1,694	9,584,631	6.777
3 - Urgent	7,920	44,993,032	31.815
4 - Semi-urgent	6,070	34,720,739	24.551
5 - Nonurgent	1,258	6,046,926	4.276
7 - Visit occured in ESA that does not conduct nursing triage	562	1,713,905	1.212

NUMBER OF MEDICATIONS CODED FOR THIS VISIT

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Total	23,844	141,420,460	100.000
0	4,929	28,868,937	20.414
1	5,706	34,387,134	24.316
2	4,754	29,487,671	20.851
3	3,230	19,189,717	13.569
4	2,046	12,118,213	8.569
5	1,259	7,204,841	5.095
6	725	3,806,527	2.692
7	398	2,514,566	1.778
8	238	1,211,827	0.857
9	163	766,931	0.542
10	83	405,662	0.287
11	80	429,208	0.303
12	43	186,806	0.132
13	53	237,651	0.168
14	19	83,190	0.059
15	14	66,479	0.047
16	23	72,449	0.051
17	20	107,402	0.076
18	11	57,802	0.041
19	10	55,792	0.039
20	7	17,815	0.013
21	10	41,055	0.029
22	5	18,525	0.013
23	6	22,571	0.016
24	2	13,711	0.010
25	1	5,326	0.004
26	4	24,985	0.018
27	1	1,167	0.001
28	1	5,326	0.004
30	3	11,174	0.008

B. EMERGENCY DEPARTMENT DRUG MENTIONS

PATIENT AGE

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Total	55,297	317,596,012	100.000
1 - Under 15 years	7,067	41,285,429	12.999
2 - 15-24 years	6,771	42,827,596	13.485
3 - 25-44 years	16,147	96,526,815	30.393
4 - 45-64 years	14,923	81,310,797	25.602
5 - 65-74 years	4,845	25,732,545	8.102
6 - 75 years and over	5,544	29,912,830	9.419

PATIENT SEX

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Total	55,297	317,596,012	100.000
1 - Female	31,039	178,918,905	56.335
2 - Male	24,258	138,677,107	43.665

PATIENT RACE (UNIMPUTED)

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Total	55,297	317,596,012	100.000
-9 - Blank	11,052	66,833,642	21.044
1 - White Only	32,491	176,779,979	55.662
2 - Black/African American Only	10,241	66,205,167	20.846
3 - Asian Only	848	4,248,309	1.338
4 - Native Hawaiian/Oth Pac Isl Only	230	682,772	0.215
5 - American Indian/Alaska Native Only	333	2,362,802	0.744
6 - More than one race reported	102	483,341	0.152

DRUG THERAPEUTIC CATEGORIES (USING LEVEL 1 CODES)

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Total	63,875	364,990,465	100.000
'001' - Anti-infectives	7,075	42,244,259	11.574
'020' - Antineoplastics	38	180,197	0.049
'028' - Biologicals	7	20,024	0.005
'040' - Cardiovascular agents	3,577	18,947,170	5.191
'057' - Central nervous system agents	25,092	147,858,749	40.510
'081' - Coagulation modifiers	1,354	7,338,219	2.011
'087' - Gastrointestinal agents	3,259	18,596,042	5.095
'097' - Hormones	1,916	10,510,700	2.880
'105' - Miscellaneous agents	1,429	8,151,595	2.233
'113' - Genitourinary tract agents	197	1,158,329	0.317
'115' - Nutritional products	5,748	29,974,737	8.212
'122' - Respiratory agents	8,851	50,029,138	13.707
'133' - Topical agents	2,018	12,808,719	3.509
'153' - Plasma expanders	9	37,734	0.010
'218' - Alternative medicines	97	733,293	0.201
'242' - Psychotherapeutic agents	798	3,973,685	1.089
'254' - Immunological agents	707	3,790,051	1.038
'331' - Radiologic agents	459	2,389,530	0.655
'358' - Metabolic agents	960	4,660,547	1.277
'365' - Medical gases	266	1,465,639	0.402
'899' - Pharmaceutical aid	18	122,108	0.033

Therapeutic categories are based on Lexicon Plus®, a proprietary database of
Cerner Multum, Inc. The Lexicon Plus is a comprehensive database of all
prescription and some nonprescription drug products available in the U.S.
drug market. For additional information on the Multum Lexicon Drug Database,
please refer to the following Web site: http://www.multum.com/lexicon.html.
For more information on coding therapeutic categories in NHAMCS, see page 21.

APPENDIX I

A. STANDARD ERRORS AND VARIANCE ESTIMATION

The standard error is primarily a measure of the sampling variability that occurs by chance because only a sample is surveyed, rather than the entire universe. The relative standard error (RSE) of an estimate is obtained by dividing the standard error of the estimate by the estimate itself and is expressed as a percentage of the estimate.   Standard errors and other measures of sampling variability are best determined by using a statistical software package that takes into account the sample designs of surveys to produce such measures.

In the past, NHAMCS micro-data file documentation contained formulas for approximating relative standard errors based on generalized variance curves as well as tables showing lowest reliable estimates based on curve coefficients. This was provided as an alternative for data users who lacked analytic software to produce standard errors and other measures of sampling variability. However, it has long been recognized that such approximations are less accurate than those produced using a statistical software package that takes into account the complex sample designs of surveys. As more data users have obtained access to sophisticated computer software over time, and as recent efforts by NCHS research staff to refine the generalized variance curves did not yield significant improvements, the decision was made starting with 2011 NHAMCS data to discontinue the provision of these approximate methods of variance estimation.

Using computer software like SUDAAN to produce standard errors will, in general, yield results that are more accurate than those produced using generalized variance curves. This is especially true for clustered variables like race, provider seen, or expected source of payment. However, standard errors produced with such software using masked design variables, while improving substantially over generalized variance curve results, will not always be as accurate as those produced using unmasked data.

Data files containing unmasked variables are confidential and are only available through the NCHS Research Data Center. While the initial release of masked design variables (starting with the 2000 data year, and continuing with re-released files for 1993-99) included the multi-stage variables necessary for running SUDAAN's full sample without-replacement design option, the 2002 release added two new variables (CSTRATM and CPSUM) needed for running programs that use an ultimate cluster model. Ultimate cluster variance estimates depend only on the first stage of the sample design, so that only first-stage cluster and first-stage stratum identification are required. The earlier version of the masked design variables could not be used with such software without substantial recoding. For 2003 forward, the decision was made to include only those two new variables on the files. The new variables, CSTRATM and CPSUM, differ from the earlier design variables STRATM and PSUM, in that providers are the first-stage sampling units in certainty areas (geographic areas selected with certainty), while geographic areas are the first-stage sampling units in non-certainty areas. Therefore, one should not use the new and old versions (CSTRATM and STRATM or CPSUM and PSUM) together (as for example, when combining years of data). Researchers who wish to combine data from 2003 forward with prior files which do not contain CSTRATM and CPSUM should refer to the technical paper, *Using Ultimate Cluster Models with NAMCS and NHAMCS Public Use Files,* at http://www.cdc.gov/nchs/ahcd/ahcd_questionnaires.htm.

IMPORTANT NOTE CONCERNING 2014 ED DATA: NHAMCS currently comprises three components: hospital emergency departments, outpatient departments (OPDs), and ambulatory surgery centers/locations (ASLs). It is important to understand that the first stage of NHAMCS sampling occurs at the geographic level, but the second stage occurs at the hospital level. However, not all hospitals have all three components, and some may choose not to participate in all components, even if they have them. Therefore, it is often the case that not all hospitals participating in NHAMCS are included on the ED file, even though for variance estimation purposes all participating hospitals should be represented (that is, there should be sampling

information on the ED public use file for each hospital participating in NHAMCS, in order to obtain the most accurate variance estimation).

In years from 1992-2009, when NHAMCS only included two components (emergency departments and outpatient departments), public use data file users were encouraged to combine the ED and OPD public use files for variance estimation purposes. That ensured that even if not all hospitals were represented on the ED file, the inclusion of records from the OPD file resulted in a complete set of participating hospitals and their sampling design variables.

Starting in 2010, when the ambulatory surgery component was added to NHAMCS, analysis was conducted within the Division of Health Care Statistics to ensure that the sampling design information was complete when combining the ED and OPD public use files, even though the ambulatory surgery file was not yet available (the 2010 ambulatory surgery public use file was released earlier this year). However, starting in 2012, changes to the mode of data collection in NHAMCS led to unforeseen problems in the sampling of OPD clinics and other related issues, which means that NCHS has not yet been able to release OPD public use files for 2012 through 2014.

For 2012 and 2013, internal research was conducted to study the effects of only using ED data, without the accompanying OPD data, on variance estimation. It was found that the effects on variance estimation were not problematic when compared with variance estimation using internal data and non-masked design variables. The effects did not warrant adding additional (dummy) records to the public use file to represent the missing hospitals with OPDs and/or ASLs but not EDs.

For 2014 data, internal research was again conducted, using the same methodology as in 2012 and 2013. The effects of the missing sampling design information were more pronounced in 2014 and may lead to more variances being understated compared with what was found in previous years. For most standard error estimates (approximately 75% of the approximately 400 estimates tested) the differences were small, but the possible understatement in variances for other estimates means a higher likelihood of a Type I error (finding a significant difference in the data that may not actually exist).

In order to decrease the possibility of a Type I error when analyzing the 2014 NHAMCS ED public use file, we recommend that researchers test for significant differences at the alpha=0.01 level, rather than the more commonly used 0.05 level. For questions, please contact the Ambulatory and Hospital Care Statistics Branch at 301-458-4600.

Examples using CSTRATM and CPSUM in SUDAAN's 1-stage WR (with replacement) design option, SAS's PROC SURVEYMEANS, Stata, and SPSS applications are presented below. These examples can be used to approximate variances for visit estimates for 2014 data alone or when combined with NAMCS data or previous years of NHAMCS data.

SUDAAN 1-stage WR (With-Replacement) Option

The program below provides a with-replacement ultimate cluster (1-stage) estimate of standard errors for a cross-tabulation with a dataset called COMB1.

```
PROC CROSSTAB DATA=ED1 DESIGN=WR FILETYPE=SAS;
NEST CSTRATM CPSUM/MISSUNIT;
```

SAS - PROC SURVEYMEANS

```
PROC SURVEYMEANS DATA=ED1;
CLUSTER CPSUM;
STRATA CSTRATM;
```

Stata - For use with ultimate cluster design option:

The pweight (PATWT), strata (CSTRATM), and PSU (CPSUM) are set with the svyset command as follows:

Stata 8:
svyset [pweight=patwt], psu(cpsum) strata(cstratm)

Stata 9 and later:
svyset cpsum [pweight=patwt], strata(cstratm)

SPSS
To obtain variance estimates which take the sample design into account, IBM SPSS Inc.'s Complex Samples module can be used. This description applies to version 24.0. From the main menu, first click on 'Analyze', then 'Complex Samples', then 'Prepare for Analysis'. The 'Analysis Preparation Wizard' can be used to set CSTRATM as the stratum variable, CPSUM as the cluster variable, and PATWT as the weighting variable. The WR design option may be chosen. This will create the PLAN FILE syntax, which should resemble the code below, where PLAN FILE reflects the location you have selected to store the file on your computer:

```
CSPLAN ANALYSIS
    /PLAN FILE='DIRECTORY\PLANNAME.CSAPLAN'
    /PLAN VARS ANALYSISWEIGHT=PATWT
    /PRINT PLAN
    /DESIGN STAGELABEL= 'ANY LABEL'   STRATA=CSTRATM   CLUSTER=CPSUM
    /ESTIMATOR TYPE=WR.
```

After creating the plan file, various analyses can be selected from the 'Complex Samples' menu. This is an example of a crosstabulation with options selected for counts, percents, and standard errors, with missing data (if any) included:

```
CSTABULATE
    /PLAN FILE='DIRECTORY\PLANNAME.CSAPLAN'
    /TABLES VARIABLES = AGER BY SEX
    /CELLS POPSIZE ROWPCT COLPCT
    /STATISTICS SE COUNT
    /MISSING SCOPE = TABLE CLASSMISSING = INCLUDE.
```

Results using IBM SPSS with the WR option were found to be the same as those obtained using SUDAAN Release 11.0.1 with the WR option.

Since the ultimate cluster procedures discussed above compute Taylor series variance estimates, results should be identical. Results differ, however, when a single case stratum, or singleton, is present on the data file because each software package treats such cases differently. There are no singletons on the 2014 NHAMCS ED file, so this should not present a problem.

IMPORTANT NOTE: These examples can be used when producing visit or drug estimates. For department-level estimates, the statements are the same, but replace PATWT with either EDWT (for emergency department estimates) or OPDWT (for outpatient department estimates). The EDWT and OPDWT are only placed on the first record for each emergency department or outpatient department on the file. When running purely facility level analysis, it is recommended that only records with EDWT > 0 or OPDWT > 0 be selected; this will give the correct sample counts and will not affect estimation of variance. Weighted estimates will be correct either way. Note that EDWT is not available on the initial release of the 2014 NHAMCS ED Public Use Data File (April 2017) but is planned for a subsequent release.

In addition to producing estimates of department-level characteristics, it is possible to compute means of visit characteristics at the department level, for example, average waiting time to see a physician in the ED. This is a more complicated process, and is described with sample SAS code at the Ambulatory Health Care Data website (http://www.cdc.gov/nchs/ahcd.htm). For more information, contact the Ambulatory and Hospital Care Statistics Branch at 301-458-4600.

B. INSTRUCTIONS FOR COMPLETING PATIENT RECORD FORMS (PRFs)

I. EMERGENCY DEPARTMENT PATIENT RECORD FORM

NOTE: In years prior to 2012, NHAMCS data collection agents were provided with a manual containing the Patient Record Form Instructions. This was used to train hospital staff in completing the questionnaires and in familiarizing the data collection agents with the survey instructions in cases where they abstracted the data directly from medical records. Starting in 2012 when a computer-assisted mode of data collection was used for the first time, data collection agents abstracted data from medical records for nearly all sampled visits and recorded them using an automated tool. This tool contained online help screens which could be accessed during data collection for most data items, replacing the old paper manuals. What is shown below is a compilation of the various help screen texts taken from the automated instrument.

PATIENT INFORMATION

DATE AND TIME OF VISIT

(1) Seen by MD/DO/PA/NP – Record the month, day, and 4-digit year (MMDDYYYY) the patient was first seen by a physician, physician assistant, or nurse practitioner in figures.

Record the hour and minutes in the format HHMM*ampmml* when the patient was first seen by a physician, physician assistant, or nurse practitioner.

(2) Date and time of ED departure, if released or transferred – The ED departure date and time only applies to patients who were release from the ED and returned to their current residence or were transferred to another facility (i.e., patients who do not have a disposition of admit to hospital or admit to observation unit). It would also include patients who left before or after triage or who left against medical advice (AMA). Leave this field blank for patients who were admitted to the hospital or admitted to the observation unit. This date and time should be the time the patient actually left the ED; however it may not be consistently available in the chart. If it is not clearly stated, then enter the last date and time recorded in the ED chart for this visit.

PATIENT RESIDENCE

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

ETHNICITY

Ethnicity refers to a person's national or cultural group.
There are two categories for ethnicity, "Hispanic or Latino" and "Not Hispanic or Latino".

Enter the appropriate category according to the information in the medical record.
If the patient's ethnicity is not known and is not obvious, enter the category which in your judgment is most appropriate. The definitions of the categories are listed below.

Do not determine the patient's ethnicity from his/her last name.

Ethnicity	Definition
1 - Hispanic or Latino	A person of Cuban, Mexican, Puerto Rican, South or Central American or other Spanish culture or origin regardless of race.
2- Not Hispanic or Latino	All other persons.

RACE

Enter all appropriate categories based on the information in medical record.
If the patient's race is not known or not obvious, enter the categories which in your judgment is (are) most appropriate. Do not determine the patient's race from their last name.

Race	Definition
1-White	A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
2-Black or African American	A person having origins in any of the black racial groups of Africa.
3-Asian	A person having origins in any of the original peoples of the Far East, Southeast Asia, or the Indian subcontinent including, for example, Cambodia, China, India, Japan, Korea, Malaysia, Pakistan, the Philippine Islands, Thailand, and Vietnam.
4-Native Hawaiian or Other Pacific Islander	A person having origins in any of the original peoples of Hawaii, Guam, Samoa, or other Pacific Islands.
5-American Indian or Alaska Native	A person having origins in any of the original peoples of North America, and who maintains cultural identification through tribal affiliation or community recognition.

ARRIVAL BY AMBULANCE

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

EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT

Expected source(s) of payment	Definition
1-Private Insurance	Charges paid in-part or in-full by a private insurer (e.g., Blue Cross/Blue Shield) either directly to the physician/CHC provider or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan.
2-Medicare	Charges paid in-part or in-full by a Medicare plan. Includes payments directly to the physician/CHC provider as well as payments reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan.
3-Medicaid or CHIP or other state-based program	Charges paid in-part or in-full by a Medicaid plan. Includes payments made directly to the the physician/CHC provider as well as payments reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan or the Children's Health Insurance Program (CHIP). PROGRAM NAMES FOR MEDICAID, CHIP, STATE-/LOCAL-SPONSORED, AND OTHER HEALTH INSURANCE PROGRAMS Please find your state. Note: Medicaid programs are often called "Medicaid", "Medical Assistance Program", or "Title 19". Children's Health Insurance Programs are often called "CHIP", "SCHIP", or "Title XXI Program". Many states have unique names for their health insurance programs. Those programs are listed below, by state. [NOTE: A comprehensive list of Medicaid/CHIP or other state-based programs are listed for each state and are not provided in this document.]
4-Worker's compensation	Includes programs designed to enable employees injured on the job to receive financial compensation regardless of fault.
5-Self-pay	Charges, to be paid by the patient or patient's family which will not be reimbursed by a third party. "Self- pay" includes visits for which the patient is expected to be ultimately responsible for most of the bill, even though the patient never actually pays it. DO NOT check this box for a copayment or deductible.
6-No charge/Charity	Visits for which no fee is charged (e.g., charity, special research, or teaching). Do not include visits paid for as part of a total

	package (e.g., prepaid plan visits, post- operative visits included in a surgical fee, and pregnancy visits included in a flat fee charged for the entire pregnancy). Mark the box or boxes that indicate how the services were originally paid.
7- Other	Any other sources of payment not covered by the above categories, such as CHAMPUS, state and local governments, private charitable organizations, and other liability insurance (e.g., automobile collision policy coverage).
8-Unknown	The primary source of payment is not known.

TEMPERATURE

Enter the patient's initial temperature if measured at this visit.
Enter the appropriate type of measurement (degrees C or F).

TRIAGE LEVEL

Enter the triage level assigned by a triage nurse upon ED arrival.

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

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

PAIN SCALE

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

Health care professionals typically measure pain on a scale of 0-10, with 0 being no pain and 10 being the worst pain imaginable. The scale they use is:

0-1 No pain
2-3 Mild pain
4-5 Discomforting - moderate pain
6-7 Distressing - severe pain
8-9 Intense - very severe pain
10 Unbearable pain

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

Wong-Baker FACES Pain Scale for children ~3-7 years old -

0   1   2   3   4   5
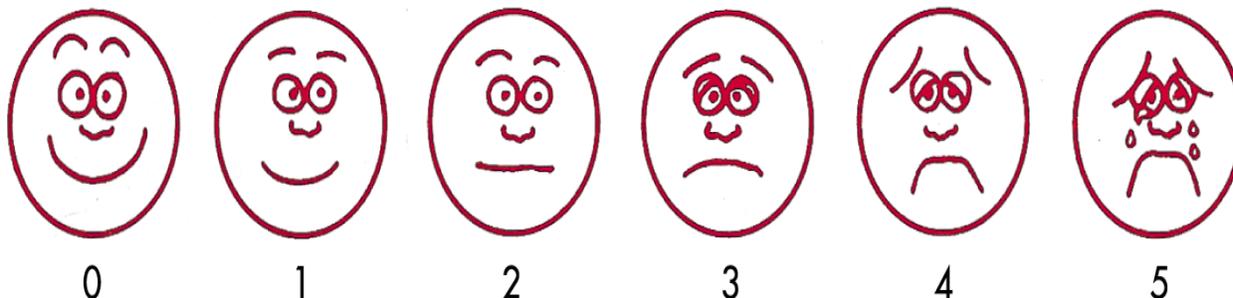
HAS PATIENT BEEN SEEN IN THIS ED WITHIN THE LAST 72 HOURS and DISCHARGED?

Indicate whether the patient was seen in this emergency department within the 72 hours prior to the current visit and then was discharged from the emergency department.

If it cannot be determined whether the patient has been seen in this time period, enter "Unknown."

LIST THE FIRST 5 REASONS FOR VISIT (I.E., SYMPTOMS, PROBLEMS, ISSUES, CONCERNS OF THE PATIENT) IN THE ORDER IN WHICH THEY APPEAR. START WITH THE CHIEF COMPLAINT AND THEN MOVE TO THE PATIENT HISTORY FOR ADDITIONAL REASONS.

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

1. Most important
2. Other
3. Other
4. Other
5. Other

The most important reason should be entered in (1). Space is available for four reasons in (2), (3), (4) and (5). By "most important" we mean the problem or symptom which in the physician's judgment was most responsible for the patient making this visit. Since we are interested only in the patient's most important complaints/ symptoms/reasons, it is not necessary to record more than five.

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

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

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

• There will be visits by patients for reasons other than some complaint or symptom. Examples might be well baby check-up or routine prenatal care. In such cases, simply record the reason for the visit.

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

EPISODE OF CARE

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

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

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

INJURY

IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE, POISONING, OR ADVERSE EFFECT OF MEDICAL TREATMENT?

If ANY PART of this visit was related to an injury or poisoning or adverse effect of medical or surgical care or an adverse effect of a medicinal drug, then enter the appropriate answer category.

The injury/poisoning/adverse effect does not need to be recent.

Injury/Poisoning/Adverse effect	Definition
1-Yes, injury	**Definition:** An injury involves damage to the body resulting from such events as motor vehicle crashes, transportation, falls, striking against or being struck by a person or object, burns, drowning, suffocation, cuts and stabbings, overexertion, foreign bodies, being crushed by machinery, beaten with fists or objects, gunshot/pellet gun wounds, etc. **Inclusion/Exclusion Criteria for Yes, Injury** **Includes** Visits involving: • New injuries • Follow-up for previously treated injuries

	• Flare-ups of problems due to old injuries **Excludes** Visits involving: • Injuries caused by medical/surgical care or ingestion of a harmful substance Bodily harm from other external causes, such as infectious diseases, and internal causes, such as chronic diseases
2-Yes, poisoning	**Definition:** A poisoning involves the ingestion, inhalation, absorption through the skin, or injection of a substance resulting in a harmful effect. **Inclusion/Exclusion Criteria for Yes, poisoning** **Includes** Visits involving ingestion/exposure to: • Household cleaners • Pesticides • Carbon monoxide • Alcohol containing products (ethanol, ethyl alcohol, methanol) except situations described in the "excludes" category. • Nonpharmaceutical inhalants • Overdose or misuse of prescription drugs, over-the-counter medications, vitamins, and illicit/street drugs • Alcohol-based topical agent used for medicinal purposes **Excludes** Visits involving: • Harmful effects from bacterial illnesses (such as "food poisoning") • Drunkenness • Alcohol withdrawal • Combination of alcohol and drugs (if drugs are involved, choose poisoning, drug-induced • Alcohol used for medicinal purposes (choose poisoning, drug-induced) • Drug withdrawal
3-Yes, adverse effect of medical/surgical care or adverse effect of medicinal drug	An adverse effect of <u>medical treatment</u> involves a reaction to the patient's own prescription or over-the-counter medication or dietary supplement taken according to directions, the label, or as prescribed. Unintended and undesired effects include: adverse drug reactions, allergic drug reactions, side effects, drug-drug interactions, drug-alcohol interactions. An adverse effect of <u>surgical treatment</u> includes bodily harm directly caused by surgical care or the placement of a medical product/device in a patient. Examples include pneumothorax from central venous catheter placement, postoperative wound infection, a foreign object left in the body after a procedure, etc. **Inclusion/Exclusion Criteria for Yes, adverse effect of medical/surgical care or adverse effect of medicinal drug**

	Includes • An adverse effect that occurred after use of one's own prescribed or over-the-counter medication/ supplement taken as prescribed or directed. • Surgical care provided in error or according to standards of practice, but resulting in bodily harm to the patient. • Presenting complaints/diagnoses may include keywords such as: "adverse," "allergic," "side effects," "caused by or induced by," "reaction to" or "secondary to." **Excludes** Visits involving: • Illegal drugs. • Patients EXCEEDING the prescribed or recommended dose of prescription drugs, OTC medications, or dietary supplements. • Patients who took LESS than the prescribed or recommended dose. • Patients who took prescribed medication belonging to someone else. Patients with an allergic reaction to a food or insect bite.
4-No	**Select No when:** Visit is not related to an injury or poisoning or adverse effect of medical/surgical treatment.
5-Unknown	**Definition:** It is unknown whether this visit is related to an injury or poisoning or adverse effect of medical or surgical treatment

CAUSE OF INJURY/TRAUMA, OVERDOSE, POISONING, OR ADVERSE EFFECT

Provide a brief description of **who**, **what**, **when**, **where**, and **why** associated with the injury, poisoning, or adverse effects of medical treatment or surgical procedures including adverse drug events (e.g., allergy to penicillin). Refer to the job aid in the NHAMCS-251.

For reasons of confidentiality, do not include proper names or dates in the description.

Indicate the place of the injury (e.g., residence, recreation or sports area, street or highway, school, hospital, public building, or industrial place). Include any post-surgical complications and if it involved an implant, specify what kind. If safety precautions were taken, describe them (e.g., seat belt use).

Be sure to include the mechanism that caused the injury (e.g., farm equipment, fire, arsenic, knife, pellet gun). If it was a work-related injury or poisoning, specify the industry of the patient's employment (e.g., food service, agricultural, mining, health services, etc.).

Describe in detail the circumstances that caused the injury (e.g., fell off monkey bars, motor vehicle collision with another car, spouse beaten with fists by spouse). Include information on the role of the patient associated with the injury (e.g., bicyclist, pedestrian, unrestrained driver or passenger in a motor vehicle, horseback rider), the specific place of occurrence (e.g., lake, school, football field), and the activity in which the patient was engaged at the time of the injury (e.g., swimming, boating, playing football).

Also include what happened to the patient and identify the mechanism that was immediately responsible for the injury. In addition, record the underlying or precipitating cause of injury (i.e., the event or external cause of injury that initiated and led to the mechanism of injury). An

example is a house fire that caused a person to jump out of the window. Both the precipitating or underlying cause (house fire) and the mechanism (fall from roof) would be important to record.

It is especially important to record as much detail about falls and motor vehicle crashes as possible.
For fall, indicate what the fall was from (e.g., steps) and where the patient landed (e.g., pavement).
For motor vehicle crash, indicate if it occurred on a street or highway versus a driveway or parking lot.

The National Center for Health Statistics will use the information collected to classify the cause of the injury using the International Classification of Diseases, Supplementary Classification of External Causes of Injury and Poisoning codes (ICD-9-CM E-Codes).

DIAGNOSIS

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

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

   (1) Primary diagnosis:
   This is one of the most important items on the Patient Record form.
   The primary diagnosis-refers to the provider's primary diagnosis for this visit. If possible, enter a final or provisional diagnosis, otherwise, use "problem" terms. Do not enter "rule out" diagnosis.
   If the patient was not seen by a physician, then the diagnosis by the main health care provider should be recorded.

   If a patient appears for postoperative care (follow-up visit after surgery), record the postoperative diagnosis as well as any other. The postoperative diagnosis should be indicated with the letters "P.O." Do not enter the operative procedure.

   (2), (3), (4), (5) Other:
   Enter up to four diagnoses which existed at the time of the visit if they are of DIRECT CONCERN to the visit. Include chronic disease.

Does the patient have –

Condition	Description
1. Alcohol misuse, abuse or dependence	Select box if 1) any of these terms are used; or 2) if terms such as alcoholism, excessive alcohol use, heavy drinking, problem drinking, binge drinking or chronic drinking are stated. 'Alcohol' may be abbreviated as 'EtOH.'
2. Alzheimer's disease/Dementia	Dementia is a loss of brain function that occurs with certain diseases. It affects memory, thinking, language, judgment, and behavior.
3. Asthma	Asthma includes extrinsic, intrinsic, and chronic obstructive

	asthma.
4.Cancer	Cancer includes any type of cancer (ca), such as carcinoma, sarcoma, leukemia, and lymphoma.
5. Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA)	Cerebrovascular disease/History of stroke or transient ischemic attack (TIA) is a group of brain dysfunctions related to disease of the blood vessels supplying the brain. Hypertension is the most important cause. The results of cerebrovascular disease can include a stroke, or occasionally a hemorrhagic stroke. A transient ischemic attack is a brief episode in which the brain gets an insufficient blood supply. Include a history of stroke or TIA.
7. Chronic obstructive pulmonary disease (COPD)	Chronic obstructive pulmonary disease (COPD) includes chronic bronchitis and emphysema, but excludes asthma.
8. Congestive heart failure (CHF)	Congestive heart failure (CHF) is generally defined as the inability of the heart to supply sufficient blood flow to meet the needs of the body. Does not include aystole or cardiac arrest.
9. Coronary artery disease (CAD), ischemic heart disease (IHD) or history of myocardial infarction (MI)	Only include if the patient had a heart attack or myocardial infarction (MI) prior to the sampled visit. A heart attack or MI occurs when the blood vessels that supply blood to the heart are blocked, preventing enough oxygen from getting to the heart. The heart muscle dies or becomes permanently damaged. Also known as acute myocardial infarction (AMI).
10. Depression	Depression includes affective disorders and major depressive disorders, such as episodes of depressive reaction, psychogenic depression, and reactive depression.
11. Diabetes mellitus (DM), Type 1	Type 1 diabetes mellitus is also known as insulin-dependent or IDDM. Excludes diabetes insipidus and gestational diabetes.
12. Diabetes mellitus (DM), Type 2	Type 2 diabetes mellitus is also known as non-insulin dependent or NIDDM. Excludes diabetes insipidus and gestational diabetes.
13. Diabetes mellitus (DM), Type unspecified	Excludes diabetes insipidus and gestational diabetes.
14. End-stage renal disease (ESRD)	Includes end-stage renal disease (ESRD) and chronic kidney failure due to diabetes or hypertension. May be abbreviated as "ESRD."
15. History of pulmonary embolism (PE) or deep vein thrombosis (DVT)	Only include if the patient had a pulmonary embolism or a diagnosis of deep vein thrombosis (DVT) prior to the sampled visit. Pulmonary embolism (PE) is a blockage of the main artery of the lung or one of its branches by a substance that has travelled from elsewhere in the body through the bloodstream (embolism). Usually this is due to embolism of a thrombus (blood clot) from the deep veins in the legs, a process termed venous thromboembolism. Deep vein thrombosis (also known as deep venous thrombosis) is the formation of a blood clot ("thrombus") in a deep vein. It is a form of thrombophlebitis (inflammation of a vein with clot formation). DVT commonly affects the leg veins (such as the femoral vein or the popliteal vein) or the deep veins of the pelvis.
16. HIV Infection/AIDS	HIV infection is a condition caused by the human immunodeficiency virus which gradually destroys the immune system and makes it harder for the body to fight infections. Asymptomatic (without symptoms) HIV infection is a phase of chronic infection with human immunodeficiency virus (HIV)

	during which there are no symptoms of HIV infection. AIDS (acquired immune deficiency syndrome) is the final stage of HIV disease, which causes severe damage to the immune system.
17. Hyperlipidemia	Hyperlipidemia is the condition of abnormally elevated levels of any or all lipids and/or lipoproteins in the blood. Also known as hypercholesterolemia.
18. Hypertension	Hypertension or high blood pressure is a cardiac chronic medical condition in which the systemic arterial blood pressure is elevated. It is the opposite of hypotension. Hypertension is classified as either primary (essential) hypertension or secondary hypertension. "Primary hypertension" means high blood pressure with no obvious medical cause. "Secondary hypertension" is caused by other conditions that affect he kidneys, arteries, heart or endocrine system. Include both primary and secondary hypertension.
19. Obesity	Obesity is a term used to describe body weight that is much greater than what is healthy. Adults with a body mass index (BMI, calculated as weight in kilograms divided by height in meters squared) greater than or equal to 30 kg/m2 are considered obese. Any patient who is more than 100 pounds overweight or who has a BMI greater than or equal to 40 kg/m2 is considered morbidly obese.
20. Obstructive sleep apnea (OSA)	Select box if obstructive sleep apnea (OSA), sleep apnea, or complex/mixed sleep apnea is stated. Do not select if central sleep apnea (CSA) is stated.
21. Osteoporosis	Osteoporosis refers to the thinning of bone tissue and loss of bone density over time. This reduction in the amount of bone mass leads to fractures after minimal trauma.
22. Substance abuse or dependence	Select box if 1) any of these terms are used; 2) if terms such as addiction, addict, illicit drug use, or injection/intravenous drug use (IDU/IVDU/IVDA) are stated; or 3) if specific drug use is stated (e.g., cocaine use, opioid dependence), not including tobacco/nicotine or alcohol.
23. None of the above	Enter "None of the above" if none of the conditions listed above exist.

DIAGNOSTIC SERVICES

Enter all services that were ordered or provided during this visit for the purpose of diagnosis (i.e., identification of health problems causing individuals to be symptomatic).

EACH SERVICE ORDERED OR PROVIDED SHOULD BE ENTERED.

Enter "NONE" if no blood tests, imaging services, or other tests were ordered or provided. If services were ordered or provided that are not listed, then enter "Other blood test," "Other test/service," or "Other imaging," as appropriate.

Service	**Definitions/Special Instructions**
2. Arterial blood gases	May be abbreviated as ABG. To obtain an ABG, an artery is punctured, usually in the wrist (radial artery). ABG measures the levels of pH, oxygen (PO_2 or PaO_2) carbon dioxide (PCO_2 or $PaCO_2$), bicarbonate (HCO_3), and oxygen saturation (SaO_2). ABG is not the same as a venous blood gas (VBG).
3. (BAC) Blood alcohol concentration	A blood alcohol concentration (BAC) test measures the amount of alcohol in the bloodstream which is reported as a percentage.
4. Blood culture	A blood culture determines if microorganisms, such as bacteria or fungi, are present in the blood. A sample of blood is put in a special laboratory preparation and incubated in a controlled environment for 1 to 7 days. Often obtained in sets of 2 or 3 at the same time. May be abbreviated as BC or blood cx.
5. BNP (brain natriuretic peptide)	Either the BNP (brain natriuretic peptide) or NT-proBNP (N-terminal pro b-type natriuretic peptide) may be used to help diagnose heart failure and to grade the severity of heart failure.
6. BUN/Creatinine	The blood urea nitrogen (BUN) test measures the amount of urea (nitrogen containing waste material) in blood serum. A high level of serum urea usually indicates poor kidney function, as it is the function of the kidney to remove urea from the bloodstream and filter it into the urine. The common laboratory abbreviation is BUN. The creatinine test measures the amount of creatinine, also a nitrogen containing waste material, in the blood serum or plasma. It is considered the most reliable test for kidney function. Since creatinine is normally produced as a protein breakdown product by muscle and excreted by the kidneys in the urine, an elevation in the creatinine blood level normally indicates a disturbance of kidney function. Elevation is also seen in dehydration scenarios, or in individuals with high protein diets.
7. Cardiac enzymes	May be abbreviated as CE. Cardiac enzymes include any of the following tests: CKMB (MB fraction of creatine kinase) or CPK-MB; troponin I or troponin T (TnI, cTnI).
8. CBC	A complete blood count includes white blood cell count (WBC), white blood cell differential (the differential classifies a person's white blood cells into each type: neutrophils [also known as segs, PMNs, granulocytes, grans], lymphocytes, monocytes, eosinophils, and basophils), red blood cell count (RBC), hemoglobin, hematocrit, platelet, mean corpuscular volume (MCV), mean corpuscular hemoglobin (MCH), and red cell distribution width (RDW).
9. D-dimer	The D-dimer test is ordered, along with other laboratory tests and imaging scans, to help rule out the presence of a thrombus. Some of the conditions that the d-dimer test is used to help rule out include: deep vein thrombosis (DVT), pulmonary embolism (PE), and stroke. Also known as fragment D-dimer and fibrin degradation fragment.
10. Electrolytes	The electrolytes test measures any of the following in the blood: sodium (Na), chloride (Cl), potassium (K), bicarbonate (HCO_3), and carbon dioxide (CO_2).
11. Glucose	The glucose test measures the amount of glucose (sugar) in serum and plasma. High blood levels of glucose (hyperglycemia) can indicate diseases such as diabetes mellitus. Glucose may also be measured in the urine during a urinalysis. A fasting blood glucose test is known as FBS.
12. Lactate	The lactate test is primarily ordered to help determine if someone has lactic acidosis, a high level of lactate in the blood. Lactic acidosis is most

	commonly caused by an inadequate amount of oxygen in cells and tissues (hypoxia). Also known as Lactic Acid; L-Lactate.
13. Liver function tests	May be abbreviated as LFT. LFTs include any of the following blood tests: ALP (alkaline phosphatase), SGPT (serum glutamate pyruvate transaminase) or ALT (alanine transaminase), SGOT (serum glutamic-oxaloacetic transaminase) or AST (aspartate aminotransferase), GGT (gamma-glutamyl transpeptidase), and serum bilirubin.
14. Prothrombin time/INR	The prothrombin time (PT)/INR test measures the clotting time of plasma (the liquid portion of the blood). Alternative names include PT and Pro-time. INR (international normalized ratio) is a system for reporting the results of blood coagulation (clotting) tests. Usually collected with PTT (partial thromboplastin time). Also known as coags.
Other tests:	
16.Cardiac monitor	A cardiac monitor is a piece of electronic equipment for continual observation of the function of the heart. Include: heart monitor, Holter monitor, ballistocardiography, cardiography, and electrocardiography (ECG or EKG).
17. EKG/ECG	EKG/ECG includes stress tests, e.g., treadmill.

18. HIV test	Antibodies to the HIV virus are often detected by an HIV screening test called an ELISA. The ELISA test is repeated if positive. The ELISA method is very sensitive but requires another test, a Western Blot, to confirm the results. Also known as AIDS test, AIDS screen, and HIV serology.

19.Influenza test	The influenza test is done almost exclusively during the flu season on patients presenting with symptoms of respiratory infection. The best sample for a flu test is usually a nasal aspirate, but the most frequently used samples are the nasal or throat swab (rapid), nasal culture, or serology (blood). The result of the rapid test may be obtained in 10 minutes. Include: flu test, rapid flu test, influenza antigen test, and viral culture for flu/influenza.
20. Pregnancy/HCG test	A pregnancy test may be done on either urine or blood. HCG or human chorionic gonadotropin is a hormone that is produced during pregnancy. Include: HCG, beta HCG, total HCG, and total beta HCG.
21.Toxicology screen	A toxicology screen evaluates the type (and roughly measures the amount) of legal and illegal drugs a person has taken. It tests for several drugs of abuse and is usually a urine sample, but could also be blood.
22. Urinalysis	A urinalysis is the chemical analysis of urine for medical diagnosis. Routine urinalysis includes determining specific gravity, observing any unusual color or odor, bacteria, and sediment to screen for urinary tract infections, renal disease, and diseases of other organs that result in abnormal products appearing in the urine. Include "clean-catch" urine sample.
23. Urine culture	The urine culture test detects and identifies bacteria and yeast in the urine and is used to diagnose a urinary tract infection (UTI). A mid-stream clean catch urine sample is submitted to the lab; sometimes a urine sample is obtained via catheter. With a urine culture, a small sample of urine is placed on one or more agar plates (a thin layer of a nutrient media) and incubated at body temperature. Any microorganisms that are present in the urine sample grow over the next 24 to 48 hours as small circular colonies.
24. Wound culture	A wound culture is used to detect and identify bacteria or fungi that may be infecting the skin or wound. Specimen is usually obtained by a cotton swab of pus or the wound base. The test involves growing the microorganisms

	from a wound in a special growth medium.
Imaging:	
26. X-ray	X-ray includes angiogram and fluoroscopy.
27. CT scan	A CT scan — also called computerized tomography or just CT — combines a series of X-ray views taken from many different angles to produce cross-sectional images of the bones and soft tissues inside the body. A CT scan is particularly well suited to quickly examine people who may have internal injuries from car accidents or other types of trauma. A CT scan can also visualize the brain and — with the help of injected contrast material — check for blockages or other problems in your blood vessels. Enter the body site that is being examined by the CT scan, i.e., abdomen, chest, head, or other.
28. MRI	Magnetic resonance imaging (MRI) is a test that uses a magnetic field and pulses of radio wave energy to make pictures of organs and structures inside the body. In many cases MRI gives different information about structures in the body than can be seen with an X-ray, ultrasound, or computed tomography (CT) scan. MRIs also may show problems that cannot be seen with other imaging methods.
29. Ultrasound	May be abbreviated as US. Ultrasound includes echocardiogram. ED physicians have begun to perform bedside ultrasound themselves, so indicate whether the ultrasound was performed by the emergency physician or someone else (e.g., x-ray tech in Radiology).
30. Other imaging	Other imaging includes PET scan.

Mark all provided at this visit. Exclude medications.

Enter all procedures provided at this visit.
Enter "NONE" if no procedures were provided.

Procedures	**Definition**
1. NONE	No procedures provided.
2. BPAP/CPAP	BPAP (variable/bilevel positive airway pressure) provides two levels of pressure: inspiratory positive airway pressure and a lower expiratory positive airway pressure for easier exhalation. CPAP is continuous positive airway pressure. The main indications for positive airway pressure are congestive heart failure and chronic obstructive pulmonary disease.
3. Bladder catheter	A bladder catheter is a latex, polyurethane or silicone tube inserted into a patient's bladder via his or her urethra. Catheterization allows the patient's urine to drain freely from the bladder for collection. It may be used to inject liquids used for treatment or diagnosis of bladder conditions, also known as a urinary catheter. May be referred to as a Foley catheter.

4. Cast/Splint/ Wrap	A cast is a rigid or flexible dressing made of plaster or fiberglass, molded to the body while pliable and hardening as it dries to give firm support. A splint is a rigid or flexible appliance used to maintain in position a displaced or moveable part, or to keep in place and protect an injured part. A wrap is an elastic bandage (also known as an ACE bandage, elastic wrap, compression bandage or crepe bandage) is a "stretchable bandage used to create localized pressure." Elastic bandages are commonly used to treat muscle sprains and strains by reducing the flow of blood to a particular area by the application of even stable pressure which can restrict swelling at the place of injury.
5. Central line	A central venous line (also known as central venous catheter or CVC) is usually inserted into a large vein in the neck, chest, or groin to administer medications or fluids and to obtain blood for testing and cardiovascular measurements.
6. CPR	CPR is cardiopulmonary resuscitation
7. Endotracheal intubation	Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea), through the mouth or the nose. Endotracheal intubation is done to open the airway to give oxygen, medication, or anesthesia, and to help with breathing. It may also be done to remove blockages (foreign bodies) from the airway or to allow the doctor to get a better view of the upper airway.
8. Incision and drainage (I & D)	Incision and drainage (I&D) is a common treatment for skin infections and abscesses. A scalpel is inserted into the skin overlying the pus and the pus is drained.
9. IV fluids	Refers to the administration of intravenous fluids.
10. Lumbar puncture	Lumbar puncture (LP) is a diagnostic and at times therapeutic procedure that is performed in order to collect a sample of cerebrospinal fluid (CSF) for biochemical, microbiological, and cytological analysis, or very rarely as a treatment ("therapeutic lumbar puncture") to relieve increased intracranial pressure. Also known as a spinal tap.
11. Nebulizer therapy	During nebulizer therapy, bronchodilator (airway-opening) medications therapy (e.g., albuterol, ipratropium) are delivered through a nebulizer which changes liquid medicine into fine droplets (in aerosol or mist form) that are inhaled through a mouthpiece or facemask. Used for patients with asthma or COPD (chronic obstructive pulmonary disease).
12. Pelvic exam	A pelvic exam is an examination of the organs of the female reproductive system.
13. Skin adhesives	Skin adhesives can be used in a wide range of wound care where gentle adhesion to skin is critical (e.g., wound dressings, pressure sore cushions, and burn treatment gauzes).
14. Suturing/Staples	Suturing/stapling is the process of using stitches, sutures or staples to

	hold the skin or tissue together.
15. Other	Enter "Other" if procedures were provided but are not listed above.

MEDICATIONS & IMMUNIZATIONS

List up to 30 drugs given at this visit or prescribed at ED discharge, using either the brand or generic names. Include prescription and over-the-counter drugs, immunizations, and anesthetics.
Do not enter broad drug classes, such as "laxative," "cough preparation," "analgesic," "antacid," "birth control pill," or "antibiotic."

If no medication was prescribed, provided, or continued, then enter "0" and continue.

Limit entries to drug name only.
Additional information such as dosage, strength, or regimen is not required.
For example, the medication might be in the form of pills, injections, salves or ointments, drops, suppositories, powders, or skin patches, but this information should not be entered.

For each drug listed, record if the medication was given in the ED, prescribed at discharge or both given in ED and at discharge.

If more than 30 drugs were given in the ED and/or prescribed at ED discharge, then enter the medications/immunizations according to the following priority:

1. All medications (including OTC drugs)/immunizations associated with the listed diagnoses.

2. All medications (including OTC drugs)/immunizations given in the ED, excluding vitamins and dietary supplements.

3. All medications (including OTC drugs)/immunizations prescribed at discharge, excluding vitamins and dietary supplements.

4. Vitamins and dietary supplements.

Enter all providers seen during this visit.

If care was provided, at least in part, by a person not represented in the eight categories, enter "Other." [Only certain categories were defined.]

Provider	Definition
3. Consulting Physician	Physician who is called to the ED by the patient's ED provider and who may leave a consultation note.
5. Nurse practitioner	Another term for "Nurse Practitioner (NP)" or "Certified Nurse Midwife (CNM)" is "Advanced Practice Registered Nurse (APRN)"
7. EMT	EMT is emergency medical technician. Only enter this category if an EMT provided care in the ED as opposed to in the ambulance.

| 8. Other mental health provider | Include psychologists, counselors, social workers, and therapists who provide mental health counseling. Exclude psychiatrists. |

DISPOSITION

Enter all that apply. Enter "other", if the visit disposition is not listed.

Visit Disposition	Definition
1. No follow-up planned	No return visit or telephone or e-mail contact is scheduled or planned for the patient's problem.
2. Return to ED	The patient was told to schedule an appointment or was given an appointment to return to the ED at a particular time.
3. Return/Refer to physician/clinic for FU	The patient was referred to the ED by his or her personal physician or some other physician and is now instructed to consult with the physician who made referral. The patient was screened, evaluated, stabilized, and then referred to another physician or clinic for follow-up.
4. Left before triage	The patient left before being triaged.
5. Left after triage	The patient left after being triaged, but before being seen by the main health care provider.
6. Left AMA	The patient left against medical advice, that is, the patient was evaluated by the hospital staff and advised to stay and receive or complete treatment.
7. DOA	The patient was dead on arrival (DOA). This patient is still included in the sample if listed on arrival log.
8. Died in ED	The patient died in the ED. This patient is still included in the sample if listed on arrival log.
9. Return/Transfer to nursing home	The patient returned to the nursing home that is their usual place of residence or was transferred to a nursing home.
10. Transfer to psychiatric hospital	The patient was transferred to a psychiatric hospital.
11. Transfer to other hospital	The patient was transferred to another non-psychiatric hospital.
12. Admit to this hospital	The patient was instructed that further care or treatment was needed and was admitted to this hospital.
13. Admit to observation unit, then hospitalized	The patient was admitted to a designated observation unit operated by the ED for evaluation and management or to wait for an impatient bed, and then was admitted to the hospital.
14. Admit to observation unit, then discharged	The patient was admitted to a designed observation unit in the ED for evaluation and management, but was discharged from the ED and was never admitted to a hospital. The observation unit must be located in a separate geographic area from the ED and does not merely indicate a change in the patient's status. Other names of ED observation units include the following: clinical decision unit (CDU), chest pain evaluation unit, short-stay unit, and rapid diagnostic and treatment unit.
15. Other	Any other disposition not in the above list.

HOSPITAL ADMISSION

ADMITTED TO:

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

ADMITTING PHYSICIAN

Indicate whether the admitting physician is a hospitalist.
A hospitalist is a physician whose primary professional focus is the general medical care of hospitalized patients.   A hospitalist oversees ED patients being admitted to the hospital.

If the records do not indicate that the admitting physician is a hospitalist, enter "Unknown".

DATE AND TIME PATIENT ACTUALLY LEFT THE ED OR OBSERVATION UNIT

Record the month, day, and year in figures when the patient actually left the ED or observation unit, for example 05/17/2012 for May 17, 2012.

Record the hour, minutes, and AM/PM/Military time indicator when the patient actually left the ED in figures. For example, enter 600am for 6:00 a.m. or 600pm for 6:00 p.m. or 1400ml for 14:00 military time.

If the date and time when the patient actually left the ED is unknown, leave the field blank.

If the patient was admitted to the hospital from the ED or observation unit, it is possible that he/she had to wait for an inpatient bed to become available after being discharged from the ED or observation unit. This is called "boarding" and the National Center for Health Statistics is interested in calculating "boarding time." Therefore, the date and time entered here should reflect the time that the patient actually left the ED or observation unit, not necessarily the time that the patient was discharged.

HOSPITAL DISCHARGE STATUS/DISPOSITION

If the patient was discharged "Alive", enter one of the following:

Disposition	Definition
1. Home /Residence	The patient was discharged to their normal place of residence (e.g., private home, assisted living, nursing home, college dormitory, homeless shelter, hospice, prison, or group home for the mentally or physically disabled).
2. Return/ Transfer to nursing home	The patient returned to the nursing home that is their normal place of residence or was transferred to a nursing home.
3. Transfer to another facility (not usual place of residence)	The patient was transferred to another facility that is not their usual place of residence (e.g., psychiatric hospital, detox, rehabilitation hospital, another short-term hospital, intermediate care facility (ICF), extended care facility or custodial care facility). If an extended care facility or custodial care facility has a distinct unit that provides skilled nursing care, enter "Return/Transfer to nursing home".
4. Other	Any other disposition where the patient neither returned to their normal place of residence nor was transferred.
5. Unknown	Information is not available to determine where the patient was discharged.

OBSERVATION UNIT STAY

Complete this item for patients who were discharged from the observation unit to return to their residence.

If the date and time when the patient was discharged from the observation unit is unknown, leave the field blank.

When entering the date and time that the patient was discharged from the observation unit, it is important to determine that this unit is a separate geographic location from the ED, not just a change in the patient's status. The ED discharge time should be the time the patient was transferred to the observation unit, not the same time the patient was discharged from the observation unit.

C. DEFINITIONS OF CERTAIN TERMS USED IN THE SURVEY

Patient - An individual seeking personal health services not currently admitted to any health care institution on the premises. Patients arriving by ambulance are included. Patients are defined as in scope or out of scope as follows:

In scope - A patient seen by hospital staff in an in scope emergency service area or clinic except as excluded below.

Out of scope - Patients seen by a physician in their private office, nursing home, or other extended care institution or in the patient's home. Patients who contact and receive advice from

hospital staff via telephone. Patients who come to the hospital only to leave a specimen, to pick up insurance forms, to pick up medication, or to pay a bill.

Visit - A direct, personal exchange between an ambulatory patient seeking care and a physician or other hospital staff member working under the physician's supervision for the purpose of rendering personal health services.

Drug mention - The health care provider's entry on the Patient Record form of a pharmaceutical agent ordered, supplied, administered or continued during the visit-- by any route of administration--for prevention, diagnosis, or treatment. Generic as well as brand name drugs are included, as are nonprescription as well as prescription drugs. Along with all new drugs, the hospital staff also records continued medications if the patient was specifically instructed during the visit to continue the medication.

Hospital - All hospitals with an average length of stay for all patients of less than 30 days (short-stay) or hospital whose specialty is general (medical or surgical) or children's general are eligible for the National Hospital Ambulatory Medical Care Survey except Federal hospitals and hospital units of institutions, and hospitals with less than six beds staffed for patient use.

Emergency department - Hospital facility for the provision of unscheduled outpatient services to patients whose conditions require immediate care and which is staffed 24 hours a day. Emergency departments that are open less than 24 hours a day are included as part of the hospital's outpatient department.

Emergency service area - Area within the emergency department where emergency services are provided. This includes services provided under the "hospital as landlord" arrangement in which the hospital rents space to a physician group.

Outpatient department - Hospital facility where non-urgent ambulatory medical care is provided under the supervision of a physician.

Clinic - Administrative unit within an organized outpatient department that provides ambulatory medical care under the supervision of a physician. This excludes the "hospital as landlord" arrangement in which the hospital only rents space to a physician group and is not otherwise involved in the delivery of services.

Clinics are grouped into the following six specialty groups for purposes of systematic sampling and non-response adjustment: general medicine, surgery, pediatrics, obstetrics/gynecology, substance abuse, and other. Clinics are defined as in scope or out of scope as follows:

In scope - General Medicine

23/24 Hour Observation
Adult - Screening
Adult HIV
AIDS
Allergy (Adult)
Ambulatory Care
Andrology
Anticoagulation
Apnea (Adult)
Arthritis/Rheumatology (Adult)
Asthma
Bariatrics/Bariatric Medicine
Brain Tumor
Breast Medical Oncology
Cancer Center
Cancer Screening
Cardiology (Adult)
Cardiovascular
CD4
Cerebral Palsy (Adult)
Chest
Chest TB
Chorea/Huntington's Disease
Coagulant
Congestive Heart Failure
Connective Tissue
Cystic Fibrosis (Adult)
Cytomegalovirus (CMV)
Dermatology
Diabetes
Digestive Disease
Down's Syndrome (Adult)
Endocrinology (Adult)
Epilepsy
Family Practice
Gastroenterology (Adult)
General Medicine
General Medicine (Outreach Program)
General Practice
Genetics (Adult)
Geriatric Medicine
Head (Non-Surgical)
Head & Neck (Non-Surgical)
Hematology (Adult)
Hemophilia (Adult)
Hepatology
HIV (Adult)
Holistic Medicine
Homeless
Huntington's Disease/Chorea
Hyperlipidemia (Adult)
Hypertension
Immunology
Immunosuppression
Infectious Diseases (Adult)

In scope - General Medicine

Internal Medicine (Adult)
Lead Poisoning (Adult)
Leukemia
Lipid
Liver
Lupus (Systemic Lupus Erythematosus/SLE)
Medical Oncology
Medical Screening
Melanoma
Metabolic
Movement and Memory Disorders
Multiple Sclerosis (MS)
Muscular Dystrophy (MD)
Nephrology (Adult)
Neurocutaneous
Non-Surgical Head
Non-Surgical Head & Neck
Obesity (Adult)
Occupational Medicine
Oncology
Outreach Program (General Medicine)
Pacemaker
Pentamidine
Peripheral Vascular Disease
Pheresis
Pigmented Lesion
Plasmapheresis
Primary Care
Pulmonary (Adult)
Renal
Respiratory
Rheumatology/Arthritis (Adult)
Sarcoidosis
Screening (Adult)
Screening - Cancer
Screening and/or Walk-In
Seizure
Senior Care
Sexually Transmitted Diseases (STD)
Sickle Cell (Adult)
Spina Bifida (Adult)
STD/Sexually Transmitted Diseases
Systemic Lupus Erythematosus/SLE (Lupus)
Thyroid
Transplant Medicine
Travel Medicine
Tuberculosis
Tumor (Brain & Other)
Urgent Care
Vascular
Walk-in and/or Screening
Weight Management
Wellness

In scope - Surgery

Abdominal Surgery
Amputee (Surgery & Rehab)
Ano-Rectal
Back Care
Bariatric Surgery
Bone Marrow Aspiration
Bone Marrow Transplant
Breast
Breast Care
Burn
Cardiothoracic Surgery
Cardiovascular Surgery
Cast/Brace
Chief Resident (Follow-up Surgery)
Chronic Wound
Cleft Palate
Club Foot
Cochlear
Colon & Rectal Surgery
Craniofacial
Cryosurgery
Elective Surgery
ENT (Ear, Nose, and Throat) (Adult)
ENT (Ear, Nose, and Throat) (Pediatric)
Eye
Eye Retinopathy of Prematurity
Fine Needle Aspiration
Fracture
General Surgery
Genitourinary
Genitourinary Surgery
Hand Surgery
Head and Neck Surgical
Heart Transplant
Injury
Injury (Pediatric)
Knee
Neurosurgery
Ophthalmologic Surgery
Ophthalmology (Adult)
Ophthalmology (Pediatric)
Orthopedic Surgery
Orthopedics (Adult)
Orthopedics (Pediatric)
Ostomy
Otolaryngologic Surgery
Otolaryngology (Adult)
Otolaryngologic (Pediatric)
Otology
Otorhinolaryngology
Plastic Surgery (Adult)
Plastic Surgery (Pediatric)
Postoperative
Preoperative

In scope - Surgery

Proctology
Pulmonary/Thoracic Surgery
Rectal & Colon Surgery
Renal Surgery
Renal Transplant
Scoliosis (Adult)
Scoliosis (Pediatric)
Spinal Cord Injury
Spine (Adult)
Spine (Pediatric)
Sports Medicine
Surg
Surgery (Adult)
Surgery (Pediatric)
Surgery Cancer Detection
Surgical Oncology
Suture
Thoracic Surgery/Pulmonary
Transplant Surgery
Trauma
Traumatic Brain Injury
Traumatic Surgery
Urodynamics
Urologic Surgery
Urology (Adult)
Urology (Pediatric)
Vascular Surgery
Visual Fields
Wound Care

In scope – Pediatrics

Abuse (Child)/Sexual Assault
Adolescent Medicine
Adolescent/Young Adult
After Hours (Pediatric)
Airway (Pediatric)
Allergy (Pediatric)
Apnea (Infant)
Arthritis/Rheumatology (Pediatric)
Asthma (Pediatric)
Attention Deficit Disorder
Autism
Behavior and Development (Child)
Birth Defect
Cardiac (Pediatric)
Cardiology (Pediatric)
Cerebral Palsy (Child)
Chest (Pediatric)
Clotting (Pediatric)
Congenital Heart
Craniomalformation
Critical Care (Pediatric)
Cystic Fibrosis (Child)
Dermatology (Pediatric)

In scope – Pediatrics (cont.)

Developmental Disability
Developmental Evaluation
Diabetes (Pediatric)
Diagnostic (Pediatric)
Down's Syndrome (Child)
Endocrinology (Pediatric)
Epilepsy (Pediatric)
Feeding Disorder (Pediatric)
Gastroenterology (Pediatric)
Gastrointestinal (Pediatric)
General Pediatrics
Genetics (Pediatric)
GI (Pediatric)
Growth Hormone
Hematology (Pediatric)
Hemoglobinopathy (Pediatric)
Hemophilia (Child)
High Risk Pediatrics
HIV Pediatrics
Hyperlipidemia (Pediatric)
Immunization
Immunology (Pediatric)
Infectious Diseases (Pediatric)
Internal Medicine (Pediatric)
Lead Poisoning (Pediatric)
Learning Disorder
Metabolic (Pediatric)
Neonatal
Neonatal Follow-up
Neonatology
Nephrology (Pediatric)
Newborn
Obesity (Pediatric)
Oncology (Pediatric)
Pediatrics (General)
Perinatal
Phenylketonuria
Prader-Willi Syndrome
Pulmonary (Pediatric)
Renal and Diabetes (Pediatric)
Rheumatic Heart Disease
Rheumatology/Arthritis (Pediatric)
Screening (Pediatric)
Sexual Assault/Abuse (Child)
Short Stay (Pediatric)
Sickle Cell (Child)
Skeletal Dysplasia
Spina Bifida (Child)
Teen Health
Teen-Tot
Teenage
Urgent care (Pediatric)
Well Child Care

In scope - Obstetrics/Gynecology

Adolescent Gynecology
Antepartum
Birth Control
Dysplasia (Gynecologic)
Endocrinology (Gynecologic)
Endocrinology (Reproductive)
Family Planning
Fertility
Gynecology (General)
Gynecology (Adolescent)
Gynecology (Dysplasia)
Gynecology (Endocrinologic)
Gynecology (Oncologic)
Gynecology (Pediatric)
Gynecology (Preteen)
High Risk Obstetrics
HIV Obstetrics
In Vitro Fertilization
Infertility
Maternal Fetal Medicine
Maternal Health
Maternity
Obstetrics (General)
Oncology (Gynecologic)
Perinatal (Obstetrics)
Postpartum (Obstetrics)
Pregnancy Verification
Prenatal
Prenatal (Obstetrics)
Preteen Gynecology
Reproductive
Reproductive Endocrinology
Well Woman
Women's Care

In scope - Substance Abuse

Alcohol Abuse
Alcohol Detoxification
Alcohol Walk-in
Chemical Dependence (excluding Methadone Maintenance)
Drug Abuse (excluding Methadone Maintenance)
Drug Detoxification (excluding Methadone Maintenance)
Substance Abuse (excluding Methadone Maintenance)
Walk-in – Alcohol
Women's Alcohol Program

In scope - Other

Anxiety
Behavioral Medicine
Biofeedback
Eating Disorder
General Preventive Medicine
Geriatric Psychiatry
Headache (Neurology)
Hyperbaric oxygen
Mental Health
Mental Hygiene
Myasthenia Gravis
Myelomeningocele
Neurofibromatosis
Neurology (Adult)
Neurology (Pediatric)
Neuromuscular
Neurophysiology
Neuropsychiatry
Neurosensory
Palliative Medicine
Preventive Medicine
Psychiatry (Adolescent)
Psychiatry (Adult)
Psychiatry (Child)
Psychiatry (Geriatric)
Psychiatry (Pediatric)
Psychopharmacology
Sleep Disorder
Sleep Medicine
Toxicology
Voice and Swallowing

Out of scope

Abortion/Pregnancy Termination
Acupuncture
Adult Day Care
Ambulatory Surgery Center
Amniocentesis
Anesthesia
Anesthesiology
Arthroscopy
Audiology
Blood Bank
Bone Density Screening
Bronchoscopy
Cardiac Catheterization
CAT Scan & Imaging
Chemotherapy
Chiropractic
Colonoscopy
Colposcopy
Cyberknife Radiology
Cystoscopy
Day Hospital

Out of scope

Dental
Dental Surgery
Diabetic Foot Clinic
Diagnostic X-ray (Imaging)/Radiology
Dialysis
Dietary
Drug Immunotherapy
Echocardiology
Electrocardiogram (ECG)
Electroconvulsive Therapy (ECT)
Electromyography
Employee Health Service/Center
Endoscopy
Fetal Diagnostic Testing
Hearing & Speech
Hemodialysis
Home Intravenous Therapy
Imaging & CAT Scan
Infusion
Infusion Therapy
IV Therapy
Kidney (Renal) Dialysis
Laser Surgery
Lasik Surgery
Lithotripsy
Mammography
Methadone Maintenance
Nuclear Medicine
Nurse Clinic/Nurse Only
Nutrition
Occupational Health
Occupational Safety and Health
Occupational Therapy
Optometry
Oral Surgery
Orthotics
Pain
Pain Block
Pain Management
Pain Medicine
Partial Hospitalization
Partial Hospitalization Program (Psyc)
Path Lab
Pathology
Pharmacy
Physiatry
Physical Medicine
Physical Therapy
Physiotherapy
Podiatry
Preadmission Testing
Pregnancy Termination/Abortion
Psychology
Pulmonary Function Lab

Out of scope (cont.)

Radiation Diagnosis
Radiation Oncology
Radiation Therapy
Radiology/Diagnostic X-ray (Imaging)
Reading & Language
Reference Lab
Reference X-Ray
Rehabilitation
Renal (Kidney) Dialysis
Same Day Surgery
School Programs
Sigmoidoscopy
Social Work
Speech & Hearing
Student Health Service/Center
Tele-Health
Transfusion
Ultrasound
Vertical Balance

Region - Hospitals are classified by location in one of the four geographic regions of the United States that correspond to those used by the U.S. Bureau of the Census.

Region	States included
Northeast	Connecticut, Maine, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, and Vermont
Midwest	Illinois, Indiana, Iowa, Kansas, Michigan, Minnesota, Missouri, Nebraska, North Dakota, Ohio, South Dakota, and Wisconsin
South	Alabama, Arkansas, Delaware, District of Columbia, Florida, Georgia, Kentucky, Louisiana, Maryland, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Virginia, and West Virginia
West	Alaska, Arizona, California, Colorado, Hawaii, Idaho, Montana, Nevada, New Mexico, Oregon, Utah, Washington, and Wyoming

APPENDIX II
REASON FOR VISIT CLASSIFICATION

NOTE: The Reason for Visit Classification used for the 2014 NHAMCS ED public use micro-data file is the same as that used for the 2014 National Ambulatory Medical Care Survey and is available here.

APPENDIX III

A.   GENERIC CODES AND NAMES IN NUMERIC ORDER

The Generic Codes and Names List for the 2014 NHAMCS ED public use micro-data file is the same as that used for the 2014 National Ambulatory Medical Care Survey and is available here.

B.   DRUG ENTRY CODES AND NAMES IN NUMERIC ORDER

The Drug Entry Codes and Names List for the 2014 NHAMCS ED public use micro-data file is the same as that used for the 2014 National Ambulatory Medical Care Survey and is available here.

C.   MULTUM LEXICON END-USER LICENSE AGREEMENT

The Multum Lexicon End-User License Agreement for the 2014 NHAMCS ED public use micro-data file is the same as that used for the 2014 National Ambulatory Medical Care Survey and is available here.

D. MULTUM CLASSIFICATION OF THERAPEUTIC CLASSES (DRUG CATEGORIES)

The Multum Classification of Therapeutic Classes for the 2014 NHAMCS ED public use-micro-data file is the same as that used for the 2014 National Ambulatory Medical Care Survey and is available here.