ABSTRACT

This material provides documentation for users of the Emergency Department public use micro-data file of the 2015 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 2015

The 2015 NHAMCS Emergency Department (ED) micro-data file is in general similar in layout to the 2014 file but there are some changes. These are described in more detail below.

Note that the questionnaire changes listed below mainly 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 2015 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.

Triage:
  a. Under Initial Vital Signs, for the Pulse Oximetry item, a new direction was added: Percent of oxyhemoglobin saturation; value is usually between 80-100%.
Injury:
  b. For the item, ""Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment?", the wording was changed to include surgical treatment. (In 2014, the item was "Is this visit related to an injury/trauma, overdose/poisoning, or adverse effect of medical treatment?".) Also, response categories were changed from to 2014's "Yes, poisoning" to 2015's "Yes, overdose/poisoning", and 2014's "Yes, adverse effect of medical treatment" to 2015's "Yes, adverse effect of medical or surgical treatment or adverse effect of medicinal drug".

  c. For the item, "Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?", the wording was changed to include adverse effect. (In 2014, the item was "Did the injury/trauma, overdose, or poisoning occur within 72 hours prior to the date and time of this visit?")

  d. For the item, "Is this injury/trauma or overdose/poisoning intentional or unintentional?" the wording was changed. (In 2014, this item was "Is this injury/overdose/poisoning intentional?".) Also, response categories were changed from 2014's four categories of "Yes, self-inflicted", "Yes, assault", "No, unintentional (e.g., accidental)" and "Intent unclear" to 2015's three categories of "Intentional", "Unintentional (e.g., accidental)", and "Intent unclear".

  e. New item: "What was the intent of the injury/trauma or overdose/poisoning?" with response categories of "Suicide attempt with intent to die", "Intentional self-harm without intent to die","Unclear if suicide attempt or intentional self-harm without intent to die", "Intentional harm inflicted by another person (e.g., assault, poisoning)" and "Intent unclear". This item only displayed in the automated instrument if an intentional injury/trauma or overdose/poisoning had been indicated. The item is NOT included on the public use file because of low item response and data quality issues.

  f. The item, "Cause of injury/trauma, overdose/poisoning, or adverse effect of medical/surgicaltreatment", was modified slightly for wording. (In 2014, the item was "Cause of injury/trauma, overdose, poisoning, or adverse effect".)

Diagnosis:
    g. In the section, "Does patient have –", the following checkbox items were modified from 2014: "Alcohol abuse" was changed to "alcohol misuse, abuse, or dependence"; "Cerebrovascular disease/stroke (CVA) or transient ischemic attack (TIA) was changed to "Cerebrovascular disease/History of stroke (CVA) or transient ischemic attack (TIA)"; "History of pulmonary embolism (PE) or deep vein thrombosis (DVT)" was changed to "History of pulmonary embolism (PE), deep vein thrombosis (DVT), or venous thromboembolism (VTE)"; and "Substance abuse" was changed to "Substance abuse or dependence."

Diagnostic Services:
    h. In the Blood Tests section, these checkboxes were added: "Basic metabolic panel (BMP)" and "Comprehensive metabolic panel (CMP)".

    i. In the Other Tests section, these checkboxes were added: "Throat culture" and "Other culture".

Procedures:
    j. The "BiPAP/CPAP" checkbox label was modified slightly. (In 2014, the checkbox was "BPAP/CPAP".)

Medications & Immunizations:
    k. If a medication was indicated, a new indicator, "When given?", appeared with an additional instruction "When was this drug given?" Response categories of "Given in ED", "Rx at discharge", and "Both given in ED and Rx at discharge" remained the same.

Hospital induction interview:

    l. The question: "Medicare and Medicaid offer incentives to hospitals that demonstrate 'meaningful use of Health IT'. Does your hospital have plans to apply for Stage 1 of these incentive payments?" was modified to: "Medicare and Medicaid offer incentives to hospitals that demonstrate 'meaningful use of Health IT'. Does your hospital have plans to apply for these incentive payments?" [Note: this appears to have been an error on the instrument; the item should have remained the same across years.]
    m. New items: "Are you able to electronically find health information from sources outside of the hospital for your patients?" ("Yes, routinely", "Yes, but not routinely", "No"). If 'Yes', three follow-up questions were asked:
        i. "How do you look up patient health information from sources outside your hospital?" ("Through your EHR/EMR", "Web portal", "View only or restricted access to other providers' EHR systems", "Other electronic method (not fax)"
        ii. "What types of information do you routinely look up?" ("Lab results", "Imaging reports", "Patient problem lists", "Medication lists", "Other")
        iii. "Do you routinely incorporate the information you look up into your EHR?" ("Yes, via manual entry or scanned copy", "Yes, automatically able to incorporate without manual entry or scanning", "No, we do not routinely incorporate into our EHR")

B. Data Collection and Comparability of 2015 NHAMCS Estimates with Previous Years of Data

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 2015, 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 2015 and 2014 data.

To accomplish this, more than 20 tables of 2015 estimates were compared with the same tables of 2014 estimates. The variables that were compared included most of those published in the annual survey web

tables (available from: https://www.cdc.gov/nchs/ahcd/ahcd_products.htm). 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, with results being weighted to national estimates:

---Visits with self-pay as the expected source of payment decreased from 11.7% in 2014 to 9.0% in 2015.

---Visits with no indication of chronic conditions decreased from 55.1% in 2014 to 51.7% in 2015. Specific chronic conditions that saw an increase include type 2 diabetes (from 3.2% to 4.6%) and obesity (from 2.6% to 3.6%).

---Injury, poisoning, and adverse effects-related visits with an accidental poisoning (by drugs, medicinal substances, biologicals, and other solid and liquid substances, gases, and vapors) increased from 2.0% in 2014 to 3.4% in 2015.

---Significant decreases from 2014 to 2015 in visits with the following blood tests ordered or provided were noted: BUN/Creatinine (15.6% to 6.7%); electrolytes (7.9% to 3.3%); and glucose (15.5% to 8.1%).

---The percentage of visits with any indication of medications given at the ED visit or prescribed at discharge did not change significantly from 2014 to 2015; however, visits with indication of 13 or more medications increased significantly from 0.6% to 1.4%.

NCHS staff will continue to monitor these and other changes with regard to 2015 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 in early 2017). 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 2015.

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 2015 data, internal research was again conducted, using the same methodology employed since 2012. Similar to 2014 data, the effects of the missing sampling design information were more pronounced in 2015 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 392 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 2015 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 or email ambcare@cdc.gov.

Table of Contents

Appendixes

NOTE: Appendix II and Appendix III are identical to those previously published in the 2015 National Ambulatory Medical Care Survey Public Use File Documentation and are not reprinted here; please use links to access.)

Table of Contents (cont.)

Page

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). 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 (November 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 2015, there were 21,061 electronic Patient Record forms (PRFs) provided by EDs that participated in the survey.

****
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 28. 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 or by sending an email inquiry to ambcare@cdc.gov.

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.

****

B. SAMPLE DESIGN

The 2015 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. The NHAMCS sample 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 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 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 sampling frame and sample were updated for the 2015 survey using hospital data from IMS Health's (now QuintilesIMS) 2012 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 sampling frame and sample will be updated again for the 2017 survey and plans are to update again every two years thereafter.

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 emergency departments (EDs) and 5,654 (90 percent) had outpatient departments (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 classes: 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 in each PSU 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. From the 427 hospitals that had neither an ED nor an OPD in the sample PSUs, a sample of 50 hospitals was selected with probability proportional to the inverse of PSU selection probabilities, making the overall selection probabilities (products of the PSU and hospital selection probabilities) equal within region.

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. These subsets were assigned on a rotating basis to 4-week reporting periods, beginning December 2, 1991, and continuing 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 2015 NHAMCS was conducted from December 29, 2014 through December 27, 2015, and used a sample of 457 hospitals. Of the sampled hospitals, 80 were found to be ineligible due to closing or other reasons. Of the 377 hospitals that were in scope (eligible) for the survey, 267 participated, for an unweighted hospital sampling response rate of 70.8 percent (68.7 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. 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 assure that an SU was sampled from each of an OPD's specialty groups.

Emergency services provided under the "hospital as landlord" arrangement were also eligible for the study. An ED was in scope if it provided unscheduled health care 24 hours a day, seven days a week. 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 457 hospitals was selected for the 2015 NHAMCS, of which 377 were in scope and had eligible EDs. Of these, 267 participated, yielding an unweighted ED response rate of 70.8 percent (68.7 percent weighted). A sample of 374 ESAs were identified from the respondent EDs. Of these, 291 responded fully or adequately by providing forms for at least half of their expected sample visits based on the total number of visits they had during their reporting period, and 83 responded minimally (i.e. they provided fewer than half of their expected forms). In all, 21,061 electronic Patient Record Forms (PRFs) were completed. The resulting unweighted ESA sample response rate was 77.8 (85.0 percent weighted), and the overall unweighted response rate (ED rate times ESA rate) was 55.1 percent (58.4 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. Within ESAs or OPD clinics, patient visits were systematically selected over the randomly assigned 4-week reporting period for the hospital. 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 departments with volumes higher than these desired figures, visits were sampled by a systematic procedure which selected every nth visit after random starts within ESAs/clinics. Visit sampling rates were determined from the expected number of visits to be seen during the reporting period and the desired number of completed PRFs. During the 2015 NHAMCS, electronic PRFs were completed for 21,061 ED visits.

C. DATA COLLECTION PROCEDURES

1. Field Training

The U.S. Census Bureau was the data collection agent for the 2015 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. Training for FRs new to the survey consisted of eight hours of self-study and 12 hours of classroom training. Continuing FRs received one hour of annual survey training and another hour of refresher 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. The following organizations endorse NHAMCS: 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.

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 FRs (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 2015, 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 2015, 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 2015, 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/2015_NHAMCS_ED_PRF_Sample_Card.pdf

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

The 2015 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, E-code (cause of injury), and ICD procedures (for the OPD sample only) were reviewed and adjudicated at NCHS. Coding error rates ranged between 0.57 and 0.71 percent for the 10 percent ED sample and between 0.21 and 1.54 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:

Variable	Variable Description	Denominator	Nonresponse %
ETHUN	Unimputed ethnicity	All visits	24.2
RACEUN	Unimputed race	All visits	19.4
WAITTIME	Waiting time to see MD/DO/PA/NP in minutes	All visits	15.7
PAYTYPER	Recoded primary expected source of payment for visit (based on hierarchy)	All visits	8.7
LOV	Length of visit in minutes	All visits	7.0
PAINSCALE	Pain scale (0-10)	All visits	29.4
IMMEDR	Immediacy with which patient should be seen (unimputed)	All visits	22.2
BPDIAS	Initial vital signs: Blood pressure - Diastolic	All visits	11.6
BPSYS	Initial vital signs: Blood pressure - Systolic	All visits	11.3
PULSE	Initial vital signs: Heart rate per minute	All visits	8.3
POPCT	Initial vital signs: Pulse oximetry (percent)	All visits	8.2
TEMPF	Initial vital signs: Temperature (Fahrenheit)	All visits	6.0
INJURY72	Did the injury/trauma, overdose/poisoning, or adverse effect occur within 72 hours prior to the date and time of this visit?	Injury-, poisoning-, and adverse effects-related visits	31.4
INTENT15	Is this injury/trauma or overdose/poisoning intentional or unintentional?	Injury- and poisoning-related visits	21.6
CAUSE1	Cause #1 of injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatrment - numeric recode	Injury-, poisoning-, and adverse effects-related visits	15.9

SEEN72	Was patient seen in this ED within the last 72 hours and discharged?	All visits	6.8
CTCONTRAST	Was CT Scan ordered/provided with intravenous (IV) contrast?	All visits	86.9
GPMED30	Medication #30 given in ED or Rx at discharge	All visits where medication 30 was listed	33.3
GPMED29	Medication #29 given in ED or Rx at discharge	All visits where medication 29 was listed	27.3
GPMED28	Medication #28 given in ED or Rx at discharge	All visits where medication 28 was listed	18.8
GPMED27	Medication #27 given in ED or Rx at discharge	All visits where medication 27 was listed	17.4
GPMED19	Medication #19 given in ED or Rx at discharge	All visits where medication 19 was listed	17.3
GPMED22	Medication #22 given in ED or Rx at discharge	All visits where medication 22 was listed	16.4
GPMED21	Medication #21 given in ED or Rx at discharge	All visits where medication 21 was listed	15.9
GPMED20	Medication #20 given in ED or Rx at discharge	All visits where medication 20 was listed	15.7
GPMED18	Medication #18 given in ED or Rx at discharge	All visits where medication 18 was listed	15.0
GPMED23	Medication #23 given in ED or Rx at discharge	All visits where medication 23 was listed	14.8
GPMED13	Medication #13 given in ED or Rx at discharge	All visits where medication 13 was listed	14.5
GPMED16	Medication #16 given in ED or Rx at discharge	All visits where medication 16 was listed	14.0
GPMED24	Medication #24 given in ED or Rx at discharge	All visits where medication 24 was listed	14.0
GPMED14	Medication #14 given in ED or Rx at discharge	All visits where medication 14 was listed	14.0
GPMED17	Medication #17 given in ED or Rx at discharge	All visits where medication 17 was listed	13.6
GPMED26	Medication #26 given in ED or Rx at discharge	All visits where medication 26 was listed	13.3

GPMED15	Medication #15 given in ED or Rx at discharge	All visits where medication 15 was listed	13.3
GPMED11	Medication #11 given in ED or Rx at discharge	All visits where medication 11 was listed	12.7
GPMED12	Medication #12 given in ED or Rx at discharge	All visits where medication 12 was listed	12.7
GPMED25	Medication #25 given in ED or Rx at discharge	All visits where medication 25 was listed	11.8
GPMED10	Medication #10 given in ED or Rx at discharge	All visits where medication 10 was listed	11.7
GPMED9	Medication #9 given in ED or Rx at discharge	All visits where medication 9 was listed	10.5
GPMED8	Medication #8 given in ED or Rx at discharge	All visits where medication 8 was listed	8.1
GPMED7	Medication #7 given in ED or Rx at discharge	All visits where medication 7 was listed	6.6
GPMED6	Medication #6 given in ED or Rx at discharge	All visits where medication 6 was listed	5.3
TEMPDF	Vitals at discharge: Temperature in Fahrenheit	All visits where vitals were taken at discharge	42.0
BPDIASD	Vitals at discharge: Diastolic blood pressure	All visits where vitals were taken at discharge	10.3
BPSYSD	Vitals at discharge: Systolic blood pressure	All visits where vitals were taken at discharge	10.1
RESPRD	Vitals at discharge: Respiratory rate (breaths per minute)	All visits where vitals were taken at discharge	9.0
PULSED	Vitals at discharge: Heart rate (beats per minute)	All visits where vitals were taken at discharge	7.5
OBSSTAY	Length of stay in observation unit in minutes	Visits that resulted in observation unit admission and discharge	51.7
ADMTPHYS	Admitting physician	Visits that resulted in hospital admission	37.9
BOARDED	Length of time boarded in ED in minutes	Visits that resulted in hospital admission	35.6
ADMIT	Admitted to:	Visits that resulted in hospital admission	11.8
LOS	If admitted, length of stay in hospital (days)	Visits that resulted in hospital admission	8.0

HDDIAG1	Hospital discharge diagnosis #1 - detailed category	Visits that resulted in hospital admission	5.9
ADISP	Disposition of live discharges	Visits that resulted in hospital admission	5.8
TOTHRDIVR	What is the total number of hours that your hospital's ED was on ambulance diversion in 2014?	All visits to EDs that went on ambulance diversion	36.3
EIMMREGE	Does your ED have the computerized capability for electronic reporting to immunization registries?	All visits where applicable	17.5
MUSTAGE2	Are there plans to apply for Stage 2 incentive payments?	All visits where applicable	15.4
EXPSPACE	Do you have plans to expand your ED's physical space within the next two years?	All visits	13.5
REGDIV	Is ambulance diversion actively managed on a regional level versus each hospital adopting diversion if and when it chooses?	All visits	13.5
EFORMULAE	If computerized capability for ordering prescriptions, are drug formulary checks performed?	All visits where applicable	12.8
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	12.6
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	12.5
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	12.1

EOUTINFOE	Are you able to electronically find health information (e.g. medications, outside encounters) from sources outside of the hospital for your patients?	All visits where applicable	11.3
ADVTRIAG	Does your ED use advanced triage (triage-based care) protocols?	All visits	11.0
EDINFO	When patients arrive at the ED, are you able to query for patients' healthcare information electronically (e.g., medications, allergies) from outside sources?	All visits where applicable	10.8
EHRTOEHRE	Is the patient health information that you share electronically sent directly from your EHR system to another EHR system?	All visits where applicable	10.8
AMBDIV	Did your ED go on ambulance diversion in 2014?	All visits	10.7
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	10.3
EGRAPHE	If yes to ERESULTE, can the EHR/EMR automatically graph a specific patient's lab results over time?	All visits where applicable	10.2
ZONENURS	Does your ED use zone nursing?	All visits	10.1
RFID	Does your ED use radio frequency identification (RFID) tracking?	All visits	10.0
EREMINDE	Does your ED have the computerized capability for providing reminders for guideline-based interventions or screening tests?	All visits where applicable	8.7
EMEDRES	Does hospital have an Emergency Medicine residency program?	All visits	8.4
POOLNURS	Does your ED use pool nurses?	All visits	8.4

EPTEDUE	Does your ED have the computerized capability for identifying educational resources for patients' specific conditions?	All visits where applicable	8.4
IMBED	Does your ED use immediate bedding?	All visits	8.1
CATRIAGE	Does your ED use computer-assisted triage?	All visits	8.1
ECQME	Does your ED have the computerized capability for reporting clinical quantity measures to federal or state agencies (such as CMS or Medicaid)?	All visits where applicable	8.0
EGENLISTE	Does your ED have the computerized capability for generating list of patients with particular health conditions?	All visits where applicable	7.7
ADMDIV	Does your hospital continue to admit elective or schedule surgery cases when ED is on ambulance diversion?	All visits	7.6
BOARDHOS	Does your ED allow some admitted patients to move from the ED to inpatient corridors while awaiting a bed ("boarding") - sometimes called "full capacity protocol"?	All visits	7.5
FASTTRAK	Does your ED use separate fast track unit for nonurgent care?	All visits	7.3
EDPTOR	Does your ED use separate operating room dedicated to ED patients?	All visits	6.8
EMSGE	Does your ED have the computerized capability for exchanging secure messages with patients?	All visits where applicable	6.8
EPTRECE	Does your ED have the computerized capability for providing patients the ability to view online, download or transmit information from their medical record?	All visits where applicable	6.6

EBILLANYE	Does your ED submit any claims electronically (electronic billing)?	All visits	6.5
WIRELESS	Does ED use wireless communication devices by providers?	All visits	6.4
INCSHX	In the last two years, did your ED increase the number of standard treatment spaces?	All visits	6.4
OBSCLIN	Does your ED have an observation or clinical decision unit?	All visits	5.6
EHRINSE	Does your ED have plans for installing a new EHR/EMR system within the next 18 months?	All visits where applicable	5.2
BEDREG	Does your ED use bedside registration?	All visits	5.2
DASHBORD	Does your ED use electronic dashboard?	All visits	5.0

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 some records for items including race, ethnicity, physician's diagnosis and hospital discharge diagnosis in order to protect respondent confidentiality. Other items such as age were top coded in accordance with NCHS confidentiality requirements; this is noted for specific items in the Codebook.

On the ED file, four items were imputed: patient's age (0.05 percent), sex (0.2 percent), race (19.4 percent), and ethnicity (24.2 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; type of ESA area; provider's MSA status; and ED weighting and volume variables.

4. Injury-Related Data

Starting in 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 of Medical/Surgical Treatment

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 of medical/surgical treatment" 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 47 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 2015, 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 49 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 six 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='209'. 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 '209' (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/hormone modifiers). Drugs that could not be assigned to any drug entry name (MED1-MED30 = 99980, 99999) were put in an NCHS-defined miscellaneous 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_2015) 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. Prior to 2006, codes used to identify the active generic ingredients of combination drugs were included on the public use file.

IMPORTANT: For 2015, 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.

The mapping file has been updated over the years and can be downloaded 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 2015 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 or emailing ambcare@cdc.gov. 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 2015 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 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 21,061 visits. In order to obtain 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 21,061 sample records for 2015, the user can obtain the estimated total of 136,943,000 ED visits made in the United States.

IMPORTANT: Estimates produced from the 2015 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. Other items such as age were top coded in accordance with NCHS confidentiality requirements; this is noted for specific items in the Codebook.

The marginal tables in Section III contain data on numbers of records for selected variables as well as the corresponding 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 each hospital's individual PRFs on the public use file. 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 submitted 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.

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 or emailing ambcare@cdc.gov.

L. POPULATION FIGURES

The base population used in computing annual visit rates is presented in table's 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, 2015 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 2015 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 2015 population estimates indicate that 2.6 percent of the total population identify themselves as being of multiple races. In contrast, multiple race patients account for 0.3 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 2009-2015 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 E.Ds. This implies that the ED visit rates by race populations calculated for 2015 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, 2015

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All Races	316,286,252	3,976,258	15,925,573	41,070,702	42,884,188	42,903,523
Male	154,555,390	2,034,264	8,140,618	20,953,859	21,643,099	21,221,400
Female	161,730,862	1,941,994	7,784,955	20,116,843	21,241,089	21,682,123
White Only	244,269,224	2,848,686	11,418,415	29,934,513	31,621,522	32,101,866
Male	120,425,502	1,458,617	5,845,801	15,314,481	16,054,090	16,130,818
Female	123,843,722	1,390,069	5,572,614	14,620,032	15,567,432	15,971,048
Black Only	41,266,683	608,830	2,426,278	6,148,441	6,569,632	5,950,948
Male	19,279,941	310,138	1,231,062	3,113,817	3,230,760	2,752,507
Female	21,986,742	298,692	1,195,216	3,034,624	3,338,872	3,198,441
AIAN* Only	3,938,592	65,570	256,687	652,258	644,249	599,555
Male	1,965,512	33,523	130,845	330,996	325,371	306,096
Female	1,973,080	32,047	125,842	321,262	318,878	293,459
Asian Only	17,892,106	197,294	830,007	2,125,724	2,361,417	3,054,413
Male	8,495,982	101,166	424,626	1,073,877	1,189,043	1,459,096
Female	9,396,124	96,128	405,381	1,051,847	1,172,374	1,595,317
NHOPI* Only	739,407	12,229	48,862	119,122	115,227	131,076
Male	370,031	6,287	25,218	60,386	57,709	66,931
Female	369,376	5,942	23,644	58,736	57,518	64,145
Multiple Race	8,180,240	243,649	945,324	2,090,644	1,572,141	1,065,665
Male	4,018,422	124,533	483,066	1,060,302	786,126	505,952
Female	4,161,818	119,116	462,258	1,030,342	786,015	559,713

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

Geographic Region totals		Metropolitan Statistical Area totals	
Northeast	55,549,017	MSA	276,538,559
Midwest	66,918,691	Non-MSA	39,747,693
South	118,889,833		
West	74,928,711		

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, 2015 - con.

Race and sex	35-44	45-54	55-64	65-74	75+
All Races	39,770,235	42,666,711	40,621,740	27,324,432	19,142,890
Male	19,484,143	20,853,087	19,528,603	12,778,167	7,918,150
Female	20,286,092	21,813,624	21,093,137	14,546,265	11,224,740
White Only	30,217,405	33,642,521	33,012,877	22,984,847	16,486,572
Male	15,088,383	16,682,449	16,067,805	10,881,903	6,901,155
Female	15,129,022	16,960,072	16,945,072	12,102,944	9,585,417
Black Only	5,248,979	5,385,295	4,720,963	2,617,822	1,589,495
Male	2,362,601	2,453,826	2,131,362	1,119,222	574,646
Female	2,886,378	2,931,469	2,589,601	1,498,600	1,014,849
AIAN* Only	522,574	489,814	390,129	207,153	110,603
Male	264,071	243,062	187,487	97,929	46,132
Female	258,503	246,752	202,642	109,224	64,471
Asian Only	2,891,291	2,445,021	1,963,514	1,229,044	794,381
Male	1,345,576	1,138,400	888,023	546,758	329,417
Female	1,545,715	1,306,621	1,075,491	682,286	464,964
NHOPI* Only	105,671	88,875	65,536	34,681	18,128
Male	53,174	43,904	31,892	16,794	7,736
Female	52,497	44,971	33,644	17,887	10,392
Multiple Races	784,315	615,185	468,721	250,885	143,711
Male	370,338	291,446	222,034	115,561	59,064
Female	413,977	323,739	246,687	135,324	84,647

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

SOURCE: These are U.S. Bureau of the Census postnasal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2015. 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, 2015 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, 2015

HISPANIC

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All races	55,936,643	1,023,711	4,118,581	10,152,225	9,361,928	8,771,371
Male	28,046,297	523,217	2,098,730	5,166,957	4,767,194	4,519,923
Female	27,890,346	500,494	2,019,851	4,985,268	4,594,734	4,251,448
White Only	49,236,812	866,517	3,506,070	8,758,287	8,181,710	7,694,087
Male	24,711,786	442,917	1,786,930	4,458,351	4,169,283	3,977,982
Female	24,525,026	423,600	1,719,140	4,299,936	4,012,427	3,716,105
Black Only	2,664,841	59,675	232,204	529,612	465,937	438,352
Male	1,293,169	30,485	118,064	269,418	235,932	211,064
Female	1,371,672	29,190	114,140	260,194	230,005	227,288
AIAN* Only	1,625,708	31,862	122,550	301,695	277,920	272,482
Male	843,010	16,287	62,296	153,510	142,401	147,729
Female	782,698	15,575	60,254	148,185	135,519	124,753
Asian Only	559,787	12,439	48,472	109,345	95,513	91,411
Male	277,008	6,341	24,688	56,098	47,732	45,362
Female	282,779	6,098	23,784	53,247	47,781	46,049
NHOPI* Only	198,152	4,183	16,552	37,720	33,017	37,088
Male	102,105	2,136	8,425	19,049	16,912	20,398
Female	96,047	2,047	8,127	18,671	16,105	16,690
Multiple Races	1,651,343	49,035	192,733	415,566	307,831	237,951
Male	819,219	25,051	98,327	210,531	154,934	117,388
Female	832,124	23,984	94,406	205,035	152,897	120,563

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, 2015 - con.

HISPANIC

Race and sex	35-44	45-54	55-64	65-74	75+
All races	8,046,068	6,475,777	4,266,895	2,258,136	1,461,951
Male	4,061,215	3,243,592	2,057,099	1,021,833	586,537
Female	3,984,853	3,232,185	2,209,796	1,236,303	875,414
White Only	7,156,185	5,814,636	3,846,392	2,060,833	1,352,095
Male	3,623,370	2,920,582	1,856,204	932,715	543,452
Female	3,532,815	2,894,054	1,990,188	1,128,118	808,643
Black Only	354,905	267,461	176,595	88,158	51,942
Male	164,027	124,305	81,649	38,513	19,712
Female	190,878	143,156	94,946	49,645	32,230
AIAN* Only	241,491	186,770	115,316	49,867	25,755
Male	128,582	98,360	58,821	24,184	10,840
Female	112,909	88,410	56,495	25,683	14,915
Asian Only	78,537	59,040	37,337	17,750	9,943
Male	38,867	28,620	17,566	7,865	3,869
Female	39,670	30,420	19,771	9,885	6,074
NHOPI* Only	29,413	20,581	11,706	5,096	2,796
Male	15,570	10,399	5,696	2,396	1,124
Female	13,843	10,182	6,010	2,700	1,672
Multiple Races	185,537	127,289	79,549	36,432	19,420
Male	90,799	61,326	37,163	16,160	7,540
Female	94,738	65,963	42,386	20,272	11,880

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

SOURCE: These are U.S. Bureau of the Census postnasal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2015. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2015 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, 2015 – con.

NON-HISPANIC

Race and sex	All ages	Under 1	1-4	5-14	15-24	25-34
All races	260,349,609	2,952,547	11,806,992	30,918,477	33,522,260	34,132,152
Male	126,509,093	1,511,047	6,041,888	15,786,902	16,875,905	16,701,477
Female	133,840,516	1,441,500	5,765,104	15,131,575	16,646,355	17,430,675
White Only	195,032,412	1,982,169	7,912,345	21,176,226	23,439,812	24,407,779
Male	95,713,716	1,015,700	4,058,871	10,856,130	11,884,807	12,152,836
Female	99,318,696	966,469	3,853,474	10,320,096	11,555,005	12,254,943
Black Only	38,601,842	549,155	2,194,074	5,618,829	6,103,695	5,512,596
Male	17,986,772	279,653	1,112,998	2,844,399	2,994,828	2,541,443
Female	20,615,070	269,502	1,081,076	2,774,430	3,108,867	2,971,153
AIAN* Only	2,312,884	33,708	134,137	350,563	366,329	327,073
Male	1,122,502	17,236	68,549	177,486	182,970	158,367
Female	1,190,382	16,472	65,588	173,077	183,359	168,706
Asian Only	17,332,319	184,855	781,535	2,016,379	2,265,904	2,963,002
Male	8,218,974	94,825	399,938	1,017,779	1,141,311	1,413,734
Female	9,113,345	90,030	381,597	998,600	1,124,593	1,549,268
NHOPI* Only	541,255	8,046	32,310	81,402	82,210	93,988
Male	267,926	4,151	16,793	41,337	40,797	46,533
Female	273,329	3,895	15,517	40,065	41,413	47,455
Multiple Races	6,528,897	194,614	752,591	1,675,078	1,264,310	827,714
Male	3,199,203	99,482	384,739	849,771	631,192	388,564
Female	3,329,694	95,132	367,852	825,307	633,118	439,150

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, 2015 - con.

NON-HISPANIC

Race and sex	35-44	45-54	55-64	65-74	75+
All races	31,724,167	36,190,934	36,354,845	25,066,296	17,680,939
Male	15,422,928	17,609,495	17,471,504	11,756,334	7,331,613
Female	16,301,239	18,581,439	18,883,341	13,309,962	10,349,326
White Only	23,061,220	27,827,885	29,166,485	20,924,014	15,134,477
Male	11,465,013	13,761,867	14,211,601	9,949,188	6,357,703
Female	11,596,207	14,066,018	14,954,884	10,974,826	8,776,774
Black Only	4,894,074	5,117,834	4,544,368	2,529,664	1,537,553
Male	2,198,574	2,329,521	2,049,713	1,080,709	554,934
Female	2,695,500	2,788,313	2,494,655	1,448,955	982,619
AIAN* Only	281,083	303,044	274,813	157,286	84,848
Male	135,489	144,702	128,666	73,745	35,292
Female	145,594	158,342	146,147	83,541	49,556
Asian Only	2,812,754	2,385,981	1,926,177	1,211,294	784,438
Male	1,306,709	1,109,780	870,457	538,893	325,548
Female	1,506,045	1,276,201	1,055,720	672,401	458,890
NHOPI* Only	76,258	68,294	53,830	29,585	15,332
Male	37,604	33,505	26,196	14,398	6,612
Female	38,654	34,789	27,634	15,187	8,720
Multiple Races	598,778	487,896	389,172	214,453	124,291
Male	279,539	230,120	184,871	99,401	51,524
Female	319,239	257,776	204,301	115,052	72,767

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

SOURCE: These are U.S. Bureau of the Census postnasal estimates of the civilian noninstitutionalized population of the United States as of July 1, 2015. They were developed by the Population Division, U.S. Census Bureau using the July 1, 2015 set of state population estimates, and reflect Census 2010 data. More information may be obtained from the Census website at www.census.gov.

REFERENCES

1. National Center for Health Statistics. National Health Interview Survey, Tables of Summary Health Statistics, https://www.cdc.gov/nchs/nhis/SHS/tables.htm, accessed 11/2/17. See Tables C-7 and A-16.

2. Tunney JB, White KL, Williamson JW. National Ambulatory Medical Care Survey: Background and Methodology. National Center for Health Statistics. Vital Health Stat 2(61). 1974.

3. Schappert SM, Rechtsteiner E. Ambulatory Medical Care Utilization Estimates for 2007. National Center for Health Statistics. Vital Health Stat 13(169). 2011.

4. McCain LF, McLemore T. Plan and Operation of the National Hospital Ambulatory Medical Care Survey. National Center for Health Statistics. Vital and Health Statistics 1(34). 1994.

5. Massey JT, Moore TF, Parsons VL, Taros W. Design and estimation for the National Health Interview Survey, 1985-94. National Center for Health Statistics. Vital and Health Statistics 2(110).1989.

6. Methodological Report on the Hospital Ambulatory Medical Care Evaluation Study. Contract No. 282-82-2111. Chicago, Illinois. National Opinion Research Center. 1984.

7. Final Report - Survey of Hospital Emergency and Outpatient Departments. Contract No. 200-88-7017. Rockville, Maryland. Westar. 1990.

8. Schneider D, Appleton L, McLemore T. A Reason for Visit Classification for Ambulatory Care. National Center for Health Statistics. Vital and Health Statistics 2(78). 1979.

9. National Ambulatory Medical Care Survey and National Hospital Ambulatory Medical Care Survey Reason for Visit Classification and Coding Manual (updated annually). Ambulatory and Hospital Care Statistics Branch, Division of Health Care Statistics, National Center for Health Statistics.

10. U.S. Department of Health and Human Services. Centers for Disease Control and Prevention, Centers for Medicare and Medicaid Services. Official version: International Classification of Diseases, Ninth Revision, Clinical Modification, Sixth Edition. DHHS Pub No. (PHS) 11-1260.

11. National Hospital Ambulatory Medical Care Survey: Coding Requirements (updated annually). Ambulatory and Hospital Care Statistics Branch, Division of Health Care Statistics, National Center for Health Statistics.

12. Koch H, Campbell W. The Collection and Processing of Drug Information. National Ambulatory Medical Care Survey, 1980. National Center for Health Statistics. Vital and Health Statistics 2 (90). 1982.

13. Food and Drug Administration. National Drug Code Directory, 1995 Edition. Washington: Public Health Service. 1995.

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 = 21,061

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	4	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) 0-1305 (reported range)
5	4	12-15	[LOV] LENGTH OF VISIT (minutes) Calculated from date and time of ED arrival and discharge -9 = Blank 0-5732 (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 001-364 = 001-364 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 24.2 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 19.4 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
0899-1090 = 89.9 – 109.0 Fahrenheit (reported range) |

| 29 | 3 | 52-54 | [PULSE] HEART RATE
-9 = Blank
0-244 (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
0-268 (reported range) |

| 32 | 3 | 61-63 | [BPDIAS] DIASTOLIC BLOOD PRESSURE
-9 = Blank
0-163 (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 2015, rescaling was required for 7 percent of records overall, or 10 percent of records where triage was conducted.

ITEM NO.	FIELD LENGTH	FILE 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. Since 2012, 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] WAS PATIENT SEEN WITHIN 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 22 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/SURGICAL 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/ SURGICAL 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, overdose/poisoning
3 = Yes, adverse effect of medical/surgical treatment
4 = No, visit is not related to injury/trauma, overdose/poisoning, or adverse effect of medical/surgical 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, overdose/poisoning
3 = Yes, adverse effect of medical/surgical treatment
4 = No, visit is not related to injury/trauma, overdose/poisoning, or adverse effect of medical/surgical 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/ SURGICAL 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, overdose/poisoning
3 = Yes, adverse effect of medical/surgical treatment
4 = No, visit is not related to injury/trauma, overdose/poisoning, or adverse effect of medical/surgical 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/poisoning, or adverse effect of medical/surgical treatment occur within 72 hours prior to the date and time of this visit?

[Note that in 2015, the wording changed to include adverse effects.]

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

50   2   112-113   [INTENT15] IS THIS INJURY/TRAUMA OR OVERDOSE/POISONING INTENTIONAL OR UNINTENTIONAL?

NOTE: The INTENT item in 2014 used different response categories. The 2015 item has been renamed to emphasize these differences.

-9 = Blank
-8 = Unknown/intent unclear
1 = Intentional
2 = Unintentional
3 = Intent unclear (note that this category from the survey instrument was simply a renaming/replacement of the "Unknown" category used prior to 2012. Responses have been recoded to -8, our standard coding convention for cases where the item is unknown)
4 = 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

1   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)

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)

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

CAUSE OF INJURY/TRAUMA, OVERDOSE/POISONING OR ADVERSE EFFECT OF MEDICAL/SURGICAL TREATMENT (See page 22 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

| 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 22).

| 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]

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

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]

PROVIDER'S DIAGNOSIS (See page 23,
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.

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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
65	2	169-170	[PRDIAG1] IS DIAGNOSIS #1 PROBABLE, QUESTIONABLE, OR RULE OUT? -7 = Not applicable 0 = No 1 = Yes
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

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

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.

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	[ETOHAB] Alcohol abuse
76	1	210	[ALZHD] Alzheimer's disease/dementia
77	1	211	[ASTHMA] Asthma
78	1	212	[CANCER] Cancer
79	1	213	[CEBVD] Cerebrovascular disease/history of 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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
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), or venous thromboembolism (VTE)
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)
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	[BMP] Basic metabolic panel
103	1	238	[BLOODCX] Blood culture
104	1	239	[BNP] BNP (Brain natriuretic peptide)
105	1	240	[BUNCREAT] BUN (Blood urea nitrogen)/Creatinine
106	1	241	[CARDENZ] Cardiac enzymes
107	1	242	[CBC] CBC (Complete blood count)
108	1	243	[CMP] Comprehensive metabolic panel
109	1	244	[DDIMER] D-dimer
110	1	245	[ELECTROL] Electrolytes
111	1	246	[GLUCOSE] Glucose
112	1	247	[LACTATE] Lactate
113	1	248	[LFT] Liver function tests
114	1	249	[PTTINR] Prothrombin time/INR
115	1	250	[OTHERBLD] Other blood test

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

Other tests:

116	1	251	[CARDMON] Cardiac monitor
117	1	252	[EKG] EKG/ECG
118	1	253	[HIVTEST] HIV test
119	1	254	[FLUTEST] Influenza test
120	1	255	[PREGTEST] Pregnancy/HCG test
121	1	256	[TRTCX] Throat culture
122	1	257	[TOXSCREN] Toxicology screen
123	1	258	[URINE] Urinalysis (UA)
124	1	259	[URINECX] Urine culture
125	1	260	[WOUNDCX] Wound culture
126	1	261	[OTHCX] Other culture
127	1	262	[OTHRTEST] Other test/service

Imaging:

128	1	263	[ANYIMAGE] Any imaging
129	1	264	[XRAY] X-ray
130	1	265	[CATSCAN] CT scan (any)

131   2   266-267   [CTCONTRAST] Was CT Scan ordered/provided with intravenous (IV) contrast?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

132	1	268	[CTAB] CT scan – abdomen/pelvis
133	1	269	[CTCHEST] CT scan – chest
134	1	270	[CTHEAD] CT scan - head
135	1	271	[CTOTHER] CT scan – other
136	1	272	[CTUNK] CT scan – site not specified
137	1	273	[MRI] MRI

138   2   274-275   [MRICONTRAST] Was MRI ordered/provided with intravenous (IV) contrast?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

139	1	276	[ULTRASND] Ultrasound
140	1	277	[OTHIMAGE] Other imaging

141   2   278-279   [TOTDIAG] TOTAL NUMBER OF DIAGNOSTIC SERVICES ORDERED OR PROVIDED
-9 = "None" box and all item fields are blank
0-21 (reported range)

142   1   280   [PROC] Were procedures provided at this visit?
0 = No
1 = Yes
2 = Entire item blank, including "None" box

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

PROCEDURES

0 = No, 1 = Yes

143	1	281	[BPAP] BPAP/CPAP
144	1	282	[BLADCATH] Bladder catheter
145	1	283	[CASTSPLINT] Cast, splint, wrap
146	1	284	[CENTLINE] Central line
147	1	285	[CPR] CPR
148	1	286	[ENDOINT] Endotracheal intubation
149	1	287	[INCDRAIN] Incision & drainage (I&D)
150	1	288	[IVFLUIDS] IV fluids
151	1	289	[LUMBAR] Lumbar puncture
152	1	290	[NEBUTHER] Nebulizer therapy
153	1	291	[PELVIC] Pelvic exam
154	1	292	[SKINADH] Skin adhesives
155	1	293	[SUTURE] Suturing/staples
156	1	294	[OTHPROC] Other procedure

157   2   295-296   [TOTPROC] TOTAL NUMBER OF PROCEDURES PROVIDED
-9 = "None" box and all item fields are blank
0-6 (reported range)

MEDICATIONS & IMMUNIZATIONS
(See page 24 for more information. See Appendix III for codes.)

158   1   297   [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

159   5   298-302   [MED1] MEDICATION #1
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

160   5   303-307   [MED2] MEDICATION #2
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

161   5   308-312   [MED3] MEDICATION #3
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

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

162   5   313-317   **[MED4] MEDICATION #4**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

163   5   318-322   **[MED5] MEDICATION #5**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

164   5   323-327   **[MED6] MEDICATION #6**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

165   5   328-332   **[MED7] MEDICATION #7**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

166   5   333-337   **[MED8] MEDICATION #8**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

167   5   338-342   **[MED9] MEDICATION #9**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

168   5   343-347   **[MED10] MEDICATION #10**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

169   5   348-352   **[MED11] MEDICATION #11**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

170   5   353-357   **[MED12] MEDICATION #12**
-9   = Blank
00001-99227 = 00001-99227
99980   = Unknown Entry; Other
99999   = Illegible Entry

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

171   5   358-362   **[MED13] MEDICATION #13**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

172   5   363-367   **[MED14] MEDICATION #14**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

173   5   368-372   **[MED15] MEDICATION #15**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

174   5   373-377   **[MED16] MEDICATION #16**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

175   5   378-382   **[MED17] MEDICATION #17**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

176   5   383-387   **[MED18] MEDICATION #18**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

177   5   388-392   **[MED19] MEDICATION #19**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

178   5   393-397   **[MED20] MEDICATION #20**

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

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

179   5   398-402   [MED21] MEDICATION #21

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

180   5   403-407   [MED22] MEDICATION #22

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

181   5   408-412   [MED23] MEDICATION #23

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

182   5   413-417   [MED24] MEDICATION #24

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

183   5   418-422   [MED25] MEDICATION #25

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

184   5   423-427   [MED26] MEDICATION #26

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

185   5   428-432   [MED27] MEDICATION #27

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

186   5   433-437   [MED28] MEDICATION #28

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

187   5   438-442   [MED29] MEDICATION #29

-9 = Blank
00001-99227 = 00001-99227
99980 = Unknown Entry; Other
99999 = Illegible Entry

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
188	5	443-447	[MED30] MEDICATION #30 -9 = Blank 00001-99227 = 00001-99227 99980 = Unknown Entry; Other 99999 = Illegible Entry
189	2	448-449	[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
190	2	450-451	[GPMED2] Was medication #2 given in ED or Rx at discharge? See GPMED1.
191	2	452-453	[GPMED3] Was medication #3 given in ED or Rx at discharge? See GPMED1.
192	2	454-455	[GPMED4] Was medication #4 given in ED or Rx at discharge? See GPMED1.
193	2	456-457	[GPMED5] Was medication #5 given in ED or Rx at discharge? See GPMED1.
194	2	458-459	[GPMED6] Was medication #6 given in ED or Rx at discharge? See GPMED1.
195	2	460-461	[GPMED7] Was medication #7 given in ED or Rx at discharge? See GPMED1.
196	2	462-463	[GPMED8] Was medication #8 given in ED or Rx at discharge? See GPMED1.
197	2	464-465	[GPMED9] Was medication #9 given in ED or Rx at discharge? See GPMED1.
198	2	466-467	[GPMED10] Was medication #10 given in ED or Rx at discharge? See GPMED1.
199	2	468-469	[GPMED11] Was medication #11 given in ED or Rx at discharge? See GPMED1.
200	2	470-471	[GPMED12] Was medication #12 given in ED or Rx at discharge? See GPMED1.
201	2	472-473	[GPMED13] Was medication #13 given in ED or Rx at discharge? See GPMED1.
202	2	474-475	[GPMED14] Was medication #14 given in ED or Rx at discharge? See GPMED1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
203	2	476-477	[GPMED15] Was medication #15 given in ED or Rx at discharge? See GPMED1.
204	2	478-479	[GPMED16] Was medication #16 given in ED or Rx at discharge? See GPMED1.
205	2	480-481	[GPMED17] Was medication #17 given in ED or Rx at discharge? See GPMED1.
206	2	482-483	[GPMED18] Was medication #18 given in ED or Rx at discharge? See GPMED1.
207	2	484-485	[GPMED19] Was medication #19 given in ED or Rx at discharge? See GPMED1.
208	2	486-487	[GPMED20] Was medication #20 given in ED or Rx at discharge? See GPMED1.
209	2	488-489	[GPMED21] Was medication #21 given in ED or Rx at discharge? See GPMED1.
210	2	490-491	[GPMED22] Was medication #22 given in ED or Rx at discharge? See GPMED1.
211	2	492-493	[GPMED23] Was medication #23 given in ED or Rx at discharge? See GPMED1.
212	2	494-495	[GPMED24] Was medication #24 given in ED or Rx at discharge? See GPMED1.
213	2	496-497	[GPMED25] Was medication #25 given in ED or Rx at discharge? See GPMED1.
214	2	498-499	[GPMED26] Was medication #26 given in ED or Rx at discharge? See GPMED1.
215	2	500-501	[GPMED27] Was medication #27 given in ED or Rx at discharge? See GPMED1.
216	2	502-503	[GPMED28] Was medication #28 given in ED or Rx at discharge? See GPMED1.
217	2	504-505	[GPMED29] Was medication #29 given in ED or Rx at discharge? See GPMED1.
218	2	506-507	[GPMED30] Was medication #30 given in ED or Rx at discharge? See GPMED1.
219	2	508-509	[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

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

Rx at discharge; and c) drug listed but unknown whether given in ED or Rx at discharge.

220	2	510-511	[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.
221	2	512-513	[NUMMED] NUMBER OF MEDICATIONS CODED 0 – 30
222	2	514-515	[VITALSD] Were vitals taken at discharge? -9= Blank 1 = Yes 2 = No
223	4	516-519	[TEMPDF] Vitals at discharge: Temperature in Farenheit -9= Blank 810-1035 = 81.0 - 103.5 Fahrenheit (reported range)
224	3	520-522	[PULSED] Vitals at discharge: Heart rate (beats per minute) -9 = Blank 0-190 (reported range) 998 = DOP, DOPPLER
225	3	523-525	[RESPRD] Vitals at discharge: Respiratory rate (breaths per minute) -9 = Blank 0-131 (reported range)
226	3	526-528	[BPSYSD] Vitals at discharge: Systolic blood pressure -9 = Blank 62-259 (reported range) 998 = DOP, DOPPLER
227	3	529-531	[BPDIASD] Vitals at discharge: Diastolic blood pressure -9 = Blank 21-154 (reported range) 998 = P, PALP, DOP, or DOPPLER

PROVIDERS SEEN

0 = No, 1 = Yes

228	1	532	[NOPROVID] No answer to item
229	1	533	[ATTPHYS] ED attending physician
230	1	534	[RESINT] ED resident/intern
231	1	535	[CONSULT] Consulting physician
232	1	536	[RNLPN] RN/LPN
233	1	537	[NURSEPR] Nurse practitioner

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
234	1	538	[PHYSASST] Physician assistant
235	1	539	[EMT] EMT
236	1	540	[MHPROV] Other mental health provider
237	1	541	[OTHPROV] Other provider

VISIT DISPOSITION

0 = No, 1 = Yes

238	1	542	[NODISP] No answer to item
239	1	543	[NOFU] No follow-up planned
240	1	544	[RETRNED] Return to ED
241	1	545	[RETREFFU] Return/Refer to physician/clinic for FU
242	1	546	[LEFTBTRI] Left before triage
243	1	547	[LEFTATRI] Left after triage
244	1	548	[LEFTAMA] Left AMA
245	1	549	[DOA] DOA
246	1	550	[DIEDED] Died in ED
247	1	551	[TRANNH] Return/transfer to nursing home
248	1	552	[TRANPSYC] Transfer to psychiatric hospital
249	1	553	[TRANOTH] Transfer to other hospital
250	1	554	[ADMITHOS] Admit to this hospital
251	1	555	[OBSHOS] Admit to observation unit, then hospitalized
252	1	556	[OBSDIS] Admit to observation unit, then discharged
253	1	557	[OTHDISP] Other visit disposition

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

254	2	558-559	[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

255	2	560-561	[ADMTPHYS] Admitting physician

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

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

256   4   562-565   [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
0000-2755 (reported range)

257   4   566-569   [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
1-39 (reported range)

258   5   570-574   [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"

259   5   575-579   [HDDIAG2] HOSPITAL DISCHARGE DIAGNOSIS #2 (ICD-9-CM)
See HDDIAG1.

260

      5   580-584   [HDDIAG3] HOSPITAL DISCHARGE DIAGNOSIS #3 (ICD-9-CM)
See HDDIAG1.

261   5   585-589   [HDDIAG4] HOSPITAL DISCHARGE DIAGNOSIS #4 (ICD-9-CM)
See HDDIAG1.

262   5   590-594   [HDDIAG5] HOSPITAL DISCHARGE DIAGNOSIS #5 (ICD-9-CM)
See HDDIAG1.

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

NUMERIC RECODES FOR HOSPITAL DISCHARGE DIAGNOSIS

263   6   595-600   [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

264   6   601-606   [HDDIAG2R] HOSPITAL DISCHARGE DIAGNOSIS #2
(Recode to Numeric Field)
See HDDIAG1R.

265   6   607-612   [HDDIAG3R] HOSPITAL DISCHARGE DIAGNOSIS #3
See HDDIAG1R.

266   6   613-618   [HDDIAG4R] HOSPITAL DISCHARGE DIAGNOSIS #3
See HDDIAG1R.

267   6   619-624   [HDDIAG5R] HOSPITAL DISCHARGE DIAGNOSIS #3
See HDDIAG1R.

268   2   625-626   [HDSTAT] Hospital discharge status
-9 = Blank
-8 = Data not available (Unknown)
-7 = Not applicable (not admitted to hospital)
1 = Alive
2 = Dead

269   2   627-628   [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

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

270   4   629-632   [OBSSTAY] Length of stay in observation unit (minutes) (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 - 7772 minutes (reported range)

271   1   633   [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 ****

272   2   634-635   [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

IMPUTED FIELDS
0 = Not imputed
1 = Imputed

273   1   636   [BDATEFL] Was patient birth date imputed?
274   1   637   [SEXFL] Was patient sex imputed?
275   1   638   [ETHNICFL] Was patient ethnicity imputed?
276   1   639   [RACERFL] Was patient race imputed?

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

277   3   640-642   [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.
1-248

278   3   643-645   [PATCODE] PATIENT CODE - A number assigned to identify each individual record from a particular hospital.
1-163

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
279	2	646-647	[EBILLANYE] DOES YOUR ED SUBMIT CLAIMS ELECTRONICALLY (ELECTRONIC BILLING)? -9 = Blank -8 = Unknown -6 = Refused to answer 1 = Yes 2 = No
280	2	648-649	[EMRED] DOES YOUR ED USE AN ELECTRONIC HEALTH RECORD (EHR) SYSTEM? (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.)
281	2	650-651	[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 (EMRED=3 or -8) -6 = Refused to answer 1 = Yes 2 = No
282	2	652-653	[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 (EMRED=3 or -8) -6 = Refused to answer 1 = Yes 2 = No
283	2	654-655	[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 (EMRED=3 or -8) -6 = Refused to answer 1 = Yes 2 = No

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

284   2   656-657   [EHRINSE] DOES YOUR ED HAVE PLANS FOR INSTALLING A NEW EHR/EMR 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 285-336)

285   2   658-659   [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

286   2   660-661   [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

287   2   662-663   [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

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

288   2   664-665   [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

289   2   666-667   [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

290   2   668-669   [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

291   2   670-671   [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

292   2   672-673   [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

293   2   674-675   [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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
294	2	676-677	[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
295	2	678-679	[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
296	2	680-681	[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
297	2	682-683	[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
298	2	684-685	[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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
299	2	686-687	[EREMINDE] REMINDERS FOR GUIDELINE-BASED INTERVENTIONS 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
300	2	688-689	[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
301	2	690-691	[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
302	2	692-693	[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
303	2	694-695	[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

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

304   2   696-697   **[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

305   2   698-699   **[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

306   2   700-701   **[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

307   2   702-703   **[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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
308	2	704-705	[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
309	2	706-707	[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
310	2	708-709	[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
311	2	710-711	[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
312	2	712-713	[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

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

313   2   714-715   [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

314   2   716-717   [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

315   2   718-719   [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

316   2   720-721   [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

317   2   722-723   [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

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

318   2   724-725   **[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

319   2   726-727   **[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

320   2   728-729   **[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

321   2   730-731   **[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

322   2   732-733   **[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

323   2   734-735   **[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

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

324   2   736-737   **[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

325   2   738-739   **[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

326   2   740-741   **[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

327   2   742-743   **[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

328   2   744-745   **[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

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
329	2	746-747	[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
330	2	748-749	[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
331	2	750-751	[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
332	2	752-753	[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
333	2	754-755	[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

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

334   2   756-757   **[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

335   2   758-759   **[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

336   2   760-761   **[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

337   2   762-763   **[ESHAREE] DOES YOUR HOSPITAL 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

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

HOW DO YOU ELECTRONICALLY SHARE PATIENT HEALTH INFORMATION?

338	2	764-765	[ESHAREEHRE] EHR/EMR
339	2	766-767	[ESHAREWEBE] Web potal (separate from EHR/EMR)
340	2	768-769	[ESHAREOTHE] Other electronic methods
341	2	770-771	[ESHAREUNKE] Unknown
342	2	772-773	[ESHAREREFE] Refused to answer

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

343	2	774-775	[EHRTOEHRE] IF HOSPITAL 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

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

344	2	776-777	[ESHAREPROVE1] Ambulatory providers inside your hospital
345	2	778-779	[ESHAREPROVE2] Ambulatory providers outside your hospital
346	2	780-781	[ESHAREPROVE3] Hospitals with which you are affiliated
347	2	782-783	[ESHAREPROVE4] Hospitals with which you are not affiliated
348	2	784-785	[ESHAREPROVE5] Behavioral health providers
349	2	786-787	[ESHAREPROVE6] Long-term care providers
350	2	788-789	[ESHAREPROVE7] Home health providers
351	2	790-791	[ESHAREPROVEREF] Refused to answer
352	2	792-793	[ESHAREPROVEUNK] Unknown

-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

353 2 796-797 [EOUTINFOE] ARE YOU ABLE TO ELECTRONICALLY FIND HEALTH INFORMATION (e.g. MEDICATIONS, OUTSIDE ENCOUNTERS) FROM SOURCES OUTSIDE OF THE HOSPITAL FOR YOUR PATIENTS?

    -9 = Blank
    -8 = Unknown
    -6 = Refused to answer
    1 = Yes, routinely
    2 = Yes, but not routinely
    3 = No

    HOW DO YOU LOOK UP PATIENT HEALTH INFORMATION FROM SOURCES OUTSIDE YOUR HOSPITAL?

354	2	796-797	[EOUTHOWE1] Through your EHR/EMR
355	2	798-799	[EOUTHOWE2] Web portal (separate from EHR/EMR)
356	2	800-801	[EOUTHOWE3] View only or restricted access to other providers' EHR systems
357	2	802-803	[EOUTHOWE4] Other electronic method (not fax)
358	2	804-805	[EOUTHOWUNK] Unknown
359	2	806-807	[EOUTHOWREF] Refused to answer

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

    WHAT TYPES OF INFORMATION DO YOU ROUTINELY LOOK UP?

360	2	808-809	[EOUTYPE1] Lab results
361	2	810-811	[EOUTYPE2] Imaging reports
362	2	812-813	[EOUTYPE3] Patent problem lists
363	2	814-815	[EOUTYPE4] Medication lists
364	2	816-817	[EOUTYPE5] Other
365	2	818-819	[EOUTYPUNK] Unknown
366	2	820-821	[EOUTYPREF] 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

367 2 822-823 **[EOUTINCORPE] DO YOU ROUTINELY INCORPORATE THE INFORMATION YOU LOOK UP INTO YOUR EHR?**
-9 = Blank
-8 = Unknown
-6 = Refused to answer
1 = Yes, via manual entry or scanned copy
2 = Yes, automatically able to incorporate without manual entry or scanning
3 = No, we do not routinely incorporate into our EHR

368 2 824-825 **[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

369 2 826-827 **[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

370 2 828-829 **[MUSTAGE1] MEDICARE AND MEDICAID OFFER INCENTIVES TO HOSPITALS THAT DEMONSTRATE "MEANINGFUL USE OF HEALTH IT". DOES YOUR HOSPITAL HAVE PLANS TO APPLY FOR THESE INCENTIVE PAYMENTS?**

[NOTE: The 2014 instrument wording for this item specified Stage 1 Incentive Payments but was altered in 2015 to the current wording.]

-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

371   2   830-831   **[MUSTAGE2] ARE THERE PLANS TO APPLY FOR STAGE 2 INCENTIVE PAYMENTS?**
-9 = Blank
-8 = Unknown
-7 = Not applicable
1 = Yes
2 = No
3 = Maybe

372   2   832-833   **[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. Starting in 2013, OBSCLIN and OBSSEP replaced the OBSUNITS item from 2012.
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

373   2   834-835   **[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?

374   2   836-837   [OBSPHYSED] ED physicians
375   2   838-839   [OBSHOSP] Hospitalists
376   2   840-841   [OBSPHYSOT] Other physicians
377   2   842-843   [OBSPHYSUN] Unknown

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

378   2   844-845   **[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

379   2   846-847   **[BOARDHOS]** DOES YOUR ED ALLOW SOME ADMITTED PATIENTS TO MOVE FROM THE ED TO INPATIENT CORRIDORS WHILE AWAITING A BED ("BOARDING") – SOMETIMES CALLED "FULL CAPACITY PROTOCOL"?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

380   2   848-849   **[AMBDIV]** DID YOUR ED GO ON AMBULANCE DIVERSION IN 2014?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

381   2   850-851   **[TOTHRDIVR]** WHAT IS THE TOTAL NUMBER OF HOURS YOUR HOSPITAL'S ED WAS ON AMBULANCE DIVERSION IN 2014? (Recoded)
-9='Blank'
-7='Not applicable'
2 = 1-99
3 = 100-499
4 = 500 or more
5 = Diversion data not available

382   2   852-853   **[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

383   2   854-855   **[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

384   2   856-857   **[INCSHX]** IN THE LAST TWO YEARS, DID YOUR ED INCREASE 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

385   2   858-859   [INCPHYS] IN THE LAST TWO YEARS, DID YOUR ED'S PHYSICAL SPACE EXPAND?
-9 = Blank
-8 = Unknown
1 = Yes
2 = No

386   2   860-861   [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

387	2	862-863	[BEDREG] Bedside registration
388	2	864-865	[KIOSELCHK] Kiosk self check-in
389	2	866-867	[CATRIAGE] Computer-assisted triage
390	2	868-869	[IMBED] Immediate bedding
391	2	870-871	[ADVTRIAG] Advanced triage (triage-based care) protocols
392	2	872-873	[PHYSPRACTRIA] Physician/practitioner at triage
393	2	874-875	[FASTTRAK] Separate fast track unit for nonurgent care
394	2	876-877	[EDPTOR] Separate operating room dedicated to ED patients
375	2	878-879	[DASHBORD] Electronic dashboard (i.e., displays updated patient information and integrates multiple data sources
396	2	880-881	[RFID] Radio frequency identification (RFID) tracking (i.e., shows exact location of patients, caregivers, and equipment)
397	2	882-883	[WIRELESS] Wireless devices by providers
398	2	884-885	[ZONENURS] Zone nursing (i.e., all of a nurse's patients are located in one area)
399	2	886-887	[POOLNURS] "Pool" nurses (i.e., nurses that can be pulled to the ED to respond to surges in demand)

400   2   888-889   [SURGDAY] HOW MANY DAYS IN A WEEK ARE INPATIENT ELECTIVE SURGERIES SCHEDULED?
-9 = Blank
-8 = Unknown
0-7

401   2   890-891   [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
402	2	892-893	[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
403	2	894-895	[HLIST] DOES YOUR HOSPITAL HAVE HOSPITALISTS ON STAFF? -9 = Blank -8 = Unknown 1 = Yes 2 = No
404	2	896-897	[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
405	2	898-899	[EMEDRES] DOES YOUR HOSPITAL HAVE AN EMERGENCY MEDICINE RESIDENCY PROGRAM? -9 = Blank -8 = Unknown 1 = Yes 2 = No
406	1	900	[REGION] GEOGRAPHIC REGION (Based on actual location of the hospital.) 1 = Northeast 2 = Midwest 3 = South 4 = West
407	1	901	[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   FIELD   FILE
 NO.   LENGTH   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 24.)

408   6   902-907   [DRUGID1] DRUG ID (See p. 156 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)

409   1   908   [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

410   1   909   [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

411   1   910   [COMSTAT1] COMPOSITION STATUS CODE
                                1 = Single Entity Drug
                                2 = Combination Drug
                                3 = Undetermined

412   3   911-913   [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 24. The complete Multum classification is shown in Appendix III.

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

413   3   914-916   [RX1CAT2] MULTUM DRUG CATEGORY # 2
                                See RX1CAT1.

ITEM NO.	FIELD LENGTH	FILE LOCATION	[ITEM NAME], DESCRIPTION, AND CODES
414	3	917-919	[RX1CAT3] MULTUM DRUG CATEGORY # 3 See RX1CAT1.
415	3	920-922	[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
416	3	923-925	[RX1V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
417	3	926-928	[RX1V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
418	3	929-931	[RX1V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
419	3	932-934	[RX1V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
420	3	935-937	[RX1V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
421	3	938-940	[RX1V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
422	3	941-943	[RX1V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
423	3	944-946	[RX1V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
424	3	947-949	[RX1V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
425	3	950-952	[RX1V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
426	3	953-955	[RX1V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
427	3	956-958	[RX1V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #2

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

428	6	959-964	[DRUGID2] Drug ID
429	1	965	[PRESCR2] PRESCRIPTION STATUS CODE
430	1	966	[CONTSUB2] CONTROLLED SUBSTANCE STATUS CODE
431	1	967	[COMSTAT2] COMPOSITION STATUS CODE
432	3	968-970	[RX2CAT1] MULTUM DRUG CATEGORY # 1
433	3	971-973	[RX2CAT2] MULTUM DRUG CATEGORY # 2 See RX2CAT1.
434	3	974-976	[RX2CAT3] MULTUM DRUG CATEGORY # 3 See RX2CAT1.
435	3	977-979	[RX2CAT4] MULTUM DRUG CATEGORY # 4 See RX2CAT1.

DRUG CATEGORY LEVELS

436	3	980-982	[RX2V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
437	3	983-985	[RX2V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
438	3	986-988	[RX2V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
439	3	989-991	[RX2V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
440	3	992-994	[RX2V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
441	3	995-997	[RX2V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
442	3	998-1000	[RX2V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
443	3	1001-1003	[RX2V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
444	3	1004-1006	[RX2V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
445	3	1007-1009	[RX2V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
446	3	1010-1012	[RX2V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
447	3	1013-1015	[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 83) for coding information.

448	6	1016-1021	[DRUGID3] Drug ID
449	1	1022	[PRESCR3] PRESCRIPTION STATUS CODE
450	1	1023	[CONTSUB3] CONTROLLED SUBSTANCE STATUS CODE
451	1	1024	[COMSTAT3] COMPOSITION STATUS CODE
452	3	1025-1027	[RX3CAT1] MULTUM DRUG CATEGORY # 1
453	3	1028-1030	[RX3CAT2] MULTUM DRUG CATEGORY # 2 See RX3CAT1.
454	3	1031-1033	[RX3CAT3] MULTUM DRUG CATEGORY # 3 See RX3CAT1.
455	3	1034-1036	[RX3CAT4] MULTUM DRUG CATEGORY # 4 See RX3CAT1.

DRUG CATEGORY LEVELS

456	3	1037-1039	[RX3V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
457	3	1040-1042	[RX3V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
458	3	1043-1045	[RX3V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
459	3	1046-1048	[RX3V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
460	3	1049-1051	[RX3V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
461	3	1052-1054	[RX3V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
462	3	1055-1057	[RX3V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
463	3	1058-1060	[RX3V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
464	3	1061-1063	[RX3V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
465	3	1064-1066	[RX3V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
466	3	1067-1069	[RX3V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
467	3	1070-1072	[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 83) for coding information.

| 468 | 6 | 1073-1078 | [DRUGID4] Drug ID |

| 469 | 1 | 1079 | [PRESCR4] PRESCRIPTION STATUS CODE |

| 470 | 1 | 1080 | [CONTSUB4] CONTROLLED SUBSTANCE STATUS CODE |

| 471 | 1 | 1081 | [COMSTAT4] COMPOSITION STATUS CODE |

| 472 | 3 | 1082-1084 | [RX4CAT1] MULTUM DRUG CATEGORY # 1 |

473   3   1085-1087   [RX4CAT2] MULTUM DRUG CATEGORY # 2
                           See RX4CAT1.

474   3   1088-1090   [RX4CAT3] MULTUM DRUG CATEGORY # 3
                           See RX4CAT1.

475   3   1091-1093   [RX4CAT4] MULTUM DRUG CATEGORY # 4
                           See RX4CAT1.

DRUG CATEGORY LEVELS

476	3	1094-1096	[RX4V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
477	3	1097-1099	[RX4V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
478	3	1100-1102	[RX4V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
479	3	1103-1105	[RX4V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

480	3	1106-1108	[RX4V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
481	3	1109-1111	[RX4V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
482	3	1112-1114	[RX4V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
483	3	1115-1117	[RX4V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

484	3	1118-1120	[RX4V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
485	3	1121-1123	[RX4V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
486	3	1124-1126	[RX4V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
487	3	1127-1129	[RX4V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #5

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

488	6	1130-1135	[DRUGID5] Drug ID
489	1	1136	[PRESCR5] PRESCRIPTION STATUS CODE
490	1	1137	[CONTSUB5] CONTROLLED SUBSTANCE STATUS CODE
491	1	1138	[COMSTAT5] COMPOSITION STATUS CODE
492	3	1139-1141	[RX5CAT1] MULTUM DRUG CATEGORY # 1
493	3	1142-1144	[RX5CAT2] MULTUM DRUG CATEGORY # 2 See RX3CAT1.
494	3	1145-1147	[RX5CAT3] MULTUM DRUG CATEGORY # 3 See RX3CAT1.
495	3	1148-1150	[RX5CAT4] MULTUM DRUG CATEGORY # 4 See RX3CAT1.

DRUG CATEGORY LEVELS

496	3	1151-1153	[RX5V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
497	3	1154-1156	[RX5V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
498	3	1157-1159	[RX5V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
499	3	1160-1162	[RX5V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
500	3	1163-1165	[RX5V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
501	3	1166-1168	[RX5V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
502	3	1169-1171	[RX5V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
503	3	1172-1174	[RX5V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
504	3	1175-1177	[RX5V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
505	3	1178-1180	[RX5V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
506	3	1181-1183	[RX5V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
507	3	1184-1186	[RX5V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #6

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

508	6	1187-1192	[DRUGID6] Drug ID
509	1	1193	[PRESCR6] PRESCRIPTION STATUS CODE
510	1	1194	[CONTSUB6] CONTROLLED SUBSTANCE STATUS CODE
511	1	1195	[COMSTAT6] COMPOSITION STATUS CODE
512	3	1196-1198	[RX6CAT1] MULTUM DRUG CATEGORY # 1
513	3	1199-1201	[RX6CAT2] MULTUM DRUG CATEGORY # 2 See RX6CAT1.
514	3	1202-1204	[RX6CAT3] MULTUM DRUG CATEGORY # 3 See RX6CAT1.
515	3	1205-1207	[RX6CAT4] MULTUM DRUG CATEGORY # 4 See RX6CAT1.

DRUG CATEGORY LEVELS

516	3	1208-1210	[RX6V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
517	3	1211-1213	[RX6V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
518	3	1214-1216	[RX6V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
519	3	1217-1219	[RX6V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
520	3	1220-1222	[RX6V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
521	3	1223-1225	[RX6V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
522	3	1226-1228	[RX6V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
523	3	1229-1231	[RX6V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
524	3	1232-1234	[RX6V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
525	3	1235-1237	[RX6V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
526	3	1238-1240	[RX6V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
527	3	1241-1243	[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 83) for coding information.

528	6	1244-1249	[DRUGID7] Drug ID
529	1	1250	[PRESCR7] PRESCRIPTION STATUS CODE
530	1	1251	[CONTSUB7] CONTROLLED SUBSTANCE STATUS CODE
531	1	1252	[COMSTAT7] COMPOSITION STATUS CODE
532	3	1253-1255	[RX7CAT1] MULTUM DRUG CATEGORY # 1
533	3	1256-1258	[RX7CAT2] MULTUM DRUG CATEGORY # 2 See RX7CAT1.
534	3	1259-1261	[RX7CAT3] MULTUM DRUG CATEGORY # 3 See RX7CAT1.
535	3	1262-1264	[RX7CAT4] MULTUM DRUG CATEGORY # 4 See RX7CAT1.

DRUG CATEGORY LEVELS

536	3	1265-1267	[RX7V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
537	3	1268-1270	[RX7V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
538	3	1271-1273	[RX7V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
539	3	1274-1276	[RX7V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
540	3	1277-1279	[RX7V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
541	3	1280-1282	[RX7V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
542	3	1283-1285	[RX7V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
543	3	1286-1288	[RX7V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
544	3	1289-1291	[RX7V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
545	3	1292-1294	[RX7V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
546	3	1295-1297	[RX7V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
547	3	1298-1300	[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 83) for coding information.

548	6	1301-1306	[DRUGID8] Drug ID
549	1	1307	[PRESCR8] PRESCRIPTION STATUS CODE
550	1	1308	[CONTSUB8] CONTROLLED SUBSTANCE STATUS CODE
551	1	1309	[COMSTAT8] COMPOSITION STATUS CODE
552	3	1310-1312	[RX8CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
553	3	1313-1315	[RX8CAT2] MULTUM DRUG CATEGORY # 2 See RX8CAT1.
554	3	1316-1318	[RX8CAT3] MULTUM DRUG CATEGORY # 3 See RX8CAT1.
555	3	1319-1321	[RX8CAT4] MULTUM DRUG CATEGORY # 4 See RX8CAT1.

DRUG CATEGORY LEVELS

556	3	1322-1324	[RX8V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
557	3	1325-1327	[RX8V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
558	3	1328-1330	[RX8V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
559	3	1331-1333	[RX8V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
560	3	1334-1336	[RX8V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
561	3	1337-1339	[RX8V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
562	3	1340-1342	[RX8V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
563	3	1343-1345	[RX8V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
564	3	1346-1348	[RX8V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
565	3	1349-1351	[RX8V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
566	3	1352-1354	[RX8V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
567	3	1355-1357	[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 83) for coding information.

568	6	1358-1363	[DRUGID9] Drug ID
569	1	1364	[PRESCR9] PRESCRIPTION STATUS CODE
570	1	1365	[CONTSUB9] CONTROLLED SUBSTANCE STATUS CODE
571	1	1366	[COMSTAT9] COMPOSITION STATUS CODE
572	3	1367-1369	[RX9CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
573	3	1370-1372	[RX9CAT2] MULTUM DRUG CATEGORY # 2 See RX9CAT1.
574	3	1373-1375	[RX9CAT3] MULTUM DRUG CATEGORY # 3 See RX9CAT1.
575	3	1376-1378	[RX9CAT4] MULTUM DRUG CATEGORY # 4 See RX9CAT1.

DRUG CATEGORY LEVELS

576	3	1379-1381	[RX9V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
577	3	1382-1384	[RX9V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
578	3	1385-1387	[RX9V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
579	3	1388-1390	[RX9V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
580	3	1391-1393	[RX9V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
581	3	1394-1396	[RX9V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
582	3	1397-1399	[RX9V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
583	3	1400-1402	[RX9V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
584	3	1403-1405	[RX9V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
585	3	1406-1408	[RX9V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
586	3	1409-1411	[RX9V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
587	3	1412-1414	[RX9V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #10

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

588	6	1415-1420	[DRUGID10] Drug ID
589	1	1421	[PRESCR10] PRESCRIPTION STATUS CODE
590	1	1422	[CONTSUB10] CONTROLLED SUBSTANCE STATUS CODE
591	1	1423	[COMSTAT10] COMPOSITION STATUS CODE
592	3	1424-1426	[RX10CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
593	3	1427-1429	[RX10CAT2] MULTUM DRUG CATEGORY # 2 See RX10CAT1.
594	3	1430-1432	[RX10CAT3] MULTUM DRUG CATEGORY # 3 See RX10CAT1.
595	3	1433-1435	[RX10CAT4] MULTUM DRUG CATEGORY # 4 See RX10CAT1.

DRUG CATEGORY LEVELS

596	3	1436-1438	[RX10V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
597	3	1439-1441	[RX10V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
598	3	1442-1444	[RX10V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
599	3	1445-1447	[RX10V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
600	3	1448-1450	[RX10V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
601	3	1451-1453	[RX10V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
602	3	1454-1456	[RX10V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
603	3	1457-1459	[RX10V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
604	3	1460-1462	[RX10V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
605	3	1463-1465	[RX10V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
606	3	1466-1468	[RX10V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
607	3	1469-1471	[RX10V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #11

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

608	6	1472-1477	[DRUGID11] Drug ID
609	1	1478	[PRESCR11] PRESCRIPTION STATUS CODE
610	1	1479	[CONTSUB11] CONTROLLED SUBSTANCE STATUS CODE
611	1	1480	[COMSTAT11] COMPOSITION STATUS CODE
612	3	1481-1483	[RX11CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
613	3	1484-1486	[RX11CAT2] MULTUM DRUG CATEGORY # 2 See RX11CAT1.
614	3	1487-1489	[RX11CAT3] MULTUM DRUG CATEGORY # 3 See RX11CAT1.
615	3	1490-1492	[RX11CAT4] MULTUM DRUG CATEGORY # 4 See RX11CAT1.

DRUG CATEGORY LEVELS

616	3	1493-1495	[RX11V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
617	3	1496-1498	[RX11V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
618	3	1499-1501	[RX11V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
619	3	1502-1504	[RX11V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
620	3	1505-1507	[RX11V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
621	3	1508-1510	[RX11V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
622	3	1511-1513	[RX11V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
623	3	1514-1516	[RX11V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
624	3	1517-1519	[RX11V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
625	3	1520-1522	[RX11V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
626	3	1523-1525	[RX11V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
627	3	1526-1528	[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 83) for coding information.

| 628 | 6 | 1529-1534 | [DRUGID12] Drug ID |

| 629 | 1 | 1535 | [PRESCR12] PRESCRIPTION STATUS CODE |

| 630 | 1 | 1536 | [CONTSUB12] CONTROLLED SUBSTANCE STATUS CODE |

| 631 | 1 | 1537 | [COMSTAT12] COMPOSITION STATUS CODE |

| 632 | 3 | 1538-1540 | [RX12CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

| 633 | 3 | 1541-1543 | [RX12CAT2] MULTUM DRUG CATEGORY # 2 See RX12CAT1. |

| 634 | 3 | 1544-1546 | [RX12CAT3] MULTUM DRUG CATEGORY # 3 See RX12CAT1. |

| 635 | 3 | 1547-1549 | [RX12CAT4] MULTUM DRUG CATEGORY # 4 See RX12CAT1. |

DRUG CATEGORY LEVELS

636	3	1550-1552	[RX12V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
637	3	1553-1555	[RX12V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
638	3	1556-1558	[RX12V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
639	3	1559-1561	[RX12V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

640	3	1562-1564	[RX12V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
641	3	1565-1567	[RX12V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
642	3	1568-1570	[RX12V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
643	3	1571-1573	[RX12V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

644	3	1574-1576	[RX12V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
645	3	1577-1579	[RX12V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
646	3	1580-1582	[RX12V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
647	3	1583-1585	[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 83) for coding information.

648	6	1586-1591	[DRUGID13] Drug ID
649	1	1592	[PRESCR13] PRESCRIPTION STATUS CODE
650	1	1593	[CONTSUB13] CONTROLLED SUBSTANCE STATUS CODE
651	1	1594	[COMSTAT13] COMPOSITION STATUS CODE
652	3	1595-1597	[RX13CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
653	3	1598-1600	[RX13CAT2] MULTUM DRUG CATEGORY # 2 See RX13CAT1.
654	3	1601-1603	[RX13CAT3] MULTUM DRUG CATEGORY # 3 See RX13CAT1.
655	3	1604-1606	[RX13CAT4] MULTUM DRUG CATEGORY # 4 See RX13CAT1.

DRUG CATEGORY LEVELS

656	3	1607-1609	[RX13V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
657	3	1610-1612	[RX13V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
658	3	1613-1615	[RX13V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
659	3	1616-1618	[RX13V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
660	3	1619-1621	[RX13V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
661	3	1622-1624	[RX13V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
662	3	1625-1627	[RX13V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
663	3	1628-1630	[RX13V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
664	3	1631-1633	[RX13V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
665	3	1634-1636	[RX13V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
666	3	1637-1639	[RX13V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
667	3	1640-1642	[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 83) for coding information.

668	6	1643-1648	[DRUGID14] Drug ID
669	1	1649	[PRESCR14] PRESCRIPTION STATUS CODE
670	1	1650	[CONTSUB14] CONTROLLED SUBSTANCE STATUS CODE
671	1	1651	[COMSTAT14] COMPOSITION STATUS CODE
672	3	1652-1654	[RX14CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
673	3	1655-1657	[RX14CAT2] MULTUM DRUG CATEGORY # 2 See RX14CAT1.
674	3	1658-1660	[RX14CAT3] MULTUM DRUG CATEGORY # 3 See RX14CAT1.
675	3	1661-1663	[RX14CAT4] MULTUM DRUG CATEGORY # 4 See RX14CAT1.

DRUG CATEGORY LEVELS

676	3	1664-1666	[RX14V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
677	3	1667-1669	[RX14V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
678	3	1670-1672	[RX14V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
679	3	1673-1675	[RX14V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
680	3	1676-1678	[RX14V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
681	3	1679-1681	[RX14V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
682	3	1682-1684	[RX14V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
683	3	1685-1687	[RX14V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
684	3	1688-1690	[RX14V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
685	3	1691-1693	[RX14V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
686	3	1694-1696	[RX14V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
687	3	1697-1699	[RX14V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #15

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

688	6	1700-1705	[DRUGID15] Drug ID
689	1	1706	[PRESCR15] PRESCRIPTION STATUS CODE
690	1	1707	[CONTSUB15] CONTROLLED SUBSTANCE STATUS CODE
691	1	1708	[COMSTAT15] COMPOSITION STATUS CODE
692	3	1709-1711	[RX15CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
693	3	1712-1714	[RX15CAT2] MULTUM DRUG CATEGORY # 2 See RX15CAT1.
694	3	1715-1717	[RX15CAT3] MULTUM DRUG CATEGORY # 3 See RX15CAT1.
695	3	1718-1720	[RX15CAT4] MULTUM DRUG CATEGORY # 4 See RX15CAT1.

DRUG CATEGORY LEVELS

696	3	1721-1723	[RX15V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
697	3	1724-1726	[RX15V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
698	3	1727-1729	[RX15V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
699	3	1730-1732	[RX15V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
700	3	1733-1735	[RX15V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
701	3	1736-1738	[RX15V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
702	3	1739-1741	[RX15V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
703	3	1742-1744	[RX15V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
704	3	1745-1747	[RX15V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
705	3	1748-1750	[RX15V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
706	3	1751-1753	[RX15V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
707	3	1754-1756	[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 83) for coding information.

708   6   1757-1762 [DRUGID16] Drug ID

709   1   1763   [PRESCR16] PRESCRIPTION STATUS CODE

710   1   1764   [CONTSUB16] CONTROLLED SUBSTANCE STATUS CODE

711   1   1765   [COMSTAT16] COMPOSITION STATUS CODE

712   3   1766-1768 [RX16CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

713   3   1769-1771 [RX16CAT2] MULTUM DRUG CATEGORY # 2
                                 See RX16CAT1.

714   3   1772-1774 [RX16CAT3] MULTUM DRUG CATEGORY # 3
                                 See RX16CAT1.

715   3   1775-1777 [RX16CAT4] MULTUM DRUG CATEGORY # 4
                                 See RX16CAT1.

                                 DRUG CATEGORY LEVELS

716   3   1778-1780 [RX16V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
717   3   1781-1783 [RX16V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
718   3   1784-1786 [RX16V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
719   3   1787-1789 [RX16V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

720   3   1790-1792 [RX16V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
721   3   1793-1795 [RX16V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
722   3   1796-1798 [RX16V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
723   3   1799-1801 [RX16V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

724   3   1802-1804 [RX16V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
725   3   1805-1807 [RX16V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
726   3   1808-1810 [RX16V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
727   3   1811-1813 [RX16V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #17

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

728	6	1814-1819	[DRUGID17] Drug ID
729	1	1820	[PRESCR17] PRESCRIPTION STATUS CODE
730	1	1821	[CONTSUB17] CONTROLLED SUBSTANCE STATUS CODE
731	1	1822	[COMSTAT17] COMPOSITION STATUS CODE
732	3	1823-1825	[RX17CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
733	3	1826-1828	[RX17CAT2] MULTUM DRUG CATEGORY # 2 See RX17CAT1.
734	3	1829-1831	[RX17CAT3] MULTUM DRUG CATEGORY # 3 See RX17CAT1.
735	3	1832-1834	[RX17CAT4] MULTUM DRUG CATEGORY # 4 See RX17CAT1.

DRUG CATEGORY LEVELS

736	3	1835-1837	[RX17V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
737	3	1838-1840	[RX17V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
738	3	1841-1843	[RX17V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
739	3	1844-1846	[RX17V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
740	3	1847-1849	[RX17V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
741	3	1850-1852	[RX17V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
742	3	1853-1855	[RX17V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
743	3	1856-1858	[RX17V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
744	3	1859-1861	[RX17V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
745	3	1862-1864	[RX17V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
746	3	1865-1867	[RX17V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
747	3	1868-1870	[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 83) for coding information.

748	6	1871-1876	[DRUGID18] Drug ID
749	1	1877	[PRESCR18] PRESCRIPTION STATUS CODE
750	1	1878	[CONTSUB18] CONTROLLED SUBSTANCE STATUS CODE
751	1	1879	[COMSTAT18] COMPOSITION STATUS CODE
752	3	1880-1882	[RX18CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
753	3	1883-1885	[RX18CAT2] MULTUM DRUG CATEGORY # 2 See RX18CAT1.
754	3	1886-1888	[RX18CAT3] MULTUM DRUG CATEGORY # 3 See RX18CAT1.
755	3	1889-1891	[RX18CAT4] MULTUM DRUG CATEGORY # 4 See RX18CAT1.

DRUG CATEGORY LEVELS

756	3	1892-1894	[RX18V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
757	3	1895-1897	[RX18V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
758	3	1898-1900	[RX18V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
759	3	1901-1903	[RX18V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
760	3	1904-1906	[RX18V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
761	3	1907-1909	[RX18V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
762	3	1910-1912	[RX18V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
763	3	1913-1915	[RX18V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
764	3	1916-1918	[RX18V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
765	3	1919-1921	[RX18V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
766	3	1922-1924	[RX18V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
767	3	1925-1927	[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 83) for coding information.

768	6	1928-1933	[DRUGID19] Drug ID
769	1	1934	[PRESCR19] PRESCRIPTION STATUS CODE
770	1	1935	[CONTSUB19] CONTROLLED SUBSTANCE STATUS CODE
771	1	1936	[COMSTAT19] COMPOSITION STATUS CODE
772	3	1937-1939	[RX19CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
773	3	1940-1942	[RX19CAT2] MULTUM DRUG CATEGORY # 2 See RX19CAT1.
774	3	1943-1945	[RX19CAT3] MULTUM DRUG CATEGORY # 3 See RX19CAT1.
775	3	1946-1948	[RX19CAT4] MULTUM DRUG CATEGORY # 4 See RX19CAT1.

DRUG CATEGORY LEVELS

776	3	1949-1951	[RX19V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
777	3	1952-1954	[RX19V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
778	3	1955-1957	[RX19V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
779	3	1958-1960	[RX19V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
780	3	1961-1963	[RX19V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
781	3	1964-1966	[RX19V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
782	3	1967-1969	[RX19V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
783	3	1970-1972	[RX19V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
784	3	1973-1975	[RX19V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
785	3	1976-1978	[RX19V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
786	3	1979-1981	[RX19V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
787	3	1982-1984	[RX19V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #20

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

788	6	1985-1990	[DRUGID20] Drug ID
789	1	1991	[PRESCR20] PRESCRIPTION STATUS CODE
790	1	1992	[CONTSUB20] CONTROLLED SUBSTANCE STATUS CODE
791	1	1993	[COMSTAT20] COMPOSITION STATUS CODE
792	3	1994-1996	[RX20CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
793	3	1997-1999	[RX20CAT2] MULTUM DRUG CATEGORY # 2 See RX20CAT1.
794	3	2000-2002	[RX20CAT3] MULTUM DRUG CATEGORY # 3 See RX20CAT1.
795	3	2003-2005	[RX20CAT4] MULTUM DRUG CATEGORY # 4 See RX20CAT1.

DRUG CATEGORY LEVELS

796	3	2006-2008	[RX20V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
797	3	2009-2011	[RX20V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
798	3	2012-2014	[RX20V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
799	3	2015-2017	[RX20V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
800	3	2018-2020	[RX20V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
801	3	2021-2023	[RX20V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
802	3	2024-2026	[RX20V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
803	3	2027-2029	[RX20V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
804	3	2030-2032	[RX20V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
805	3	2033-2035	[RX20V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
806	3	2036-2038	[RX20V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
807	3	2039-2041	[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 83) for coding information.

808	6	2042-2047	[DRUGID21] Drug ID
809	1	2048	[PRESCR21] PRESCRIPTION STATUS CODE
810	1	2049	[CONTSUB21] CONTROLLED SUBSTANCE STATUS CODE
811	1	2050	[COMSTAT21] COMPOSITION STATUS CODE
812	3	2051-2053	[RX21CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
813	3	2054-2056	[RX21CAT2] MULTUM DRUG CATEGORY # 2 See RX21CAT1.
814	3	2057-2059	[RX21CAT3] MULTUM DRUG CATEGORY # 3 See RX21CAT1.
815	3	2060-2062	[RX21CAT4] MULTUM DRUG CATEGORY # 4 See RX21CAT1.

DRUG CATEGORY LEVELS

816	3	2063-2065	[RX21V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
817	3	2066-2068	[RX21V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
818	3	2069-2071	[RX21V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
819	3	2072-2074	[RX21V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
820	3	2075-2077	[RX21V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
821	3	2078-2080	[RX21V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
822	3	2081-2083	[RX21V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
823	3	2084-2086	[RX21V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
824	3	2087-2089	[RX21V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
825	3	2090-2092	[RX21V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
826	3	2093-2095	[RX21V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
827	3	2096-2098	[RX21V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

DRUG-RELATED INFO FOR MEDICATION #22

Please see "DRUG-RELATED INFO FOR MEDICATION #1" (page 83) for coding information.

828	6	2099-2104	[DRUGID22] Drug ID
829	1	2105	[PRESCR22] PRESCRIPTION STATUS CODE
830	1	2106	[CONTSUB22] CONTROLLED SUBSTANCE STATUS CODE
831	1	2107	[COMSTAT22] COMPOSITION STATUS CODE
832	3	2108-2110	[RX22CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
833	3	2111-2113	[RX22CAT2] MULTUM DRUG CATEGORY # 2 See RX22CAT1.
834	3	2114-2116	[RX22CAT3] MULTUM DRUG CATEGORY # 3 See RX22CAT1.
835	3	2117-2119	[RX22CAT4] MULTUM DRUG CATEGORY # 4 See RX22CAT1.

DRUG CATEGORY LEVELS

836	3	2120-2122	[RX22V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
837	3	2123-2125	[RX22V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
838	3	2126-2128	[RX22V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
839	3	2129-2131	[RX22V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
840	3	2132-2134	[RX22V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
841	3	2135-2137	[RX22V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
842	3	2138-2140	[RX22V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
843	3	2141-2143	[RX22V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
844	3	2144-2146	[RX22V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
845	3	2147-2149	[RX22V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
846	3	2150-2152	[RX22V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
847	3	2154-2155	[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 83) for coding information.

848	6	2156-2161	[DRUGID23] Drug ID
849	1	2162	[PRESCR23] PRESCRIPTION STATUS CODE
850	1	2163	[CONTSUB23] CONTROLLED SUBSTANCE STATUS CODE
851	1	2164	[COMSTAT23] COMPOSITION STATUS CODE
852	3	2165-2167	[RX23CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
853	3	2168-2170	[RX23CAT2] MULTUM DRUG CATEGORY # 2 See RX23CAT1.
854	3	2171-2173	[RX23CAT3] MULTUM DRUG CATEGORY # 3 See RX23CAT1.
855	3	2174-2176	[RX23CAT4] MULTUM DRUG CATEGORY # 4 See RX23CAT1.

DRUG CATEGORY LEVELS

856	3	2177-2179	[RX23V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
857	3	2180-2182	[RX23V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
858	3	2183-2185	[RX23V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
859	3	2186-2188	[RX23V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
860	3	2189-2191	[RX23V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
861	3	2192-2194	[RX23V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
862	3	2195-2197	[RX23V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
863	3	2198-2200	[RX23V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
864	3	2201-2203	[RX23V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
865	3	2204-2206	[RX23V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
866	3	2207-2209	[RX23V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
867	3	2210-2212	[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 83) for coding information.

868	6	2213-2218	[DRUGID24] Drug ID
869	1	2219	[PRESCR24] PRESCRIPTION STATUS CODE
870	1	2220	[CONTSUB24] CONTROLLED SUBSTANCE STATUS CODE
871	1	2221	[COMSTAT24] COMPOSITION STATUS CODE
872	3	2222-2224	[RX24CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
873	3	2225-2227	[RX24CAT2] MULTUM DRUG CATEGORY # 2 See RX24CAT1.
874	3	2228-2230	[RX24CAT3] MULTUM DRUG CATEGORY # 3 See RX24CAT1.
875	3	2231-2233	[RX24CAT4] MULTUM DRUG CATEGORY # 4 See RX24CAT1.

DRUG CATEGORY LEVELS

876	3	2234-2236	[RX24V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
877	3	2237-2239	[RX24V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
878	3	2240-2242	[RX24V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
879	3	2243-2245	[RX24V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
880	3	2246-2248	[RX24V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
881	3	2249-2251	[RX24V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
882	3	2252-2254	[RX24V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
883	3	2255-2257	[RX24V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
884	3	2258-2260	[RX24V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
885	3	2261-2263	[RX24V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
886	3	2264-2266	[RX24V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
887	3	2267-2269	[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 83) for coding information.

888	6	2270-2275	[DRUGID25] Drug ID
889	1	2276	[PRESCR25] PRESCRIPTION STATUS CODE
890	1	2277	[CONTSUB25] CONTROLLED SUBSTANCE STATUS CODE
891	1	2278	[COMSTAT25] COMPOSITION STATUS CODE
892	3	2279-2281	[RX25CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
893	3	2282-2284	[RX25CAT2] MULTUM DRUG CATEGORY # 2 See RX25CAT1.
894	3	2285-2287	[RX25CAT3] MULTUM DRUG CATEGORY # 3 See RX25CAT1.
895	3	2288-2290	[RX25CAT4] MULTUM DRUG CATEGORY # 4 See RX25CAT1.

DRUG CATEGORY LEVELS

896	3	2291-2293	[RX25V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
897	3	2294-2296	[RX25V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
898	3	2297-2299	[RX25V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
899	3	2300-2302	[RX25V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
900	3	2303-2305	[RX25V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
901	3	2306-2308	[RX25V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
902	3	2309-2311	[RX25V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
903	3	2312-2314	[RX25V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
904	3	2315-2317	[RX25V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
905	3	2318-2320	[RX25V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
906	3	2321-2323	[RX25V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
907	3	2324-2326	[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 83) for coding information.

908	6	2327-2332	[DRUGID26] Drug ID
909	1	2333	[PRESCR26] PRESCRIPTION STATUS CODE
910	1	2334	[CONTSUB26] CONTROLLED SUBSTANCE STATUS CODE
911	1	2335	[COMSTAT26] COMPOSITION STATUS CODE
912	3	2336-2338	[RX26CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
913	3	2339-2341	[RX26CAT2] MULTUM DRUG CATEGORY # 2 See RX26CAT1.
914	3	2342-2344	[RX26CAT3] MULTUM DRUG CATEGORY # 3 See RX26CAT1.
915	3	2345-2347	[RX26CAT4] MULTUM DRUG CATEGORY # 4 See RX26CAT1.

DRUG CATEGORY LEVELS

916	3	2348-2350	[RX26V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
917	3	2351-2353	[RX26V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
918	3	2354-2356	[RX26V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
919	3	2357-2359	[RX26V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
920	3	2360-2362	[RX26V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
921	3	2363-2365	[RX26V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
922	3	2366-2368	[RX26V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
923	3	2369-2371	[RX26V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
924	3	2372-2374	[RX26V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
925	3	2375-2377	[RX26V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
926	3	2378-2380	[RX26V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
927	3	2381-2383	[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 83) for coding information.

928	6	2384-2389	[DRUGID27] Drug ID
929	1	2390	[PRESCR27] PRESCRIPTION STATUS CODE
930	1	2391	[CONTSUB27] CONTROLLED SUBSTANCE STATUS CODE
931	1	2392	[COMSTAT27] COMPOSITION STATUS CODE
932	3	2393-2395	[RX27CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
933	3	2396-2398	[RX27CAT2] MULTUM DRUG CATEGORY # 2 See RX27CAT1.
934	3	2399-2401	[RX27CAT3] MULTUM DRUG CATEGORY # 3 See RX27CAT1.
935	3	2402-2404	[RX27CAT4] MULTUM DRUG CATEGORY # 4 See RX27CAT1.

DRUG CATEGORY LEVELS

936	3	2405-2407	[RX27V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
937	3	2408-2410	[RX27V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
938	3	2411-2413	[RX27V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
939	3	2414-2416	[RX27V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
940	3	2417-2419	[RX27V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
941	3	2420-2422	[RX27V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
942	3	2423-2425	[RX27V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
943	3	2426-2428	[RX27V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
944	3	2429-2431	[RX27V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
945	3	2432-2434	[RX27V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
946	3	2435-2437	[RX27V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
947	3	2438-2440	[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 83) for coding information.

948   6   2441-2446 [DRUGID28] Drug ID

949   1   2447   [PRESCR28] PRESCRIPTION STATUS CODE

950   1   2448   [CONTSUB28] CONTROLLED SUBSTANCE STATUS CODE

951   1   2449   [COMSTAT28] COMPOSITION STATUS CODE

952   3   2450-2452 [RX28CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)

953   3   2453-2455 [RX28CAT2] MULTUM DRUG CATEGORY # 2
                                See RX28CAT1.

954   3   2456-2458 [RX28CAT3] MULTUM DRUG CATEGORY # 3
                                See RX28CAT1.

955   3   2459-2461 [RX28CAT4] MULTUM DRUG CATEGORY # 4
                                See RX28CAT1.

DRUG CATEGORY LEVELS

956   3   2462-2464 [RX28V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
957   3   2465-2467 [RX28V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
958   3   2468-2470 [RX28V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
959   3   2471-2473 [RX28V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

960   3   2474-2476 [RX28V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
961   3   2477-2479 [RX28V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
962   3   2480-2482 [RX28V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
963   3   2483-2485 [RX28V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

964   3   2486-2488 [RX28V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
965   3   2489-2491 [RX28V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
966   3   2492-2494 [RX28V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
967   3   2495-2497 [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 83) for coding information.

968	6	2498-2503	[DRUGID29] Drug ID
969	1	2504	[PRESCR29] PRESCRIPTION STATUS CODE
970	1	2505	[CONTSUB29] CONTROLLED SUBSTANCE STATUS CODE
971	1	2506	[COMSTAT29] COMPOSITION STATUS CODE
972	3	2507-2509	[RX29CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class)
973	3	2510-2512	[RX29CAT2] MULTUM DRUG CATEGORY # 2 See RX29CAT1.
974	3	2513-2515	[RX29CAT3] MULTUM DRUG CATEGORY # 3 See RX29CAT1.
975	3	2516-2518	[RX29CAT4] MULTUM DRUG CATEGORY # 4 See RX29CAT1.

DRUG CATEGORY LEVELS

976	3	2519-2521	[RX29V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
977	3	2522-2524	[RX29V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
978	3	2525-2527	[RX29V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
979	3	2528-2530	[RX29V1C4] Level 1 of MULTUM DRUG CATEGORY # 4
980	3	2531-2533	[RX29V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
981	3	2534-2536	[RX29V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
982	3	2537-2539	[RX29V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
983	3	2540-2542	[RX29V2C4] Level 2 of MULTUM DRUG CATEGORY # 4
984	3	2543-2545	[RX29V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
985	3	2546-2548	[RX29V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
986	3	2549-2551	[RX29V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
987	3	2552-2554	[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 83) for coding information.

988	6	2555-2560	[DRUGID30] Drug ID

| 989 | 1 | 2561 | [PRESCR30] PRESCRIPTION STATUS CODE |

| 990 | 1 | 2562 | [CONTSUB30] CONTROLLED SUBSTANCE STATUS CODE |

| 991 | 1 | 2563 | [COMSTAT30] COMPOSITION STATUS CODE |

| 992 | 3 | 2564-2566 | [RX30CAT1] MULTUM DRUG CATEGORY # 1 (therapeutic class) |

| 993 | 3 | 2567-2569 | [RX30CAT2] MULTUM DRUG CATEGORY # 2 See RX30CAT1. |

| 994 | 3 | 2570-2572 | [RX30CAT3] MULTUM DRUG CATEGORY # 3 See RX30CAT1. |

| 995 | 3 | 2573-2575 | [RX30CAT4] MULTUM DRUG CATEGORY # 4 See RX30CAT1. |

DRUG CATEGORY LEVELS

996	3	2576-2578	[RX30V1C1] Level 1 of MULTUM DRUG CATEGORY # 1
998	3	2579-2581	[RX30V1C2] Level 1 of MULTUM DRUG CATEGORY # 2
998	3	2582-2584	[RX30V1C3] Level 1 of MULTUM DRUG CATEGORY # 3
999	3	2585-2587	[RX30V1C4] Level 1 of MULTUM DRUG CATEGORY # 4

1000	3	2588-2590	[RX30V2C1] Level 2 of MULTUM DRUG CATEGORY # 1
1001	3	2591-2593	[RX30V2C2] Level 2 of MULTUM DRUG CATEGORY # 2
1002	3	2594-2596	[RX30V2C3] Level 2 of MULTUM DRUG CATEGORY # 3
1003	3	2597-2599	[RX30V2C4] Level 2 of MULTUM DRUG CATEGORY # 4

1004	3	2600-2602	[RX30V3C1] Level 3 of MULTUM DRUG CATEGORY # 1
1005	3	2603-2605	[RX30V3C2] Level 3 of MULTUM DRUG CATEGORY # 2
1006	3	2606-2608	[RX30V3C3] Level 3 of MULTUM DRUG CATEGORY # 3
1007	3	2609-2611	[RX30V3C4] Level 3 of MULTUM DRUG CATEGORY # 4

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

*************************************** END OF DRUG CHARACTERISTICS ***************************************

1008   1   2612   [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)

1009   4   2613-2616 [YEAR] SURVEY YEAR (2015)

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.

1010   8   2617-2624 [CSTRATM] CLUSTERED PSU STRATUM MARKER (masked)
                                       20115201-40400000

1011   6   2625-2630 [CPSUM] CLUSTERED PSU MARKER (masked)
                                       1-100243

*** WEIGHTING VARIABLES ***

1012   6   2631-2636 [PATWT] PATIENT VISIT WEIGHT (See page 28 in Section I.)
                                       A right-justified integer developed by NCHS staff for the purpose of
                                       producing national estimates from sample data.
                                       117-42002

1013   6   2637-2642 [EDWT] EMERGENCY DEPARTMENT WEIGHT
                                       EDWT enables data users to make emergency-department-level
                                       estimates. Please see page 28 for more information.
                                       1-86

III. MARGINAL DATA

A. EMERGENCY DEPARTMENT PATIENT VISITS

CATEGORY	RECORDS	WEIGHTED VISITS	PERCENT
Age recode			
Total	21,061	136,943,181	100.000
1 - Under 15 years	3,927	27,155,714	19.830
2 - 15-24 years	3,173	20,152,749	14.716
3 - 25-44 years	6,068	39,143,581	28.584
4 - 45-64 years	4,560	29,119,282	21.264
5 - 65-74 years	1,491	9,797,313	7.154
6 - 75 years and over	1,842	11,574,542	8.452
Patient sex			
Total	21,061	136,943,181	100.000
1 - Female	11,610	75,916,414	55.436
2 - Male	9,451	61,026,767	44.564
Imputed ethnicity			
Total	21,061	136,943,181	100.000
1 - Hispanic or Latino	3,344	22,586,622	16.493
2 - Not Hispanic or Latino	17,717	114,356,559	83.507
Unimputed race			
Total	21,061	136,943,181	100.000
-9 - Blank	4,084	28,544,950	20.844
1 - White Only	12,520	79,080,674	57.747
2 - Black/African American Only	3,937	26,118,751	19.073
3 - Asian Only	303	1,817,247	1.327
4 - Native Hawaiian/Oth Pac Isl Only	48	308,678	0.225
5 - American Indian/Alaska Native Only	131	802,499	0.586
6 - More than one race reported	38	270,382	0.197

Recoded primary expected source of payment for visit (based on hierarchy)

Total	21,061	136,943,181	100.000
-9 - All sources of payment are blank	402	3,380,490	2.469
-8 - Unknown	1,436	11,360,734	8.296
1 - Private insurance	6,039	37,759,149	27.573
2 - Medicare	3,811	24,295,817	17.742
3 - Medicaid, CHIP or other state-based program	6,781	42,660,184	31.152
4 - Workers' compensation	154	956,901	0.699
5 - Self-pay	1,890	12,370,100	9.033
6 - No charge/Charity	119	1,139,485	0.832
7 - Other	429	3,020,321	2.206

Immediacy with which patient should be seen (unimputed)

Total	21,061	136,943,181	100.000
-9 - Blank	488	4,799,967	3.505
-8 - Unknown	4,183	31,659,347	23.119
0 - 'No triage' for this visit but ESA does conduct nursing triage	573	2,678,029	1.956
1 - Immediate	210	951,193	0.695
2 - Emergent	1,583	10,103,506	7.378
3 - Urgent	6,605	40,870,483	29.845
4 - Semi-urgent	5,652	35,786,580	26.132
5 - Nonurgent	1,043	7,466,234	5.452
7 - Visit occurred in ESA that does not conduct nursing triage	724	2,627,842	1.919

NUMBER OF MEDICATION CODES THIS VISIT

Number of medications	RECORDS	WEIGHTED VISITS	PERCENT
Total	21,061	136,943,181	100.000
0	4,281	28,679,587	20.943
1	4,731	30,068,590	21.957
2	4,088	27,320,569	19.950
3	2,869	18,387,135	13.427
4	1,897	12,519,184	9.142
5	1,117	7,335,161	5.356
6	664	4,012,506	2.930
7	427	2,754,090	2.011
8	252	1,456,317	1.063
9	163	962,066	0.703
10	132	749,332	0.547
11	70	449,606	0.328
12	53	300,194	0.219
13	59	360,898	0.264
14	48	286,716	0.209
15	39	265,870	0.194
16	31	180,123	0.132
17	20	122,231	0.089
18	22	136,814	0.100
19	15	79,238	0.058
20	14	77,124	0.056
21	8	46,569	0.034
22	7	21,241	0.016
23	11	81,903	0.060
24	9	56,329	0.041
25	4	44,194	0.032
26	7	44,221	0.032
27	7	42,711	0.031
28	5	42,017	0.031
29	5	25,695	0.019
30	6	34,950	0.026

B. EMERGENCY DEPARTMENT DRUG MENTIONS

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Age recode			
Total	53,417	340,550,921	100.000
1 - Under 15 years	6,190	43,453,194	12.760
2 - 15-24 years	6,522	41,322,662	12.134
3 - 25-44 years	16,089	102,092,089	29.979
4 - 45-64 years	14,354	90,555,530	26.591
5 - 65-74 years	4,776	30,774,004	9.037
6 - 75 years and over	5,486	32,353,442	9.500
Patient sex			
Total	53,417	340,550,921	100.000
1 - Female	30,486	194,139,104	57.007
2 - Male	22,931	146,411,817	42.993
Unimputed race			
Total	53,417	340,550,921	100.000
-9 - Blank	9,657	67,151,505	19.718
1 - White Only	32,843	201,372,784	59.131
2 - Black/African American Only	9,420	62,924,320	18.477
3 - Asian Only	879	5,225,826	1.535
4 - Native Hawaiian/Oth Pac Isl Only	130	867,750	0.255
5 - American Indian/Alaska Native Only	395	2,459,356	0.722
6 - More than one race reported	93	549,380	0.161

DRUG THERAPEUTIC CATEGORIES (USING LEVEL 1 CODES)

CATEGORY	RECORDS	WEIGHTED MENTIONS	PERCENT
Drug therapeutic categories (using level 1 codes)			
Total	44,556	277,366,627	100.000
'001'=Anti-infectives	5,280	33,456,335	12.062
'020'=Antineoplastics	54	273,304	0.099
'028'=Biologicals	11	64,000	0.023
'040'=Cardiovascular agents	3,420	21,250,798	7.662
'057'=Central nervous system agents	13,850	88,188,505	31.795
'081'=Coagulation modifiers	1,036	6,653,300	2.399
'087'=Gastrointestinal agents	3,197	20,498,939	7.391
'097'=Hormones/hormone modifiers	1,586	10,094,351	3.639
'105'=Miscellaneous agents	1,220	7,604,720	2.742
'113'=Genitourinary tract agents	233	1,198,198	0.432
'115'=Nutritional products	3,702	21,540,062	7.766
'122'=Respiratory agents	5,252	32,276,093	11.637
'133'=Topical agents	1,918	12,104,372	4.364
'153'=Plasma expanders	15	108,878	0.039
'218'=Alternative medicines	161	768,627	0.277
'242'=Psychotherapeutic agents	1,109	5,061,098	1.825
'254'=Immunologic agents	611	4,205,998	1.516
'331'=Radiologic agents	490	3,531,060	1.273
'358'=Metabolic agents	1,106	6,806,072	2.454
'365'=Medical gas	287	1,568,192	0.565
'899'=Pharmaceutical aids	18	113,725	0.041

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 24.

C. EMERGENCY DEPARTMENTS

REGION

CATEGORY	RECORDS	WEIGHTED EMERGENCY DEPTS	PERCENT
Total	248	4,820	100.000
Northeast	57	604	12.531
Midwest	59	1,430	29.668
South	88	1,877	38.942
West	44	909	18.859

METROPOLITAN STATISTICAL AREA (MSA)

CATEGORY	RECORDS	WEIGHTED EMERGENCY DEPTS	PERCENT
Total	248	4,820	100.000
MSA	212	3,238	67.178
Non-MSA	36	1,582	32.822

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.

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 2015 data alone or when combined with NAMCS data or previous years of NHAMCS data.

It should be noted that in previous years, public use file data users were urged to combine data from the ED and OPD components of NHAMCS in order to ensure that all hospitals were included (because hospitals were sampled prior to the selection of EDs and OPDs) to get the best variance estimation. In the public use files, there can be hospitals with EDs but no OPDs, and vice versa, and if only one file were used, not all sample hospitals would be accounted for when calculating variances. However, because OPD data are not being released at this time, research was conducted to determine if special steps should be taken to preserve all sampling clusters when computing variances with ED records alone.

It was found that SUDAAN's with-replacement (WR) option (using an ultimate cluster design) with ED data alone yielded standard errors that may underestimate those produced with internal data using SUDAAN's without-replacement (WOR) option. For most standard error estimates, 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 NHAMCS ED public use files, 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 or email ambcare@cdc.gov.

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 21.0. 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 2015 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.

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 or email ambcare@cdc.gov.

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

Date and Time	Definition
	Enter the first documented date and time the patient arrived in the ED. This is the first recorded contact in the ED record and not necessarily registration time, triage time, or pre-arrival notification.

For the date of arrival, enter the month, day, and last digit of the year.

Enter the time of arrival. Pay attention to the a.m., p.m., and Military time indicators.

Cross-check all of the times to make sure that they are in chronological order. For example, the time of arrival should be before the provider contact time. |

Date and Time	Definitions
Seen by MD/DO/PA/NP	Enter the documented date and time of first contact with an MD/DO/PA/NP (includes Advanced Practice Registered Nurse - nurse practitioners and clinical nurse specialists) in the ED.

 Any MD/DO/PA/NP who contacts the patient is eligible. It is not determined by the hospital's definition of which providers are |

	credentialed to perform a medical screening examination.
	For the date of the provider contact, enter the month, day, and last digit of the year.
	Enter the time of the provider contact. Pay attention to the a.m., p.m., and Military time indicators.
	Cross-check all of the times to make sure that they are in chronological order. For example, the time seen by the provider should be after the arrival time.

Date and Time	**Definition**
Date and time of ED departure, if released or transferred	Enter the documented date and time of the patient's physical departure from the ED. This date and time only applies to patients who were released 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 also includes 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 refer to when the patient actually left the ED and includes the time period after the disposition time (i.e., time of the order for transfer or discharge or time of death) during which a patient awaits family or transport in an ED treatment space. It may not be consistently available in the chart; therefore, if it is not clearly stated, then enter the last date and time recorded in the ED chart for this visit.
	For the date of ED departure, enter the month, day, and last digit of the year.
	Enter the time the ED departure time. Pay attention to the a.m., p.m., and Military time indicators.

	Cross-check all of the times to make sure that they are in chronological order. For example, the time the patient departed the ED should be after the first contact with a provider.

PATIENT RESIDENCE

Type of 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. If there is no indication on the medical record that the patient came from a nursing home, an institution, was homeless, or had a residence other than private, then select 1-Private residence.
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 non-institutional setting(such as a hotel/motel, college dormitory, boarding school, assisted-living center) or an institution other than a nursing home (such as a prison/jail, mental hospital, supportive housing or 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.

WAS THE PATIENT TRANSFERRED FROM ANOTHER HOSPITAL OR URGENT CARE FACILITY?

	Definition
1-Yes	The patient was seen at another hospital or urgent care facility and after being evaluated was transferred to this hospital by ambulance. An urgent care facility delivers ambulatory health care outside of a hospital ED on a walk-in basis without a scheduled appointment. Also include freestanding EDs which operate outside of a hospital and typically have 24/7 operating hours and provide a higher level of care than urgent care facilities.

2-No	The patient arrived at this hospital by ambulance, but was not transferred from another hospital or urgent care facility or freestanding ED.
3-Unknown	The patient arrived at this hospital by ambulance, but it is not known if he/she was transferred from another hospital or urgent care facility or freestanding ED.

EXPECTED SOURCE(S) OF PAYMENT FOR THIS VISIT

Type of payment	Definitions
1-Private insurance	Charges paid in-full by a private insurer (e.g., Blue Cross/Blue Shield) or in-part (e.g., deductibles or copays from another plan) either directly to the (*hospital/provider*) or reimbursed to the patient. Include charges covered under a private insurance sponsored prepaid plan. Excludes Medicare Advantage Plans.
2-Medicare	Charges paid in-full by a Medicare plan or in-part (e.g., deductibles or copays from another plan) either directly to the (*hospital/provider*) or reimbursed to the patient. Include charges covered under a Medicare sponsored prepaid plan. Includes Medicare Advantage Plan which is a type of Medicare health plan offered by a private company that contracts with Medicare to provide all Part A and Part B benefits. Medicare Advantage Plans include Health Maintenance Organizations, Preferred Provider Organizations, Private Fee-for-Service Plans, Special Needs Plans, and Medicare Medical Savings Account Plans.
3-Medicaid or CHIP or other state-based program	Charges paid in-full by a Medicaid plan or in-part (e.g., deductibles or copays from another plan) either directly to the (*hospital/provider*) or reimbursed to the patient. Include charges covered under a Medicaid sponsored prepaid plan (HMO), "managed Medicaid" or the Children's Health Insurance Program (CHIP). PROGRAM NAMES FOR MEDICAID, CHIP, STATE-/LOCAL-SPONSORED, AND OTHER HEALTH INSURANCE PROGRAMS Please find the state where the facility is located in the FR Manual. . 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 program names are listed by state.
4-Workers' 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 enter "Self-pay" 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). Enter the payment category or categories that indicate how the services were originally paid.
7-Other	Other sources of payment not covered by the above categories, such as TRICARE, state and local governments, private charitable organizations, and other liability insurance (e.g., automobile collision policy coverage).
8-Unknown	The expected source of payment is unknown.

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.
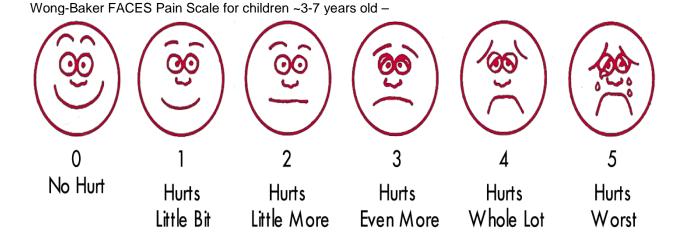Enter "Unknown" if the triage level is unknown.

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
No Hurt	Hurts Little Bit	Hurts Little More	Hurts Even More	Hurts Whole Lot	Hurts Worst

WAS PATIENT 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.

List the first 5 reasons for visit (i.e., complaint(s), symptom(s), problem(s), concern(s) of the patient) in the order in which they appear. Start with the Chief Complaint which should be entered in (1). Move on to the Patient History section of the chart and enter up to four additional reasons for the visit in (2), (3), (4) and (5). It is not necessary to record more than five . Enter 0 for None/No more.

By "most important" we mean the problem or symptom which in the physician's judgment was most responsible for the patient making this visit .

This is one of the most important items on the Patient Record form. No similar data on ambulatory visits are available in any other survey and there is great interest in the findings. Please be mindful of the following points:

•   In this item, NCHS is interested in how the patient defines the reason for the visit (e.g., "cramps after eating," or "fell and twisted my ankle") or the Chief Complaint. However, when taking the Patient History, the provider may probe and elicit other complaints or reasons for the visit. These should be entered in lines (2)-(5).

•   Conceivably, the patient may be undergoing a course of treatment for a serious illness, but if his/her most important reason for this visit is a sore throat or a cut finger, then that is the reason that should be entered.

• 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, have an insurance form completed, or drop off a specimen, then this patient's visit is not eligible for the sample and a Patient Record form should not be completed.

INJURY

IS THIS VISIT RELATED TO AN INJURY/TRAUMA, OVERDOSE/POISONING, OR ADVERSE EFFECT OF MEDICAL/SURGICAL TREATMENT? (continued on next page)

Response	Description
1. Yes, injury/trauma	Select this if the visit involves an injury/trauma, i.e., physical damage to the body typically from the application of an external force. Types of physical injuries include: Bruises, cuts, lacerations, open wounds, amputations, sprains, strains, fractures (broken bones), dislocations, damage to internal organs, traumatic brain injury (TBI), concussion, damage to nerves or spinal cord, burns, hypothermia, near drowning, suffocation, foreign bodies, insect/animal bites, etc. Types of events that can result in injury include: motor vehicle crashes, transportation events, falls, striking against or being struck by a person or object as in sports, burns, drowning, suffocation, cuts and stabbings, overexertion, foreign bodies, being crushed by machinery, beaten with fists or objects, gunshot/pellet gun wounds, etc. **<u>Includes</u>** Visits involving: • New injuries. • Follow-up for previously treated injuries. • Flare-ups of problems due to old injuries. **<u>Excludes</u>** Visits involving: • Injuries caused by medical/surgical treatment or ingestion of a harmful substance. • Bodily harm from other external causes, such as infectious diseases, and internal causes, such as chronic diseases. • Psychological trauma, such as Post Traumatic Stress Disorder • Suicidal ideation with no physical injury • Complaint of pain without evidence of physical injury or an injury mechanism

2. Yes, overdose/ poisoning	Select this if the visit involves a poisoning, i.e., ingestion, inhalation, absorption through the skin or mucous membranes, or injection of a substance resulting in a harmful effect. Poisoning can result from both overdose from medications/drugs as well as exposure to toxic substances. **Includes** Visits involving ingestion/exposure to: • Overdose or misuse of prescription drugs, over-the-counter medications, vitamins, and illicit/street drugs • Household cleaners, bleach, soaps, detergents, solvents • Pesticides • Carbon monoxide • Alcohol containing products (ethanol, ethyl alcohol, methanol) except situations described in the "excludes" category • Nonpharmaceutical inhalants • Alcohol-based topical agent used for medicinal purposes. • Poisonous mushrooms, berries **Excludes** Visits involving: • Harmful effects from bacterial illnesses (such as "food poisoning") • Drunkenness • Alcohol withdrawal • Drug withdrawal • Drug dependency • Medical conditions such as liver failure, pancreatitis, or renal failure resulting from past drug or alcohol abuse • Referrals for detox or medical clearance • Allergic reaction to a drug • Dermatitis from contact with poison ivy, poison oak, etc.

3. Yes, adverse effect of medical/surgical treatment or adverse effect of medicinal drug	Select this if the visit involves an **adverse effect of medical treatment**, i.e., 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.
	Also select this is visit involves an **adverse effect of surgical treatment**, i.e., 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.
	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 this if visit is not related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment.
5. Unknown	Select if it is unclear from the documentation whether or not this visit is related to an injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment or adverse effect of medicinal drug.

DID THE INJURY/TRAUMA, OVERDOSE/POISONING, OR ADVERSE EFFECT OCCUR WITHIN 72 HOURS PRIOR TO THE DATE AND TIME OF THIS VISIT?

Injury within 72 hours	Definitions
1-Yes	Select this response if the injury/trauma or overdose/poisoning occurred within 72 hours prior to this visit. Use either of these methods to verify timing:

	• If the date/time of the injury/trauma or overdose/poisoning is documented in the medical record, then use that information to calculate if the event occurred within 72 hours. • If the date/time of the injury/trauma or overdose/poisoning is not specifically provided, look for other text that might describe if the even occurred within 72 hours (e.g., "this morning," "last night", "two days ago").
2-No	Select this response if the injury/trauma or overdose/poisoning occurred more than 72 hours prior to this visit. Use any of the following methods to verify timing: • If the date/time of the injury/trauma or overdose/poisoning is documented in the medical record, then use that information to calculate if the event occurred more than 72 hours. • If the date/time of the injury/trauma or overdose/poisoning is not specifically provided, look for other text that might describe if the even occurred more than 72 hours (e.g., "two weeks ago," "since childhood", "a long time ago"). • If it's clear that the visit is for flare-up or problems due to an old injury, select "No". • If the date and time of the injury/trauma or overdose/poisoning is not provided and it is documented in the medical record that this is a follow-up visit (e.g., for suture removal, for removal of a cast, for follow-up), then select "No".
3-Unknown	Select this response if there is no date/time or text that indicates when the injury/trauma or overdose/poisoning might have occurred.
4-Not applicable	Select this response if the visit does not involve an injury/trauma or overdose/poisoning.

IS THIS INJURY/TRAUMA OR OVERDOSE/POISONING INTENTIONAL OR UNINTENTIONAL?

Intentional/Unintentional	Definition
1-Intentional	The injury/trauma or overdose/poisoning resulted from an act carried out on purpose by one or more persons with the intent of causing harm, injury, or death to another person. This category includes harm to both intended as well as unintended victims of violent acts (e.g., innocent bystanders). This category excludes unintentional shooting victims (other than those occurring during an act of violence), unintentional drug overdoses, and children or teenagers "horsing" around.

2-Unintentional (e.g., accidental)	The injury/trauma or overdose/poisoning was not purposely inflicted with the intent to harm. This category includes those injuries/traumas and overdoses/poisonings described as unintended or "accidental", regardless of whether the injury was inflicted by oneself or by another person. Because the medical record rarely uses the specific words "accidental" or "unintentional", this box should be the default choice for injury/trauma or overdose/poisoning visits when there is no specific information about intent to harm documented in the medical record.
3-Intent unclear	The medical record clearly states that there is difficulty in determining whether the event was intentional or accidental. Examples include drug poisoning events where it is unclear whether the overdose was accidental or a suicide attempt, or injuries to children or adults where it is unclear whether the injury was accidental or due to child abuse or domestic violence or elder abuse. Select this response only if there are statements in the medical record that question whether the event was intentional or accidental.

CAUSE OF INJURY/TRAUMA, OVERDOSE/POISONING, OR ADVERSE EFFECT OF MEDICAL/SURGICAL TREATMENT

Provide a brief description of **who**, **what**, **when**, **where**, and **why** associated with the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment including adverse effects of a medicinal drug (e.g., allergy to penicillin).

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

Indicate the place of the injury/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (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/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (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/trauma, overdose/poisoning, or adverse effect of medical/surgical treatment (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/trauma, overdose/poisoning, or adverse effect of medical/surgical

treatment. In addition, record the underlying or precipitating cause (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 falls, 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 in the Patient Record. While the diagnosis may be tentative, provisional, or definitive, it should represent the provider's best judgment at this time, expressed in acceptable terminology including "problem" terms. 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 or conditions that are recorded in the medical record as being related to this visit, including chronic conditions/diseases (e.g., hypertension, depression).

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 tests 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 TEST ORDERED OR PROVIDED SHOULD BE ENTERED.

Enter "NONE" if no blood tests, imaging, or other tests were ordered or provided.
If tests/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
1. NONE	No blood tests, imaging, or other tests/services not listed were ordered or provided at this visit.
Blood tests: 2. Arterial blood gases	ABG measures the levels of pH, oxygen (PO2 or PaO2) carbon dioxide (PCO2 or PaCO2), bicarbonate (HCO3), and oxygen saturation (SaO2). To obtain an ABG, an artery is punctured, usually in the wrist (radial artery). 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. Enter the blood alcohol concentration percentage from the BAC test. • If chart reports BAC test results as "within normal limits" or "WNL", leave the item blank • If chart reports BAC test results as "negative", enter 0 percent • If chart indicates BAC test was provided, but does not report results, leave the item blank.
4. Basic metabolic panel (BMP)	Examples of documentation of a basic metabolic panel (BMP) include SMA-7, Chem-1, CPBASIC. A basic metabolic panel includes kidney tests (BUN/creatinine), electrolytes (sodium, potassium, bicarbonate, and chloride) and glucose.
5. 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. Might be abbreviated as BC, blood Cx, or blood C&S (culture and sensitivity).
6. 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.
7. BUN/Creatinine	Select box if 1) any of these terms are used; or 2) if terms such as BUN-to-Creatinine ratio; BUN/Creatinine; or BUN/Cr are stated. Creatinine may be abbreviated as 'Cr.' Select box for blood (serum or plasma) Creatinine test. Do not select box for urine Creatinine; urine Albumin-to-Creatinine ratio; Creatinine Clearance; or Creatine Kinase.
8. Cardiac enzymes	Cardiac enzymes (CE) include any of the following tests: CKMB (MB fraction of creatine kinase) or CPK-MB; troponin I or troponin T (TnI, cTnI).
9. CBC	A CBC or 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). Might be abbreviated as ABC (automated blood count).
10.Comprehensive metabolic panel (CMP)	Examples of documentation of a CMP include SMA-18 or 20, Chem-20, CPCOMP. A CMP includes the 7 basic metabolic panel (BMP) tests as well as albumin, alkaline phosphatase, ALT, AST, GGT, bilirubin, calcium, cholesterol and triglycerides, lactate dehydrogenase, phosphate, total serum protein, and uric acid.
11. 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.
12. Electrolytes	The electrolytes test measures any of the following in the blood: sodium (Na), chloride (CI), potassium (K), bicarbonate (HCO_3), and carbon dioxide (CO_2).
13. Glucose	Select box for blood Glucose test. Do not select box for urine Glucose test. The serum 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. A fasting blood glucose test may be abbreviated as FBG or FBS.
14. Lactate	The lactate or lactate dehydrogenase (LDH) test is primarily ordered to help determine if someone has lactic acidosis, i.e., 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). This test is also known as Lactic Acid; L-Lactate.
15. Liver function tests	Select box if LFTs (liver function tests), AST (aspartate aminotransferase), or ALT (alanine aminotransaminase) are listed.
16. 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.
17. Other blood test	Select box if LFTs (liver function tests), AST (aspartate aminotransferase), or ALT (alanine aminotransaminase) are listed.
Other tests: 18.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).
19. EKG/ECG	An electrocardiogram (EKG or ECG) is a test that checks for problems with the electrical activity of the heart. An EKG/ECG translates the heart's electrical activity into line tracings. Includes stress tests, e.g., treadmill.
20. HIV test	Also known as AIDS test, AIDS screen, and HIV serology. 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.
21.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 flue 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.
22. 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. For HCG blood test, may see "quant" in the chart.
23. Throat culture	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. For HCG blood test, may see "quant" in the chart.
24.Toxicology screen	A toxicology screen evaluates the type (and roughly measures the amount) of legal drugs (e.g., prescriptions, over-the-counter [OTC], vitamins, supplements) and illegal drugs (e.g., heroin, cocaine, methamphetamines) a person has taken. The test typically involves a urine sample, but could also be blood.
25. Urinalysis (UA)	A urinalysis (U/A) checks different components of urine to identify potential problems. More than 100 different tests can be done on urine, including specific gravity, color, clarity, odor, pH, protein, and glucose. Include "clean catch" urine sample. Often abbreviated as U/A. Include urine dipstick.
26. 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. Might be abbreviated urine Cx or urine C&S (culture and sensitivity).
27. Wound culture	A wound culture is used to detect and identify bacteria or fungi that may be infecting the skin or wound. The 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.
28. Other culture	Might be abbreviated Cx or C&S-culture and sensitivity.
Imaging: 30. X-ray	An X-ray is a picture of structures and organs in the body produced by focusing X-rays (a form of radiation) focused into a beam.
31. CT scan	A computed tomography (CT) scan uses X-rays to make detailed pictures of structures inside the body. It can be performed on the head, chest, abdomen, pelvis, bone, and spinal cord. In some cases, a dye called contrast material may be used.
32. 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. MRI may also show problems that cannot be seen with other imaging methods.
33. Ultrasound	Ultrasound includes fetal, pelvic, and abdominal ultrasound tests as well as echocardiogram. Might be abbreviated as US or U/S. 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).
34. Other imaging	Select this box if an imaging test not listed above was ordered or provided at this visit. Other imaging includes PET scan.

WAS CT ORDERED/PROVIDED WITH INTRAVENOUS (IV) CONTRAST?

Tests	Definitions
1-Yes	Select this box if the CT was ordered or provided with intravenous (IV) contrast. The type of IV contrast used in CT scans is iodinated contrast. CT scans with IV contrast are performed to get a detailed image of the inside of the body.
2-No	Select this box if the CT was ordered or provided without intravenous (IV) contrast.
3-Unknown	Select this box if it is unknown whether the CT was ordered or provided with or without intravenous (IV) contrast.

WAS MRI ORDERED/PROVIDED WITH INTRAVENOUS (IV) CONTRAST (ALSO WRITTEN AS 'WITH GADOLINIUM' OR 'WITH GADO')?

Test	Definitions
1. Yes	Select this box if the MRI was ordered or provided with intravenous (IV) contrast. The most commonly used contrast medium or agent is gadolinium- (or gado-) based. When injected into the body, contrast medium makes certain tissues, abnormalities or disease processes more clearly visible on MRIs.
2. No	Select this box if the MRI was ordered or provided without intravenous (IV) contrast.
3. Unknown	Select this box if it is unknown whether the MRI was ordered or provided with or without intravenous (IV) contrast.

ENTER ALL PROCEDURES PROVIDED AT THIS VISIT, SEPARATE WITH COMMAS. EXCLUDE MEDICATIONS.

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

Procedures	Definition
1. NONE	No procedures provided.
2. BiPAP/CPAP	BiPAP (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 (CHF) and chronic obstructive pulmonary disease (COPD).
3. Bladder catheter	A bladder catheter is a latex, polyurethane or silicone tube is 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	Cast: Rigid or flexible dressing made of plaster or fiberglass, molded to the body while pliable and hardening as it dries to

	give firm support. Splint: Rigid or flexible appliance used to maintain in position a displaced or moveable part, or to keep in place and protect an injured part. Wrap: 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. A wrap includes the following: ACE wrap/bandage, compression wrap/bandage, and elastic wrap/bandage. It excludes kling wrap/rolls.
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 (EI, Endotracheal intubation is a medical procedure in which a tube is placed into the windpipe (trachea), through the mouth or the nose. It is performed in seriously ill or injured patients who are most likely admitted to a critical care unit in the hospital or die in the ED. 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 provider to get a better view of the upper airway. Look for ETT or rapid sequence in the chart.
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. An IV is used to administer medication or fluids and upon insertion, the line can be used to draw blood. Exclude IVs started in the ambulance or in another health care facility prior to arrival at this ED. Exclude central venous catheters (CVC).
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 (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

ENTER UP TO 30 DRUGS GIVEN AT THIS VISIT OR PRESCRIBED AT ED DISCHARGE. INCLUDE RX AND OTC DRUGS, IMMUNIZATIONS, AND ANESTHETICS. ENTER 0 FOR NONE/NO MORE.

PROVIDERS SEEN

Enter all providers seen during this visit, separate with commas

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."

Provider	**Definition**
1. ED attending physician	The ED attending physician is the physician who is primarily responsible for the patient's care in the ED. In teaching hospitals, the attending physician is also responsible for supervising and training interns, residents, and medical students. If the chart indicates that a physician was seen, but does not specify the type, assume that this individual was an ED attending physician.
2. ED resident/Intern	An ED resident is medical school graduate who is participating in a program of graduate medical education and training in emergency medicine. An intern is a physician in their first year of residency training.
3. Consulting Physician	A consulting physician is called to the ED by the patient's ED provider and may leave a consultation note. If a consulting physician specializes in psychiatry, choose psychiatrist on the Specialty of consulting physician screen.
4. RN/LPN	A registered nurse (RN) is a nurse who has graduated from a nursing program at a college or university and has passed a national licensing exam to obtain a nursing license. An LPN (licensed practical nurse) is a nurse who has completed a basic level of training and is licensed to provide routine care to sick people.
5. Nurse practitioner	A nurse practitioner (NP) is an Advanced Practice Registered Nurse (APRN) who has acquired the knowledge base, decision-making skills, and clinical competencies for expanded practice beyond that of an RN.
6. Physician assistant	A physician assistant (PA) is a medical professional who is

	nationally certified and state-licensed to practice medicine.
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	Select this box, if another type of mental health provider (e.g., Certified Alcohol Counselor (CAC) or psychiatric nurse practitioner).
9. Other	Select this box, if health care was provided by a provider not listed above. Exclude those who provided ancillary services, e.g., x-ray technician, phlebotomist, respiratory therapist.

VISIT DISPOSITION (ENTER ALL THAT APPLY, SEPARATE WITH COMMAS)

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 email contact was 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 a physician outside of the ED, such as a personal physician, or an outpatient clinic for follow-up after being screened, evaluated, and stabilized in the ED.
4. Left before triage	The patient left the ED before being triaged.
5. Left after triage	The patient left the ED after being triaged, but before being seen by the main health care provider, e.g., physician, APRN (Advanced Practice Registered Nurse – includes nurse practitioners and clinical nurse specialists), or PA.
6. Left AMA	The patient left before treatment was completed and against medical advice (AMA). The patient was evaluated by a physician, APRN (Advanced Practice Registered Nurse – includes nurse practitioners and clinical nurse specialists), or PA, 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 hospital which specializes in treating mental and/or behavioral health problems and where patients stay overnight and receive psychological/educational therapy alone or combined with medication.
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 for evaluation and management or to wait for an inpatient bed, and then was admitted to the hospital. The observation unit may be located in a separate geographic area from the ED or in an in-hospital observation space. Observation processes vary by hospital and within hospitals based on the location and service providing care. Other names

	of ED observation units include: clinical decision unit (CDU), chest pain evaluation unit, short-stay unit, and rapid diagnostic and treatment unit.
14. Admit to observation unit, then discharged	The patient was admitted to a designated observation unit in the ED for evaluation and management, but was discharged from the ED and was never admitted to a hospital. The observation unit may be located in a separate geographic area from the ED or in an in-hospital observation space. Observation processes vary by hospital and within hospitals based on the location and service providing care. Other names of ED observation units include: clinical decision unit (CDU), chest pain evaluation unit, short-stay unit, and rapid diagnostic and treatment unit.
15. Other	Any other disposition not included in the above list.

OBSERVATION UNIT

Date and Time	**Definition**
Date and time of observation unit discharge	Enter the first documented date and time of the order to discharge the patient from the observation unit (e.g., "discharge from observation" order). Observation processes vary by hospital and within hospitals based on the location and service providing care (e.g. ED observation unit vs. in hospital observation space). For the date of the observation unit discharge order, enter the month, day, and last digit of the year. Enter the time of the observation unit discharge order. Pay attention to the a.m., p.m., and Military time indicators. Cross-check all of the times to make sure that they are in chronological order. For example, the time of the observation unit discharge order should be after the time the patient physically left the ED.

HOSPITAL

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 BED WAS REQUESTED FOR HOSPITAL ADMISSION OR TRANSFER

Date and Time	Definitions
Date and time bed was requested for hospital admission or transfer	Enter the documented date and time of the bed request for hospital admission or transfer. This is not the same as the "Bed assignment time." For the date of the bed request, enter the month, day, and last digit of the year. Enter the time of the bed request. Pay attention to the a.m., p.m., and Military time indicators. Cross-check all of the times to make sure that they are in chronological order. For example, the time of the bed request should be after

	the time the patient was first seen by a provider.

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 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.

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	Epilepsy
Adult - Screening	Family Practice
Adult HIV	Gastroenterology (Adult)
AIDS	General Medicine
Allergy (Adult)	General Medicine (Outreach Program)
Ambulatory Care	General Practice
Andrology	Genetics (Adult)
Anticoagulation	Geriatric Medicine
Apnea (Adult)	Head (Non-Surgical)
Arthritis/Rheumatology (Adult)	Head & Neck (Non-Surgical)
Asthma	Hematology (Adult)
Bariatrics/Bariatric Medicine	Hemophilia (Adult)
Brain Tumor	Hepatology
Breast Medical Oncology	HIV (Adult)
Cancer Center	Holistic Medicine
Cancer Screening	Homeless
Cardiology (Adult)	Huntington's Disease/Chorea
Cardiovascular	Hyperlipidemia (Adult)
CD4	Hypertension
Cerebral Palsy (Adult)	Immunology
Chest	Immunosuppression
Chest TB	Infectious Diseases (Adult)
Chorea/Huntington's Disease	Internal Medicine (Adult)
Coagulant	Lead Poisoning (Adult)
Congestive Heart Failure	Leukemia
Connective Tissue	Lipid
Cystic Fibrosis (Adult)	Liver
Cytomegalovirus (CMV)	Lupus (Systemic Lupus Erythematosus/SLE)
Dermatology	Medical Oncology
Diabetes	Medical Screening
Digestive Disease	Melanoma
Down's Syndrome (Adult)	Metabolic
Endocrinology (Adult)	Movement and Memory Disorders

In scope - General Medicine (cont.)

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
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
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)

In scope – Surgery (cont.)

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)
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)

In scope - Obstetrics/Gynecology

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
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

Out of scope (cont.)

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
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 2015 NHAMCS ED public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey and is available <u>here</u>.

APPENDIX III

A. GENERIC CODES AND NAMES IN NUMERIC ORDER

The Generic Codes and Names List for the 2015 NHAMCS ED public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey and is available <u>here</u>.

B. DRUG ENTRY CODES AND NAMES IN NUMERIC ORDER

The Drug Entry Codes and Names List for the 2015 NHAMCS ED public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey and is available <u>here</u>.

C. MULTUM LEXICON END-USER LICENSE AGREEMENT

The Multum Lexicon End-User License Agreement for the 2015 NHAMCS ED public use micro-data file is the same as that used for the 2015 National Ambulatory Medical Care Survey and is available <u>here</u>.

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 <u>here</u>.