Healthcare Cost and Utilization Project — HCUP
A Federal-State-Industry Partnership in Health Data
Sponsored by the Agency for Healthcare Research and Quality – AHRQ

INTRODUCTION TO

THE AHRQ HCUP NATIONWIDE EMERGENCY DEPARTMENT SAMPLE (NEDS) 2024

These pages provide only an introduction to the 2024 AHRQ NEDS.

For full documentation and notification of changes,
visit the HCUP User Support (HCUP-US) website at
https://hcup-us.ahrq.gov.

Please read all documentation carefully.

Issued October 2026

AHRQ NEDS data available through
AHRQ HCUP Central Distributor Online Reporting System (CDORS) at
https://cdors.ahrq.gov/

AHRQ NEDS documentation available through
AHRQ HCUP User Support (HCUP-US) website at
https://hcup-us.ahrq.gov/

AHRQ NEDS technical support available via
Email: hcup@ahrq.gov

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AHRQ HCUP NATIONWIDE EMERGENCY DEPARTMENT SAMPLE (NEDS)

SUMMARY OF DATA USE RESTRICTIONS

******* REMINDER *******

All users of the AHRQ HCUP NEDS must take the online HCUP Data Use Agreement (DUA) Training Course, and read and sign a Data Use Agreement for Nationwide databases. Details and links may be found on the following page.

Authorized users of HCUP data agree to the following restrictions:[a]

- Will not use the data for any purpose other than research, analysis, and aggregate statistical reporting.
- Will not rerelease any data to unauthorized users.
- Will not redistribute HCUP data by posting on any website or publishing in any other publicly accessible online repository. If a journal or publication requests access to data or analytic files, will cite restrictions on data sharing in the Data Use Agreement and direct them to AHRQ HCUP (https://hcup-us.ahrq.gov) for more information on accessing HCUP data.
- Will not identify or attempt to identify any individual, including by the use of vulnerability analysis or penetration testing. Methods that could be used to identify individuals directly or indirectly shall not be disclosed or published.
- Will not report any statistics where the number of observations (i.e., individual discharge records) in any given cell of tabulated data is less than or equal to 10 (≤10).
- Will not publish information that could identify individual establishments (e.g., hospitals) and will not contact establishments.
- Will not use the data concerning individual establishments for commercial or competitive purposes affecting establishments or to determine rights, benefits, or privileges of individual establishments.
- Will not use the data for criminal and civil litigation, including expert witness testimony or for law enforcement activities.
- Will acknowledge in reports that data from the "Healthcare Cost and Utilization Project (HCUP)" were used, including names of the specific databases used for analysis.[b]

Any violation of the limitations in the AHRQ HCUP Data Use Agreement is punishable under Federal law by a fine, up to 5 years in prison, or both. Violations may also be subject to penalties under State statutes.

[a] This is a summary of key terms of the Data Use Agreement for Nationwide Databases; please refer to the DUA for full terms and conditions.

[b] Suggested citations for the HCUP databases are provided in the Requirements for Publishing with HCUP Data available at https://hcup-us.ahrq.gov/db/publishing.jsp.

AHRQ HCUP DATA USE AGREEMENT REQUIREMENTS

All HCUP data users, including data purchasers and collaborators, must complete the online AHRQ HCUP Data Use Agreement (DUA) Training Tool, and read and sign the AHRQ HCUP Data Use Agreement for Nationwide databases.

When placing an order through the AHRQ HCUP Central Distributor Online Reporting System (CDORS), you will be prompted to enter the AHRQ HCUP DUA Training Course completion certification code and electronically sign the AHRQ HCUP DUA for Nationwide databases. Please note, you will be required to execute the DUA requirements for each purchase and each project being considered, but the DUA training course only needs to be completed every two years.

The online **AHRQ HCUP Data Use Agreement (DUA) Training Course** is available at: https://hcup-us.ahrq.gov/tech_assist/dua.jsp.

The **AHRQ HCUP Data Use Agreement (DUA) for the Nationwide Database** is available at: https://hcup-us.ahrq.gov/team/NationwideDUA.jsp.

AHRQ HCUP CONTACT INFORMATION

HCUP User Support

Information about the content of the AHRQ HCUP databases is available on the HCUP User Support (HCUP-US) website at https://hcup-us.ahrq.gov.

If you have questions, please review the HCUP Frequently Asked Questions located at https://hcup-us.ahrq.gov/tech_assist/faq.jsp.

If you need further technical assistance, please contact the HCUP User Support team via email at hcup@ahrq.gov.

HCUP Central Distributor

If you have questions specific to the purchase or re-use of the data, please contact the HCUP Central Distributor team via email at HCUP-RequestData@ahrq.gov.

We would like to receive your feedback on the HCUP data products.
Please send user feedback to hcup@ahrq.gov.

WHAT IS THE AHRQ NATIONWIDE EMERGENCY DEPARTMENT SAMPLE (NEDS)?

- The Nationwide Emergency Department Sample (NEDS) tracks information about emergency department (ED) visits across the country. Information includes geographic characteristics, hospital characteristics, patient characteristics, and the nature of visits (e.g., common reasons for ED visits, acute and chronic conditions, and injuries).
- The NEDS was constructed using the Healthcare Cost and Utilization Project (HCUP) State Emergency Department Databases (SEDD) and the State Inpatient Databases (SID). The SEDD capture discharge information on ED visits that do not result in an admission (e.g., treat-and-release visits and transfers to another hospital). The SID contain information on patients initially seen in the emergency room and then admitted to the same hospital.
- The 2006-2024 NEDS are available for purchase through the AHRQ HCUP Central Distributor Online Reporting System (CDORS). All HCUP data users, including data purchasers and collaborators, must complete the online HCUP Data Use Agreement Training Tool, and must read and sign the AHRQ HCUP Data Use Agreement for Nationwide Databases.

WHAT'S NEW IN THE 2024 NATIONWIDE EMERGENCY DEPARTMENT SAMPLE (NEDS)?

- Because of a change in the states available to participate in the 2024 NEDS and a need to produce accurate national estimates, the following modifications have been made to the data elements included in the NEDS:
  - Information available on hospital charges
    - For treat-and-release ED visits, the data element TOTCHG_ED_2024 includes two separate adjustments to the hospital charge for treat-and-release ED visits in the Western and Midwest regions. The adjustment is specific to the West and Midwest because the sampling of hospital-owned emergency departments in those regions are most impacted by the change in available data and practice patterns can vary substantially by region.
    - For ED visits that result in an admission to the same hospital, the data element specific to hospital charge for the inpatient stay (TOTCHG_IP) is not included in the 2024 NEDS and the data element specific to the hospital charge for ED services (TOTCHG_ED_2024) is set to missing. This is consistent with the handling of TOTCHG_ED_2023 in the 2023 NEDS.
- Changes to the Diagnosis and Procedure Groups file:
  - Used v2026.2 for the Clinical Classifications Software Refined (CCSR) for ICD-10-PCS procedures and used v2026.1 for all other HCUP software tools included in the Diagnosis and Procedures Group file.
- For more information on NEDS data elements, see the Appendix C: NEDS Data Elements and Codes.
- Please note that these modifications to the 2024 NEDS data elements may make comparisons of some estimates across years more difficult.

UNDERSTANDING THE AHRQ NEDS

- This document, *Introduction to the AHRQ HCUP Nationwide Emergency Department Sample (NEDS), 2024*, summarizes the content of the NEDS and describes the development of the NEDS sample and weights.
- In-depth documentation for the NEDS is available on the HCUP User Support (HCUP-US) website (https://hcup-us.ahrq.gov/db/nation/neds/nedsdbdocumentation.jsp). Please refer to detailed documentation before using the data, including descriptions of available data elements.
- Important considerations for data analysis are provided along with references to detailed reports available on the HCUP-US website at https://hcup-us.ahrq.gov/reports/methods.jsp.

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The Agency for Healthcare Research and Quality (AHRQ) and the staff of the Healthcare Cost and Utilization Project (HCUP) thank users for purchasing the HCUP Nationwide Emergency Department Samples (NEDS).

AHRQ HCUP Nationwide Emergency Department Sample (NEDS)

ABSTRACT

The Nationwide Emergency Department Sample (NEDS) is part of the Healthcare Cost and Utilization Project (HCUP), sponsored by the Agency for Healthcare Research and Quality (AHRQ).

The NEDS is created to enable analyses of emergency department (ED) utilization patterns and to support researchers, public health professionals, administrators, policymakers, and clinicians in their decision making regarding this critical source of care. The ED serves a dual role in the U.S. healthcare system infrastructure—as a point of entry for inpatient hospital admissions and as a setting for treat-and-release outpatient visits.

The 2024 NEDS is the largest all-payer ED database that is publicly available in the United States, containing information from 34 million ED visits at 939 sampled hospital-owned EDs in the U.S. Weights are provided to calculate national estimates representing about 144 million ED visits at 4,356 hospital-owned EDs in the United States in 2024. The NEDS is made possible by the voluntary participation of statewide data organizations that provide HCUP with data from ED visits that may or may not have resulted in a hospital admission. Forty HCUP Partner organizations participated in the 2024 NEDS. See Appendix A, Table A1 for a list of HCUP Partner organizations participating in the NEDS.

Key features of the most recent NEDS (2024) include:

- The NEDS is a 20-percent stratified probability sample of emergency departments owned by community, non-rehabilitation hospitals in the United States. Community hospitals are non-federal, acute care hospitals.
- The NEDS includes information on both treat-and-release ED visits from the AHRQ HCUP State Emergency Department Databases (SEDD) and ED visits that result in an admission to the same hospital from the AHRQ HCUP State Inpatient Databases (SID).
- The NEDS has many research applications, because it contains information about hospital and patient characteristics, as well as descriptions of the nature of the visits (e.g., common reasons for ED visits, including injuries).
- The NEDS includes information on hospital characteristics such as an indicator of trauma center level, including pediatric trauma centers, urban/rural location, ownership, and teaching status.
- The NEDS includes demographic data such as patient age, sex, community income quartile, and urbanicity of the county of the patient's residence.
- The data elements included in the NEDS are designed to protect patient and hospital confidentiality.

Appendix C provides a list of data elements in the 2024 NEDS. Although some modifications have been made to the data elements included in the 2024 NEDS, no changes have been made to the sample design.

The 2024 NEDS is designed to produce national estimates of ED utilization, access, cost, quality, and outcomes. The following analyses are not possible using the 2024 NEDS:

- Analyses by geographic areas such as ZIP Code of the hospital or patient residence, county of the hospital or patient residence, state of the hospital or patient residence, or Census region.
- Analyses requiring the identification of hospitals.
- Analyses by the patient's race and ethnicity.
- Analyses of the urbanicity of the county of the patient residence requiring more detail than the distinction of metropolitan and non-metropolitan.

These analyses can be done using the HCUP SEDD and SID, available through the HCUP Central Distributor.

The 2006-2024 NEDS are available for purchase online through the AHRQ HCUP Central Distributor Online Reporting System (CDORS). All HCUP data users, including data purchasers and collaborators, must complete the online AHRQ HCUP Data Use Agreement Training Tool, and must read and sign the AHRQ HCUP Data Use Agreement for Nationwide Databases.

For more information on the NEDS, visit the AHRQ-sponsored HCUP User Support (HCUP-US) website at https://hcup-us.ahrq.gov/db/nation/neds/nedsdbdocumentation.jsp.

INTRODUCTION TO THE AHRQ HCUP NATIONWIDE EMERGENCY DEPARTMENT SAMPLE (NEDS)

Overview of 2024 AHRQ HCUP NEDS Data

The Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS) was created to enable analyses of emergency department (ED) utilization patterns and to support researchers, public health professionals, administrators, policymakers, and clinicians in their decision making regarding this critical source of care. The ED serves a dual role in the U.S. healthcare system infrastructure, as a point of entry for inpatient hospital admissions and as a setting for treat-and-release outpatient visits. The 2024 NEDS supports many research applications, because it contains detailed information about hospital and patient characteristics, as well as the nature of visits (e.g., common reasons for ED visits, acute and chronic conditions, and injuries).

The 2024 NEDS contains information from 34 million ED visits at 939 sampled hospital-owned EDs in the U.S. Weights are provided to calculate national estimates representing about 144 million ED visits at 4,356 hospital-owned EDs in the United States in 2024.

Because of a change in the states available to participate in the 2024 NEDS and a need to produce accurate national estimates, the following modifications have been made to the data elements included in the NEDS:

- Information available on hospital charges
    - For treat-and-release ED visits, the data element TOTCHG_ED_2024 includes two separate adjustments to the hospital charge for treat-and-release ED visits in the Western region and Midwest regions. The adjustment is specific to the West and Midwest because the sampling of hospital-owned emergency departments in those regions are most impacted by the change in available data and practice patterns can vary substantially by region.
    - For ED visits that result in an admission to the same hospital, the data element specific to hospital charge for the inpatient stay (TOTCHG_IP) is not included in the 2024 NEDS and the data element specific to the hospital charge for ED services (TOTCHG_ED_2024) is set to missing. This is consistent with the handling of TOTCHG_ED_2023 in the 2023 NEDS.

NEDS Data Sources, Hospitals, and ED Visits

The names of the HCUP Partner organizations that contribute to the 2024 NEDS are listed in Appendix A, Table A1 with the geographic distribution of the 40 HCUP Partner organizations shown in Appendix A, Figure A1. Based on U.S. Census Bureau data, the States included in the 2024 NEDS account for 71.4 percent of the U.S. population in 2024. The 40 HCUP Partner organizations account for 73.9 percent of the ED visits reported in the 2024 American Hospital Association (AHA) Annual Survey Database. Details on the percentage of 2024 population and ED visits by region are provided in Appendix A, Table A2. Information on the numbers of States, hospital-owned EDs, and ED visits included in the NEDS by data year are provided in Appendix A, Table A3.

Identification of HCUP Records with Emergency Department Services

Records for ED visits are contained in two existing HCUP databases:

The State Emergency Department Databases (SEDD) capture discharge information on all ED visits that do not result in an admission to that hospital (e.g., treat-and-release visits, transfers to another hospital, deaths).

The State Inpatient Databases (SID) contain information on patients initially seen in the emergency room and then admitted to the same hospital.

Both of these HCUP databases contain a core set of clinical and nonclinical data elements defined in a uniform scheme for all patients, regardless of payer. This scheme makes it possible to combine records across databases.

Selection of ED records from the SEDD and SID for the NEDS is based on evidence of ED services reported on the record. HCUP Partner organizations use differing methods to identify ED records. The HCUP criterion for identifying an ED record (i.e., a discharge record for a patient with an ED visit) is that it meets at least one of the following conditions:

Revenue center code of 450–459 reported on discharge record, indicating ED services.

ED charge greater than zero dollars, when revenue center codes were not available.

Current Procedural Terminology (CPT®) code of 99281–99285 reported on discharge record, indicating ED physician services.

ED identified by admission source (National Uniform Billing Committee [NUBC] preferred coding prior to October 1, 2007), point of origin (NUBC preferred coding from October 1, 2007, to June 30, 2010), or condition code of P7 (NUBC preferred coding for public reporting as of July 1, 2010). These criteria are used primarily for ED admissions.

Of the 40 HCUP Partner organizations contributing to the 2024 NEDS, 14 (Arkansas, Arizona, Connecticut, Florida, Massachusetts, Mississippi, Nevada, New Hampshire, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, and Utah) provided a source file that contained only ED treat-and-release records. Because the data source provided a dedicated outpatient ED file, all the SEDD records were considered ED records, even though information may not have been available to determine whether HCUP criteria were met.

Partner-Specific Restrictions

Some HCUP Partner organizations that contributed data to the NEDS imposed restrictions on the release of certain data elements or on the number and types of hospitals that could be included in the database. In addition, because of confidentiality laws, some data sources were prohibited from providing HCUP with discharge records that indicated specific medical conditions, such as HIV/AIDS or behavioral health conditions. Detailed information on these Partner-specific restrictions is available in Appendix B, Table B1.

File Structure of the NEDS

Because of the size of the NEDS and the difference in information collected on records for patients admitted into the hospital directly from the ED (SID records) and for ED patients that are not admitted (SEDD records), the NEDS is divided into five types of files:

- **Core File:** This file contains records for all the ED visits in the SID and SEDD—whether resulting in admission or not—from the sample of hospitals in participating States and the District of Columbia.

- **Supplemental ED File:** This file contains additional information for patients who were treated in the ED and not admitted directly to the hospital (e.g., released home, transferred). This information came from the SEDD.

    - The unique NEDS record identifier (KEY_ED) provides the linkage between the NEDS Core File and the Supplemental ED File. For patients seen in the ED and admitted to the same hospital (SID records), information about the stay is contained in the Supplemental Inpatient File.

- **Supplemental Inpatient File:** This file contains data elements that are specific to the inpatient stay, such as total charges, length of inpatient stay, and procedure codes from the SID record. Procedures reported on the SID records may have been performed in the ED, but there is currently no way to verify this information.

    - The unique NEDS record identifier (KEY_ED) provides the linkage between the NEDS Core File and the Supplemental Inpatient File.

- **Hospital Weights File:** This file contains one observation for each hospital-owned ED sampled for the NEDS, with its weight and variance estimation data elements. The unit of observation is the *ED*.

    - The HCUP ED hospital identifier (HOSP_ED) provides the linkage between the NEDS Core File and the Hospital Weights File.

- **Diagnosis and Procedure Groups File:** This file contains additional information on ICD-10-CM/PCS diagnoses and procedures, which is generally derived from the HCUP software tools.

    - The unique NEDS record identifier (KEY_ED) provides the linkage between the NEDS Core File and the Diagnosis and Procedure Groups File.

On the HCUP-US website, NEDS users can access complete file documentation, including data element notes, file layouts, summary statistics, and related technical reports. Similarly, users can also download SAS, SPSS, and Stata load programs from this website. Available online documentation and supporting files are detailed in Appendix A, Table A4.

NEDS Data Elements

The coding of data elements in the NEDS is consistent with other HCUP databases. The following three objectives guided the definition of data elements in all HCUP databases:

Ensure usability; minimize editing by analysts

Retain the largest amount of information available from the original sources, while maintaining consistency among sources

Structure the information for efficient storage, manipulation, and analysis.

More information on the coding of HCUP data elements is available on the HCUP Coding Practices page of the HCUP-US website.

The 2024 NEDS contains more than 100 clinical and nonclinical variables provided in a hospital discharge abstract, such as the following:

- Patient demographics (e.g., sex, age, metropolitan/nonmetropolitan designation of residence, national quartile of the median household annual income for the patient's ZIP Code)
- Expected payment source (e.g., Medicare, Medicaid, private insurance, self-pay)
- Hospital characteristics (e.g., indicator of trauma center level, including pediatric trauma centers, urban-rural designation of county, ownership, teaching status)
- ICD-10-CM diagnoses and external cause of morbidity codes
- Identification of injury-related ED visits and the mechanism and intent of the injury
- CPT procedure codes for treat-and-release ED visits and ICD-10-PCS procedure codes for ED visits that result in admission to the same hospital
- Hospital total charges for treat-and-release ED visits
- Data elements derived from the HCUP software tools for ICD-10-CM/PCS.[1]

Appendix C identifies the data elements in each NEDS file:

- Table C1 for the NEDS Core File (record = ED visit)
- Table C2 for the NEDS Supplemental ED File (record = ED visit that did not result in direct inpatient admission to the same hospital)
- Table C3 for the NEDS Supplemental Inpatient File (record = ED visit that resulted in a direct inpatient admission to the same hospital)
- Table C4 for the Hospital Weights File (record = hospital-owned ED)
- Table C5 for the Diagnosis and Procedure Groups File (record = ED visit).

The tables in Appendix C provide a summary of data documentation. Please refer to the NEDS Description of Data Elements page on the HCUP-US website (https://hcup-us.ahrq.gov) for more comprehensive information about the data elements and the files.

Getting Started

The HCUP NEDS is distributed as comma-separated values (CSV) files delivered via secure digital download through the AHRQ HCUP Central Distributor Online Reporting System (CDORS). The files are compressed and encrypted with 7-Zip©. **Users will need the password provided to the original data purchaser through the HCUP Central Distributor.**

The NEDS product is downloaded as a single zipped file for each year, which contains several data-related files and accompanying documentation. The five compressed data-related files are as follows:

1) Core File (NEDS_2024_Core.zip)
2) Supplemental ED File (NEDS_2024_ED.zip)
3) Supplemental Inpatient File (NEDS_2024_IP.zip)
4) Hospital Weights File (NEDS_2024_Hospital.zip)
5) Diagnosis and Procedure Groups File (NEDS_2024_DX_PR_GRPS.zip)

[1] Users interested in applying HCUP software tools to the NEDS to produce data elements not available for a certain data year may do so by downloading the respective tool(s) from the HCUP Research Tools section of the HCUP-US website. Further, users may wish to review the HCUP Software Tools Tutorial, which provides instructions on how to apply the HCUP software tools to HCUP or other administrative databases.

Computer Specifications Required for Using the NEDS

To load and analyze the NEDS data on a computer, users will need the following:

- A hard drive with *at least* 300 gigabytes (GB) of space available
- A third-party zip utility such as ZIP Reader, SecureZIP, WinZip®, 7-Zip©, or Stuffit Expander®
- SAS®, SPSS®, Stata®, or similar analysis software
- Load program (described below)

The total size of the CSV version of the NEDS is 66 GB. The NEDS files loaded into SAS are about 90 GB. Most SAS data steps will require twice the storage capacity so that the input and output files can coexist. In addition, the largest use of space in SAS typically occurs during PROC SORT, which requires workspace about three times the size of the file. Thus, the NEDS files would require approximately 270 GB of available workspace to perform a sort. The NEDS files loaded into SPSS are estimated to be about 70 GB (under estimate). Because Stata loads the entire file into memory, it may not be possible to load every data element in the NEDS Core file into Stata. Stata users will need to maximize memory and use the "_skip" option to select a subset of data elements. More details are provided in the Stata load programs.

With a file of this size and without careful planning, space could easily become a problem in a multistep process. It is common to produce several versions of a file during data preparation, as well as further multiple versions for analysis. Therefore, the amount of space required could escalate rapidly.

Decompressing the NEDS Files

To extract the data files from the compressed download file, follow these steps:

1) Create a directory for the NEDS on your hard drive.
2) Unzip the compressed NEDS product file into the new directory using a third-party zip utility. This will place four compressed, encrypted data-related files in the new directory. You will be prompted to enter the encryption password (sent separately by email) to decrypt the file.

   Please note that attempts to unzip encrypted files using the built-in zip utility in Windows® (Windows Explorer) or Macintosh® (Archive Utility) will produce an error message warning of incorrect password and/or file or folder errors. The solution is to use a third-party zip utility.

   Third-party zip utilities are available from the following reputable vendors on their official websites.

   - 7-Zip© (Windows) (free download offered by 7-Zip)
   - ZIP Reader (Windows) (free download offered by the PKWARE corporation)
   - SecureZIP for Mac or Windows (free evaluation and licensed/fee software offered by the PKWARE corporation)
   - WinZip (Windows) (evaluation and fee versions offered by the WinZip corporation)
   - Stuffit Expander® (Mac) (free evaluation and licensed/fee software offered by Smith Micro corporation)

3) Unzip each of the compressed, encrypted data-related files using the same password and third-party zip utility method. This will place the data-related CSV files in this same directory by default.

Downloading and Running the Load Programs

Programs to load the data into SAS, SPSS, or Stata are available on the HCUP-US website. To download and run the load programs, follow these steps:

1) Go to the NEDS Database Documentation page on the HCUP-US website.
2) Go to the File Specifications and Load Programs section on this page.
3) Click on "Nationwide SAS Load Programs," "Nationwide SPSS Load Programs," or "Nationwide Stata Load Programs" to go to the corresponding Load Programs page.
4) Select the data year and the database (NEDS) from the drop-down lists on this page. Or you may select "NEDS Load All Years" to obtain a zipped file with all load programs for multiple years at once.
5) Select and save the load programs you need. **The load programs are specific to the data year and data-related file**. For example, the load program for the 2024 NEDS Core File is found under the link "SAS NEDS 2024 Core File" in the list generated by selecting "2024" and "NEDS." Save the load programs into the same directory as the NEDS CSV files on your computer.
6) Edit and run the load programs as appropriate for your computing environment to create the analysis files. For example, modify the directory paths to point to the location of your input and output files.

NEDS Documentation

Comprehensive documentation for the NEDS files is available on the NEDS Database Documentation page of the HCUP-US website (https://hcup-us.ahrq.gov). Users of the NEDS can access complete file documentation, including variable notes, file layouts, summary statistics, and related technical reports. Data users can also download SAS, SPSS, and Stata load programs. These important resources help the user understand the structure and content of the NEDS and aid in using the database. Appendix A, Table A4 details the comprehensive NEDS documentation available on HCUP-US.

HCUP Online Tutorials

For additional assistance, AHRQ has created the HCUP Online Tutorial Series, a series of free, interactive courses that provide information on using HCUP data and tools and training on technical methods for conducting research with HCUP data. Topics include an HCUP Overview Course and these tutorials:

- The Load and Check HCUP Data tutorial provides instructions on how to unzip (decompress) HCUP data, save it on your computer, and load the data into a standard statistical software package. This tutorial also describes how to verify that the data have loaded correctly.
- The HCUP Software Tools Tutorial introduces users to the HCUP software tools, which can be applied to HCUP and other administrative databases to create new data elements from existing data, thereby enhancing a researcher's ability to conduct analyses. There are four modules within this course grouping the HCUP tools by the following coding systems: ICD-10-CM diagnoses, ICD-10-PCS procedures, CPT and HCPCS Level II codes, and ICD-9-CM diagnoses and procedures. Users will learn about

the purpose of each tool and receive technical guidance for applying the tools to their data.

- The HCUP Sample Design tutorial is designed to help users learn how to account for sample design in their work with HCUP nationwide databases.
- The Producing National HCUP Estimates tutorial is designed to help users understand how three of the nationwide databases—the National (Nationwide) Inpatient Sample (NIS), the NEDS, and the Kids' Inpatient Database (KID)—can be used to produce national and regional estimates.
- The Calculating Standard Errors tutorial shows how to accurately determine the precision of the estimates produced from the HCUP nationwide databases. Users will learn two methods for calculating standard errors for estimates produced from the HCUP nationwide databases.
- The HCUP Multi-year Analysis tutorial presents solutions that may be necessary when conducting analyses that span multiple years of HCUP data.

New tutorials are added periodically. The tutorials can be found on the HCUP Online Tutorial Series page of the HCUP-US website.

SAMPLING DESIGN OF THE NEDS

The NEDS is built using a 20-percent stratified sample of hospital-owned EDs in the United States. The main objective of a stratified sample is to ensure that it is representative of the target universe. By stratifying on important hospital characteristics, the NEDS represents a "microcosm" of EDs in the United States. For example, by including *trauma center designation* in the sampling strategy, the NEDS has the same percentage of trauma hospitals as the entire United States. The NEDS contains all the ED visits that occurred at the hospital-owned EDs in the sample.

Universe of Hospital-Owned Emergency Departments

The AHA Annual Survey Database is used to define the universe of hospital-owned emergency departments for two reasons. First, the AHA data provide the necessary hospital characteristics, such as ownership type and teaching status, and also report total ED visits for hospitals. Second, the crosswalk linkage from the HCUP databases to the AHA data is already established. The universe of hospital-owned EDs is defined as the AHA community, non-rehabilitation hospitals that reported total ED visits. The AHA defines community hospitals as "all non-Federal, short-term, general, and other specialty hospitals open to the public."[2] Included among community hospitals are pediatric institutions, public hospitals, and academic medical centers.

Sampling Frame of the NEDS

The sampling frame of the NEDS does not cover the entire target universe. The target universe consists of all the hospital-owned EDs in the U.S. (including the District of Columbia). The coverage of the sampling frame is limited because HCUP ED data (SID and SEDD) are not available in all States, the identification of HCUP hospitals in the AHA is imperfect, and the AHA data is incomplete. The sampling frame, a set of hospital-owned EDs, consists of AHA community, non-rehabilitation hospitals that report total ED visits and *that could be accurately matched to the ED data provided to HCUP*. If an ED in the AHA survey could not be matched to

[2] More of the AHA "community hospital designation" is available at www.ahadataviewer.com/glossary.

the ED data provided by the HCUP data source, it was eliminated from the sampling frame (but not from the target universe).

Stratification Variables

The following hospital characteristics were used for sample stratification: U.S. census region, trauma center designation, urban-rural location of the hospital, ownership, and teaching status. ED bed size was not used because no data source for this information could be identified. A number of data sources report the bed size of the hospital, but no source distinguishes between inpatient and ED beds.

The NEDS stratification variables are described below and detailed in Appendix A, Table A5.

U.S. Census Region

The four census regions—Northeast, Midwest, South, and West—were used to stratify EDs by geographic location because practice patterns may vary substantially by region. Appendix A, Figure A1 maps the NEDS States by region.

Trauma Centers

A *trauma center* is a hospital equipped to provide comprehensive emergency medical services 24 hours a day, 365 days a year to patients with traumatic injuries. In 1976, the American College of Surgeons Committee on Trauma (ACS/COT) defined five levels of trauma centers:[3]

- Level I centers have comprehensive resources, can care for the most severely injured patients, and provide leadership in education and research.
- Level II centers have comprehensive resources and can care for the most severely injured patients but do not provide leadership in education and research.
- Level III centers provide prompt assessment and resuscitation, emergency surgery, and, if needed, transfer to a level I or II center.
- Level IV/V centers provide trauma support in remote areas in which no higher level of care is available. These centers resuscitate and stabilize patients and arrange transfer to an appropriate trauma facility.

The ACS/COT verifies hospitals as trauma level I, II, or III.[4] It is important to note that although all level I, II, and III trauma centers offer a high level of trauma care, there may be differences in the specific services and resources offered by hospitals between the different levels. Trauma levels IV and V are designated at the State level (and not by ACS/COT) with varying criteria applied across States.

The level of the trauma centers in the NEDS was identified using the Trauma Information Exchange Program (TIEP) database, a national inventory of trauma centers in the United States collected by the American Trauma Society (ATS).[5] The TIEP database identifies all U.S. trauma centers that are level I, II, or III that treat both adults and children. TIEP includes some

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[3] MacKenzie EJ, Hoyt DB, Sacra JC, et al. National inventory of hospital trauma centers. JAMA. 2003;289:1515-22.

[4] American College of Surgeons Committee on Trauma, Verification, Review, and Consultation Program for Hospitals. Verification, Review, and Consultation (VRC) Program. https://www.facs.org/quality-programs/trauma/tqp/center-programs/vrc. Accessed September 2018.

[5] American Trauma Society. Trauma Information Exchange Program. https://www.amtrauma.org/page/TIEP. Accessed December 2019.

information on trauma centers within children's hospitals, but this is not the focus. To ensure that all trauma centers are identified for the NEDS, ATS reviews the ACS/COT list of trauma centers and all State-specific websites on emergency services to identify any additional trauma centers within children's hospitals and their associated trauma levels.

The stratum for trauma center in the NEDS was limited to trauma levels I, II, and III. The distinction between Level IV and V centers was not incorporated because the criteria for these designations varied across States. For hospital confidentiality purposes, a collapsed stratification was necessary if the stratum size in the universe or the frame was fewer than two hospitals. In such situations, the collapsed categories varied by data year:

- Level I and II trauma centers could be grouped together in all years of the NEDS.
- Level I, II, and III trauma centers could be grouped together in the 2006–2010 NEDS.
- Level III trauma centers could be grouped with non-trauma hospitals beginning in the 2011 NEDS.

The change between the 2010 and 2011 NEDS was prompted by differences between injury-related services provided by level I and II trauma centers versus injury-related services provided by level III trauma centers. Services at level III trauma centers were more similar to non-trauma hospitals.

Urban-Rural Location of the ED

The urban-rural location of hospital-owned EDs was determined by the county in which the hospital was located. The categorization is based on Urban Influence Codes (UIC).[6] The 12 detailed UIC categories are combined into 4 broader categories:

- Large metropolitan area—areas with at least 1 million residents
- Small metropolitan area—areas with fewer than 1 million residents
- Micropolitan area—nonmetropolitan area with at least 10,000 people or more
- Nonurban residual.

If the stratum size in the universe or frame was fewer than two hospitals, a collapsed stratification of metropolitan (large and small), nonmetropolitan (micropolitan and nonurban residual), small metropolitan and micropolitan,[7] or all areas[8] was necessary.

Teaching Status

A hospital-owned ED is considered a teaching hospital if it has one or more Accreditation Council for Graduate Medical Education (ACGME)-approved residency program, is a member of the Council of Teaching Hospitals, or has a ratio of full-time equivalent interns and residents to beds of 0.25 or higher.

Hospital Ownership

Hospital ownership or control was categorized according to information reported in the AHA Annual Survey Database. The ownership categories include (1) public (government, non-

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[6] U.S. Department of Agriculture Economic Research Service. Urban Influence Codes. Last updated October 23, 2019. www.ers.usda.gov/data-products/urban-influence-codes.aspx. Accessed June 26, 2020.

[7] The collapsing of small metropolitan and micropolitan areas was required in the South in 2011–2015.

[8] The collapsing of all areas was required in the South in 2014.

Federal), (2) voluntary (private, not for profit), and (3) proprietary (private, investor owned/for profit).

When there were enough hospitals of each type, EDs were stratified into public, voluntary, and proprietary categories. If necessary, because of small stratum size in the universe, a collapsed stratification of public versus private was used; that is, the voluntary, nonprofit, and proprietary/for-profit hospitals were combined to form a single “private” category. Stratification based on ownership or control was not implemented in some regions (e.g., Northeast) because of the dominance of one hospital type.

Sample Weights

To enable nationwide estimates, weights were developed using the AHA universe as the standard. Two weights were developed to allow analysis of two distinct units of observation: facilities (hospital-owned EDs) and ED visits. Hospital-level weights expand the NEDS sample of EDs to represent the universe of hospital-owned EDs. Similarly, discharge-level weights expand the ED visits in the NEDS sample to represent the universe of ED visits.

Hospital Weights

Hospital weights were calculated by stratum. Hospital-owned EDs were stratified on the same variables that were used for sampling: geographic region, trauma center designation, urban-rural location, teaching status, and ownership or control. The strata that were collapsed for sampling were also collapsed for sample weight calculations. Within each stratum, *s*, each ED in the NEDS sample received a weight:

$$\text{HOSPWT} = W_s(\text{universe}) = N_s(\text{universe}) \div N_s(\text{sample})$$

where W_s(universe) was the ED universe weight, and N_s(universe) and N_s(sample) were the number of hospital-owned EDs within stratum *s* in the universe and sample, respectively. Thus, each hospital's universe weight (HOSPWT) is equal to the number of universe hospitals it represents during that year. Because 20 percent of the hospitals in each stratum were sampled when possible, the ED weights were usually near a value of 5.

Discharge Weights

Discharge weights were also calculated by stratum. Hospital-owned EDs were stratified in a manner similar to that for universe hospital-weight calculations. Within stratum *s* for hospital *i*, the universe weight for each visit in the NEDS sample was calculated as follows:

$$\text{DISCWT} = DW_{is}(\text{universe}) = [DN_s(\text{universe}) \div ADN_s(\text{sample})] * (4 \div Q_i)$$

where DW_{is}(universe) is the discharge weight; DN_s(universe) is the number of ED visits from community, non-rehabilitation hospitals in the universe within stratum *s*; ADN_s(sample) is the number of adjusted ED visits from sample hospitals selected for the NEDS; and Q_i represents the number of quarters of ED visits contributed by hospital *i* to the NEDS (usually $Q_i = 4$). Thus, each discharge’s weight (DISCWT) is equal to the number of universe ED visits it represents in stratum *s* during that year.

Final NEDS Sample

The target universe for the NEDS was: (1) community, non-rehabilitation hospital-owned EDs in the United States that were included in the 2024 AHA Annual Survey Database, and (2)

reported total ED visits. Excluded were 14 non-rural hospitals that reported fewer than 10 ED visits in data year 2024.

The 2024 NEDS sampling frame included hospital-owned ED visits from community, non-rehabilitation hospitals in the 40 HCUP Partner organizations that provided discharge abstracts on patients admitted to the hospital through the ED and on patients treated and released or transferred to another hospital from the ED. The HCUP hospitals were required to be represented in the AHA data and have no more than 90 percent of their ED visits resulting in admission. Appendix A, Table A6 lists the number of EDs and ED visits in the target universe, the sampling frame, and the sample.

Using the universe of U.S. hospital-owned EDs, strata were defined by region, trauma designation, urban-rural location, teaching status, and hospital ownership or control. Strata with fewer than two hospitals in the universe and frame were collapsed with adjacent strata on the dimensions of urban-rural location, trauma designation, or ownership or control. Prior to sampling, the list of frame hospitals within each stratum is sorted as follows to ensure geographic representation within strata: (1) sorted by the first three digits of the hospital's ZIP Code and (2) sorted by a random number within the three-digit ZIP Code.[9] After stratifying and sorting the frame hospitals, a random sample of up to 20 percent of the total number of hospital-owned EDs in the United States was selected within each stratum. A stratum with a shortfall was defined as having an insufficient number of EDs in the frame to meet the threshold of 20 percent of the universe for that stratum. In strata with shortfalls, the sampling rate from the universe was less than 20 percent and all possible EDs in the frame were selected for the NEDS. In contrast, the sampling rate is larger than 20 percent in some strata because protecting hospital confidentiality required a minimum of two sampled EDs in each stratum.

HOW TO USE THE 2024 NEDS FOR DATA ANALYSIS

This section provides a brief synopsis of special considerations for analyzing NEDS data. Before reporting findings using the NEDS, you should refer to the *Checklist for Working with the NEDS* (https://hcup-us.ahrq.gov/db/nation/neds/nedschecklist.jsp) to verify adherence to data use, methodology, and reporting requirements. For more details, refer to the comprehensive documentation on the NEDS Database Documentation page of the HCUP-US website.

AHRQ HCUP Data Use Agreement

Anyone accessing the NEDS (whether or not they are the original recipient of the data) must complete the online HCUP Data Use Agreement Training available on the HCUP-US website and then read and sign a Data Use Agreement. A copy of the signed Data Use Agreements must be sent to the HCUP Central Distributor through the CDORS website (https://cdors.ahrq.gov).

Limitations of the NEDS

The 2024 NEDS contains about 34 million ED visit records and more than 100 clinical and nonclinical data elements. A multitude of research studies can be conducted with the data, but there are some limitations.

[9] The ZIP Code of the hospital is not included in the NEDS data files.

The NEDS is an extremely large database that requires sophisticated statistical software for analysis and at least 300 GB of available computer space. The CSV version of the 2024 NEDS is 66 GB. When loaded into statistical software such as SAS or SPSS, the file size generally will increase. Refer to the *Computer Specifications Required for Using the NEDS.*

Some data elements in the NEDS may be missing for a given hospital. For example, some hospitals may not report total hospital charge on treat-and-release ED visits (TOTCHG_ED_2024 in data year 2024). National estimates of aggregate charges should be interpreted and reported with caveats about missing data.

Current Dental Terminology (CDT) codes are excluded from the NEDS Supplemental ED File because of inconsistent reporting of information across States.

The NEDS contains *encounter*-level records, not *patient*-level records. This means that individual patients who visit the ED multiple times in a year may be present in the NEDS multiple times. There is no uniform patient identifier available that would allow a patient-level analysis to identify individuals with more than one ED visit. (In contrast, other HCUP State databases may support this type of analysis.)

If a patient is directly admitted from the ED to the same hospital, one discharge record is included in the NEDS. If a patient is transferred from an ED to another ED, there would be two discharge records—one from the “transfer out” hospital and one from the receiving hospital. However, both of these records are included in the NEDS only if both hospitals were selected for inclusion in the NEDS sample. It is possible that only one of these two records is included in the NEDS if only one of the hospitals was sampled. This type of transfer (from an ED to another ED or acute care hospital) occurs in under 2 percent of the NEDS records.

For a patient who was directly admitted to the same hospital through the ED, clearly identifying whether a procedure was performed in the ED or as part of the inpatient stay is not currently possible. Information on procedures for ED admissions is stored in the NEDS Supplemental Inpatient File.

The reporting of outpatient surgery records that originate in the ED (e.g., fracture and dislocation procedures, appendectomies) can vary by State. These types of events are captured in the NEDS if they are included in the SEDD.

The NEDS is not linkable to other HCUP databases, does not intentionally contain the same hospitals as the HCUP Nationwide Inpatient Sample (NIS), and cannot be used for State-level analyses. In fact, States and the District of Columbia are not identified in the NEDS.

Identifying Different Types of ED Events

The HCUP data element *ED event* distinguishes among the different types of ED visits. Appendix A, Table A7 provides the number and percentage of records in the 2024 NEDS for each of the six ED event types.

Calculating National Estimates

To produce national estimates, weights MUST be applied to the sample.

The hospital weight (HOSPWT) should be used for producing nationwide hospital-level statistics for analyses that use the hospital-owned ED as the unit of analysis.

The discharge weight (DISCWT) should be used for producing nationwide visit-level statistics for analyses that use the ED visit as the unit of analysis.

Because the NEDS is a stratified sample, proper statistical techniques must be used to calculate standard errors and confidence intervals. For detailed instructions, refer to the HCUP Methods Series report #2003-02, *Calculating Nationwide Inpatient Sample (NIS) Variances for Data Years 2011 and Earlier*, on the HCUP-US website. The NEDS uses a stratified sampling design similar to the HCUP NIS prior to 2012, so techniques appropriate for the NIS prior to 2012 are also appropriate for the NEDS.

When creating national estimates, it is advisable to check results against other data sources, if available. Summary of independent benchmarks for NEDS estimates are in Appendix D. Other ED data sources include, for example, the National Hospital Ambulatory Medical Care Survey which has an ED component and publishes national health statistics annually.

To ensure that weights are applied appropriately and estimates and variances are calculated accurately, researchers can also access HCUPnet, the free online query system. HCUPnet is a web-based query tool for identifying, tracking, analyzing, and comparing statistics on hospitals at the national, regional, and State levels. HCUPnet offers easy access to national statistics and trends as well as selected State statistics about hospital stays, ED visits, and ambulatory surgeries. This tool provides step-by-step guidance, helping researchers quickly obtain the statistics they need. HCUPnet generates statistics from the HCUP databases.

Calculating National Estimates of Total Charge and Cost for Treat-and-Release ED Visits

Because of a change in the states available to participate in the 2024 NEDS and a need to produce accurate national estimates, the data element TOTCHG_ED_2024 includes two separate adjustments to the hospital charge for treat-and-release ED visits in the Western and Midwest regions. The adjustment is specific to the West and Midwest because the sampling of hospital-owned emergency departments in those regions are most impacted by the change in available data and practice patterns can vary substantially by region.

To estimate the national average charge for treat-and-release ED visits using the 2024 NEDS, use the data element TOTCHG_ED_2024 with the discharge weight (DISCWT). To estimate the national average cost for treat-and-release ED visits, use the data element TOTCHG_ED_2024, the NEDS Cost-to-Charge Ratio (CCR_NEDS), and the discharge weight (DISCWT). The CCR_NEDS is available in the separate file edcc2024NEDS.csv. First, merge the CCR_NEDS onto the NEDS Core file by the hospital identifier HOSP_ED. For each treat-and-release ED visit (identified by HCUPFILE="SEDD", multiply TOTCHG_ED_2024 by CCR_NEDS (TOTCHG_ED_2024 × CCR_NEDS) to estimate the hospital cost for that ED visit. Next, weight the data using DISCWT when calculating average cost. Information on the development of the HCUP CCRs for emergency department data is available online at HCUP Cost-to-Charge Ratios for Emergency Department Files.

Caution should be used when comparing 2024 total charges and cost to prior years. Weighted estimates within some characteristics (e.g., age, urban/rural location, expected payer) may be affected by differences in states included in the sampling frame of the NEDS.

Choosing Data Elements for Analysis

For any data element of interest, the analyst should first examine descriptive statistics such as the range of values and the number of missing values. Summary statistics are also available on the NEDS Summary Statistics page of the HCUP-US website. When anomalies (e.g., a large amount of missing values) are detected, descriptive statistics by region or by hospital (HOSP_ED) may be informative.

ICD-10-CM/PCS Diagnosis and Procedure Codes and CPT Procedure Codes

- The meaning of the first-listed diagnosis (DX1) differs depending on the type of ED visit. The first-listed diagnosis on an ED admission (SID record) is the condition principally responsible for the inpatient stay. The first-listed diagnosis on an ED treat-and-release visit (SEDD record) is the condition, problem, or symptom identified in the medical record to be chiefly responsible for the services provided. Secondary diagnoses reported on an inpatient admission from the ED may be from both the ED and inpatient hospital settings. It may be useful to compare diagnosis-specific ED visits that do not result in hospitalization to those resulting in hospitalization. Please refer to HCUP Methods Series Report #2011-03, *Special Study on the Meaning of the First-Listed Diagnosis on Emergency Department and Ambulatory Surgery Records*.
- ICD-10-CM diagnosis and ICD-10-PCS procedure codes provide valuable insights into the reasons for hospitalization and what procedures patients receive, but these codes need to be used and interpreted carefully. ICD-10-CM/PCS codes change every October as new codes are introduced, and some codes are retired. It is critical to check all ICD-10-CM/PCS codes used for analysis to ensure that the codes are in effect during the period studied.
- The 2024 NEDS contains fields for up to 40 diagnoses. External cause of morbidity codes are included at the end of the ICD-10-CM diagnosis array. To reduce the file size of the NEDS, the number of codes was limited. Less than 1 percent of all ED records report more codes than the maximum allowed on the NEDS.
- The 2024 NEDS contains fields for up to 15 ICD-10-PCS procedures and 50 CPT procedures per ED record, although the number of code fields populated varies across States because of reporting differences. Some States provide more than the maximum code fields retained on the NEDS.
- The collection and reporting of external cause of morbidity (V, W, X, and Y codes under ICD-10-CM) also vary across hospitals depending on the presence of State laws or mandates for the collection of these codes. Some States do not require hospitals to report codes for “misadventures to patients during surgical and medical care,” which means that these occurrences will be underreported.

Missing Values

Missing data values can compromise the quality of estimates. For example, if the outcome for ED visits with missing values differs from the outcome for ED visits with valid values, then estimates for that outcome will be biased and inaccurately represent the ED utilization patterns. Several techniques are available to help overcome this bias. One strategy is to use imputation to replace missing values with acceptable values. Another strategy is to use sample weight adjustments to compensate for missing values. Descriptions of such data preparation and adjustment are outside the scope of this report; however, it is recommended that researchers evaluate and adjust for missing data, if necessary.

Alternatively, if the cases with and without missing values are assumed to be similar with respect to their outcomes, no adjustment may be necessary for estimates of means and rates because the nonmissing cases would be representative of the missing cases. However, some adjustment may still be necessary for the estimates of totals. Sums of data elements (e.g., aggregate ED charges) containing missing values would be incomplete because cases with missing values would be omitted from the calculations. Estimates of the sum of charges can be

calculated as the product of the number of cases times the average charge to account for records with missing information.

Variance Calculations

It may be important for researchers to calculate a measure of precision for some estimates based on the NEDS sample data. Variance estimates must account for both the sampling design and the form of the statistic. The sampling design consisted of a stratified, single-stage cluster sample. A stratified random sample of hospital-owned EDs (clusters) was drawn, and then all ED visits were included from each selected hospital. **To accurately calculate variances from the NEDS, appropriate statistical software and techniques must be used.** For detailed instructions, refer to the HCUP Methods Series report #2003-02, *Calculating Nationwide Inpatient Sample (NIS) Variances for Data Years 2011 and Earlier*. Prior to 2012, the NIS used a stratified sample design similar to the NEDS, so techniques appropriate for the NIS prior to 2012 are also appropriate for the NEDS.

A multitude of statistics can be estimated from the NEDS data. Several computer programs that calculate statistics and their variances from sample survey data are listed in the next section. Some of these programs use general methods of variance calculations (e.g., the jackknife and balanced half-sample replications) that account for the sampling design. However, it may be desirable to calculate variances using formulas specifically developed for certain statistics.

Variance calculations that factor in the cluster and strata are based on finite-sample theory, which is an appropriate method for obtaining cross-sectional, nationwide estimates of outcomes. According to finite-sample theory, the intent of the estimation process is to obtain estimates that are precise representations of the nationwide population at a specific point in time. In the context of the NEDS, any estimates that attempt to accurately describe characteristics and interrelationships among hospitals and ED visits during a specific year should be governed by finite-sample theory. Examples would be estimates of expenditure and utilization patterns.

Alternatively, in the study of hypothetical population outcomes not limited to a specific point in time, the concept of a "superpopulation" may be useful. Analysts may be less interested in specific characteristics of the finite population (and period) from which the *sample* was drawn than they are in hypothetical characteristics of a conceptual superpopulation from which any particular finite *population* in a given year might have been drawn. According to this superpopulation model, the nationwide population in a given year is only a snapshot in time of the possible interrelationships between hospital, market, and discharge characteristics. In a given year, all possible interactions between such characteristics may not have been observed, but analysts may wish to predict or simulate interrelationships that may occur in the future.

Under the finite-population model, the variances of estimates approach zero as the sampling fraction approaches one. This is the case because the population is defined at that point in time and because the estimate is for a characteristic as it existed when sampled. The superpopulation model, in contrast, adopts a stochastic viewpoint rather than a deterministic viewpoint. That is, the nationwide population in a particular year is viewed as a random sample of some underlying superpopulation over time. Different methods are used for calculating variances under the two sample theories. The choice of an appropriate method for calculating variances for nationwide estimates depends on the type of measure and the intent of the estimation process.

Computer Software for Applying Weights and Calculating Variance

The hospital weights produce hospital-level statistics for analysis at the *hospital-owned ED* unit of analysis. In contrast, the discharge weights produce visit-level statistics for analysis that centers on the *ED visit* as the unit of analysis.

Variance estimates for commonly derived statistics (e.g., means, totals, basic regression model coefficients) can be derived using Taylor Series Linearization. Some more complex statistical modeling might require alternative methods such as the Jackknife, Bootstrap, or Balanced Repeated Replication. Commonly available statistical software packages that calculate statistics and their variances from sample survey data include:

- R, open-source programming language and environment.
    - Strengths: Extensive package ecosystem for statistical modeling, data visualization (e.g., ggplot2), and machine learning.
- Stata, commercially available statistical software
    - Strengths: User-friendly syntax, strong for econometrics, survey data analysis, and epidemiology.
- SAS, commercially available analytics suite.
    - Strengths: Highly reliable and validated for use in regulated industries (e.g., pharmaceutical, finance), efficient handling of large datasets.
- Python, open-source general-purpose programming language.
    - Strengths: Versatile, rich ecosystem of libraries (such as pandas, NumPy, scikit-learn, and statsmodels) for data analysis and machine learning.
- SPSS, commercially available statistical software
    - Graphical user interface with minimal coding needed, well-suited for descriptive statistics and basic modeling.

Examples of the use of SAS, SUDAAN, and Stata to calculate NIS variances are presented in the special report *Calculating Nationwide Inpatient Sample (NIS) Variances for Data Years 2011 and Earlier*. Although the examples using the NIS also apply to the NEDS, it should be noted that the NEDS is a much larger dataset. Please consult the documentation for the different software packages concerning the use of large databases. For a review of programs to calculate statistics from survey data, visit the Summary of Survey Analysis Software page on the Harvard Medical School website: https://hcp.med.harvard.edu/statistics/survey-soft/.

The NEDS includes a Hospital Weights File with variables required by these programs to calculate finite-population statistics. The file includes hospital identifiers (Primary Sampling Units), stratification variables, and stratum-specific totals for the number of ED visits and hospitals so that finite-population corrections can be applied to variance estimates.

In addition to these subroutines, standard errors can be estimated by validation and cross-validation techniques. Given that a very large number of observations will be available for most NEDS analyses, it may be feasible to set aside a part of the data for validation purposes. Standard errors and confidence intervals then can be calculated from the validation data.

If the analytic file is too small to set aside a large validation sample, cross-validation techniques may be used. For example, 10-fold cross-validation would split the data into 10 subsets of equal size. The estimation would take place in 10 iterations. In each iteration, the outcome of interest is predicted for one-tenth of the observations by an estimate based on a model that is fit to the other nine-tenths of the observations. Unbiased estimates of error variance are then obtained by comparing the actual values to the predicted values obtained in this manner.

COMPARABLE ED DATA SOURCES

To aid in understanding the NEDS, analysts can compare national estimates from the NEDS to other available data sources (Table 1). Each of the ED data sources in Table 1 has potential for use in research addressing ED utilization and policy.

Table 1. Sources of Emergency Department (ED) Data by Type

Type of ED Data	ED Data Source	Description
National inventories of EDs	AHA Annual Survey Database	Database containing characteristics and descriptions of hospitals in the United States reported by hospitals via survey. Owned by Health Forum.
	National Emergency Department Inventory – USA	Inventory of ED locations in the United States and annual ED visit volume that integrates information from the AHA Annual Survey Database, the Hospital Market Profiling Solution©, internet searches, and direct communication with hospital staff. Created by the Emergency Medicine Network.
ED visit information from a sample of Eds	HCUP Nationwide Emergency Department Sample	Nationwide sample drawn from the HCUP SID and SEDD, stratified and weighted to be nationally representative of ED visits and facilities. Sponsored by AHRQ.
	National Hospital Ambulatory Medical Care Survey	National probability sample survey of utilization and provision of ambulatory services in hospital emergency and outpatient departments. Sponsored by the National Center for Health Statistics of the CDC. The National Hospital Ambulatory Medical Care Survey ended in data year 2022.
	National Electronic Injury Surveillance System – All Injury Program	National probability sample providing counts of injuries seen in the ED. Sponsored by the National Center for Injury Prevention and Control of the CDC and the U.S. Consumer Product Safety Commission.
ED visit information from a sample of patients	National Health Interview Survey	A comprehensive survey of the civilian noninstitutionalized population residing in the United States at the time of the interview. Sponsored by the National Center for Health Statistics of the CDC.

Abbreviations: AHA, American Hospital Association; AHRQ, Agency for Healthcare Research and Quality; CDC, the Centers for Disease Control and Prevention; HCUP, Healthcare Cost and Utilization Project; SEDD, State Emergency Department Databases; SID, State Inpatient Databases.

Information on total ED visits in 2024 for the United States was available from three data sources (AHA, NEDS, and National Health Interview Survey). Appendix D, Figure D1 displays

the range of aggregate ED visits; Appendix D, Table D1 lists the total ED visits in the United States by census region. The total U.S. ED visit counts are relatively consistent across the data sources. The South consistently had the highest number of ED visits.

Estimates of the number of hospital-owned EDs by ED visit volume are available from two data sources (NEDS and AHA) and are displayed in Appendix D, Table D2.

Estimates of the number of ED visits related to nonfatal ED visits are available from two data sources (NEDS and National Electronic Injury Surveillance System – All Injury Program) and are displayed in Appendix D, Table D4.

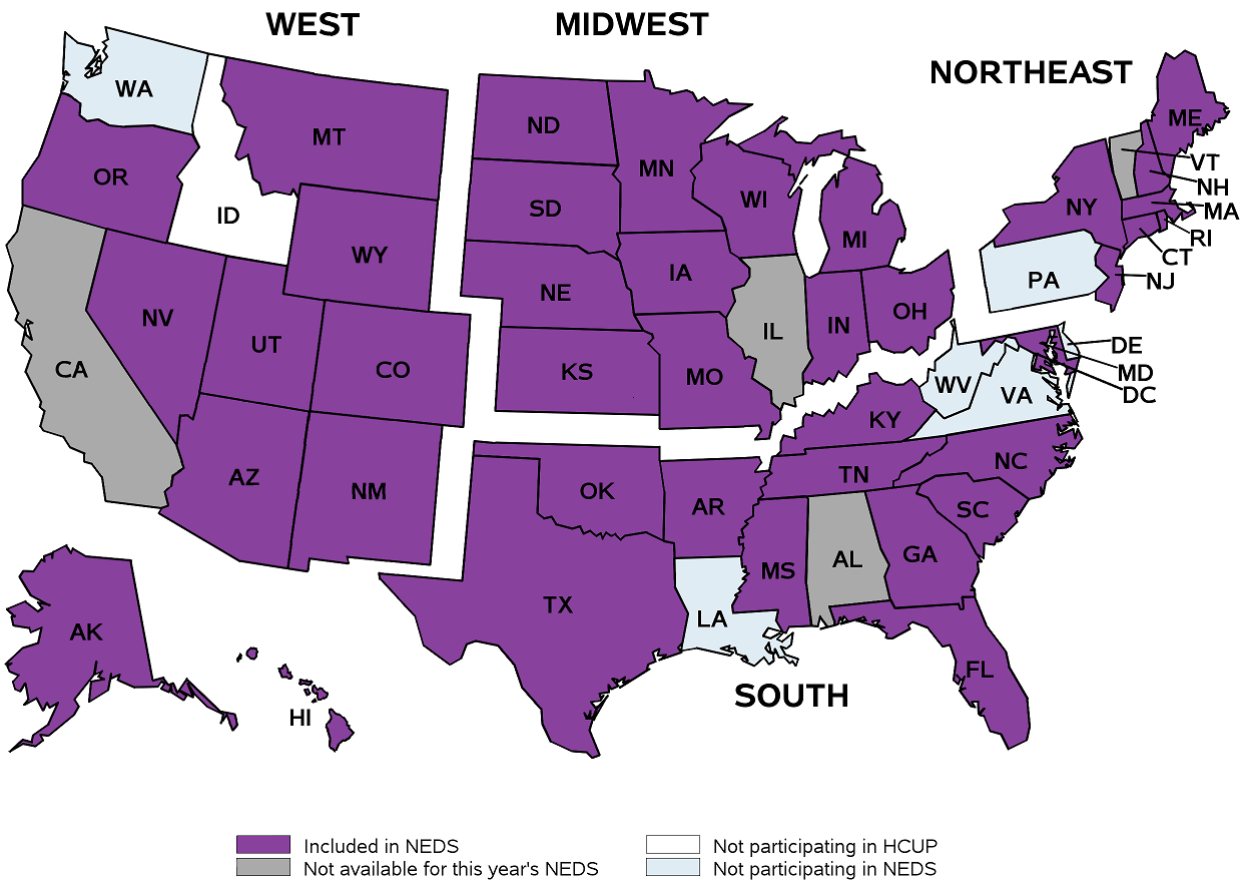
Appendix A: NEDS States, Sampling Strata and Rates, and Website Resources

Table A1. HCUP Partner Organizations Contributing SID and SEDD to the 2024 NEDS

State	Data Organization
AK	Alaska Department of Health
AR	Arkansas Department of Health
AZ	Arizona Department of Health Services
CO	Colorado Hospital Association
CT	Connecticut Hospital Association
DC	District of Columbia Hospital Association
FL	Florida Agency for Health Care Administration
GA	Georgia Hospital Association
HI	Hawaii Laulima Data Alliance
IA	Iowa Hospital Association
IN	Indiana Hospital Association
KS	Kansas Hospital Association
KY	Kentucky Cabinet for Health and Family Services
MA	Massachusetts Center for Health Information and Analysis
MD	Maryland Health Services Cost Review Commission
ME	Maine Health Data Organization
MI	Michigan Health and Hospital Association
MN	Minnesota Hospital Association
MO	Missouri Hospital Industry Data Institute
MS	Mississippi State Department of Health
MT	Montana Hospital Association
NC	North Carolina Department of Health and Human Services
ND	North Dakota (data provided by the Minnesota Hospital Association)
NE	Nebraska Hospital Association
NH	New Hampshire Department of Health & Human Services
NJ	New Jersey Department of Health
NM	New Mexico Department of Health
NY	New York State Department of Health
NV	Nevada Health Authority
OH	Ohio Hospital Association
OR	Oregon Association of Hospitals and Health Systems
OK	Oklahoma State Department of Health
RI	Rhode Island Department of Health
SC	South Carolina Revenue and Fiscal Affairs Office
SD	South Dakota Association of Healthcare Organizations
TN	Tennessee Hospital Association
TX	Texas Health Care Information Collection
UT	Utah Department of Health and Human Services
WI	Wisconsin Department of Health Services
WY	Wyoming Hospital Association

Abbreviation: NEDS, Nationwide Emergency Department Sample.

Figure A1. HCUP States and the District of Columbia Included in the 2024 NEDS



Abbreviations: HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample.

Data from HCUP Partner organizations in Alabama, California, Illinois, and Vermont are not available for the 2024 NEDS.

Represented populations from states included in the NEDS vary by Census region: 38.3 percent of the population in the West, 81.7 percent of the population in the Midwest, 83.9 percent of the population in the South, and 76.4 percent of the population in the Northeast. The data element indicating Census region (HOSP_REGION) is not included in the 2024 NEDS.

Table A2. Percentage of U.S. Population and AHA ED Visits in the 2024 NEDS by Census Region, Calculated using the Estimated U.S. Population on July 1, 2024.

Region	Population, 2024	Population Residing in NEDS States	Percent of Population Residing in NEDS States	Number of AHA ED Visits, 2024	Number of ED Visits in NEDS States	Percent of ED Visits in NEDS States
Northeast	57,940,522	44,248,153	76.4	26,746,780	20,154,784	75.4
Midwest	69,518,281	56,815,248	81.7	32,041,511	26,905,191	84.0
South	132,662,072	111,246,972	83.9	58,494,272	48,179,106	82.4
West	79,882,922	30,589,318	38.3	26,440,027	11,006,733	41.6
U.S.	**340,003,797**	**242,899,691**	**71.4**	**143,722,590**	**106,245,814**	**73.9**

Abbreviations: AHA, American Hospital Association; ED, emergency department; HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample.

Sources: Annual Estimates of the Resident Population for the United States, Regions, States, District of Columbia, and Puerto Rico: April 1, 2020 to July 1, 2025 (NST-EST2025-POP). U.S. Census Bureau, Population Division. Release Date: January 2026).

AHA ED visit counts from the American Hospital Association Annual Survey of Hospitals, 2024.

ED visit counts for NEDS States from the HCUP SID and SEDD.

The data element indicating Census region (HOSP_REGION) is not included in the 2024 NEDS.

Table A3. Number of States, Hospital-Owned Emergency Departments, and Records in the NEDS by Year

Data Year	Number of HCUP States in the NEDS	HCUP States in the NEDS	Number of Hospital-Owned EDs Sampled	Number of ED Visits in Sample (Unweighted)	Number of ED Visits, Weighted National Estimate
2024	40	AK, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NV, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, WI, and WY (Added NV; AL, CA, IL and VT data were not available)	939	33,534,546	143,722,590
2023	40	AK, AR, AZ, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OK, OR, RI, SC, SD, TN, TX, UT, WI, and WY (Added OK; CA, NV and VT data were not available)	963	31,003,348	142,193,558
2022	41	AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NM, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY (Added NM; NV data were not available	993	32,298,120	136,974,618
2021	40	AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY (NV data were not available)	993	30,099,368	126,968,321
2020	41	AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY	995	28,037,034	123,278,165
2019	41	AK, AR, AZ, CA, CO, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NH, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY (Added AK, HI, NH, and UT)	989	33,147,251	143,432,284
2018	37	AR, AZ, CA, CO, CT, DC, FL, GA, IA, IL, IN, KS, KY, MA, MD, ME, MI, MN, MO, MS, MT, NC, ND, NE, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, VT, WI, and WY (Added MI; UT data were not available)	990	35,807,950	143,454,430

Data Year	Number of HCUP States in the NEDS	HCUP States in the NEDS	Number of Hospital-Owned EDs Sampled	Number of ED Visits in Sample (Unweighted)	Number of ED Visits, Weighted National Estimate
2017	37	AR, AZ, CA, CO, CT, DC, FL, GA, IA, IL, IN, KS, KY, MA, MD, ME, MN, MO, MS, MT, NC, ND, NE, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY (Added CO; HI data were not available)	984	33,506,645	144,814,803
2016	37	AR, AZ, CA, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MN, MO, MS, MT, NC, ND, NE, NJ, NV, NY, OH, OR, RI, SC, SD, TN, TX, UT, VT, WI, and WY (Added OR and MS)	953	32,680,232	144,842,742
2015	35	AR, AZ, CA, CT, DC, FL, GA, HI, IA, IL, IN, KS, KY, MA, MD, ME, MN, MO, MT, NC, ND, NE, NJ, NV, NY, OH, RI, SC, SD, TN, TX, UT, VT, WI, and WY (Added TX)	953	31,465,407	143,469,670
2014	34	AR, AZ, CA, CT, DC, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, ME, MN, MO, MT, NC, ND, NE, NJ, NV, NY, OH, RI, SC, SD, TN, UT, VT, WI, and WY (Added DC, MT, and WY)	945	31,026,417	137,807,901
2013	30	AR, AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, MN, MO, NC, ND, NE, NJ, NV, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added AR; ME data were not available)	947	29,581,718	134,869,015
2012	30	AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, ME, MN, MO, NC, ND, NE, NJ, NV, NY, OH, RI, SC, SD, TN, UT, VT, and WI	950	31,091,029	134,399,179
2011	30	AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, ME, MN, MO, NC, ND, NE, NJ, NV, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added ND; NH data were not available)	951	29,421,411	131,048,605
2010	28	AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, MN, MO, NC, NE, NJ, NV, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added NV; ME and NH data were not available)	961	28,584,301	128,970,364

Data Year	Number of HCUP States in the NEDS	HCUP States in the NEDS	Number of Hospital-Owned EDs Sampled	Number of ED Visits in Sample (Unweighted)	Number of ED Visits, Weighted National Estimate
2009	29	AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, IL, MA, MD, ME, MN, MO, NC, NE, NH, NJ, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added IL)	964	28,861,047	128,885,040
2008	28	AZ, CA, CT, FL, GA, HI, IA, IN, KS, KY, MA, MD, ME, MN, MO, NC, NE, NH, NJ, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added KY)	980	28,447,148	124,945,264
2007	27	AZ, CA, CT, FL, GA, HI, IA, IN, KS, MA, MD, ME, MN, MO, NC, NE, NH, NJ, NY, OH, RI, SC, SD, TN, UT, VT, and WI (Added NC, NY, RI)	966	26,627,923	122,331,739
2006	24	AZ, CA, CT, FL, GA, HI, IA, IN, KS, MA, MD, ME, MN, MO, NE, NH, NJ, OH, SC, SD, TN, UT, VT, and WI	955	25,702,597	120,033,570

Abbreviations: ED, emergency department; HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample.

Table A4. AHRQ HCUP NEDS Related Reports and Database Documentation Available on the HCUP-US

Description of NEDS Database
• NEDS Overview
  ○ HCUP Partners in the NEDS
• Introduction to the NEDS, 2024 (*this document*) and prior years
• NEDS Related Reports
• Checklist for Working With the NEDS
Restrictions on Use
• HCUP Data Use Agreement Training
• Data Use Agreement for the HCUP Nationwide Databases
• Requirements for Publishing With HCUP Data
File Specifications and Load Programs
• NEDS File Specifications—details data file names, number of records, record length, and record layout
• Nationwide SAS Load Programs
• Nationwide SPSS Load Programs
• Nationwide Stata Load Programs
Data Elements
• NEDS Description of Data Elements—details uniform coding and State-specific idiosyncrasies
• NEDS Summary Statistics—lists means and frequencies on nearly all data elements
• Frequencies by Diagnosis and Procedure Codes, NEDS – includes frequency distributions for ICD-10-CM/PCS codes (individually and by the CCSR categories).
Additional Resources for NEDS Data Elements
• HCUP Quality Control Procedures—describes procedures used to assess data quality
• HCUP Coding Practices—describes how HCUP data elements are coded
• HCUP Hospital Identifiers—explains data elements that characterize individual hospitals
	ICD-10-CM/PCS Data Included in the NEDS Starting With 2015
	• NEDS Changes Beginning Data Year 2016
	• Caution: 2015 NEDS includes ICD-9-CM and ICD-10-CM/PCS
	  ○ 2015 NEDS Revised File Structure and New Data Elements
	• Additional ICD-10-CM/PCS Resources—contains documentation to assist with the transition to ICD-10-CM/PCS
	• HCUP Software Tools Tutorial
	Known Data Issues
	• 2022
	• 2011
	• 2006 and 2007
	HCUP Tools: Labels and Formats
	• Format Programs—to create value labels
	  ○ DRG Formats
	  ○ HCUP Formats
	  ○ HCUP Diagnoses and Procedure Groups Formats, including Clinical Classifications Software Refined (CCSR) categories
	  ○ ICD-9-CM Formats
	  ○ ICD-10-CM Formats
	Obtaining HCUP Data
	• Purchase HCUP Data from the HCUP Central Distributor

Abbreviations: DRG, diagnosis-related group; HCUP, Healthcare Cost and Utilization Project; HCUP-US, Healthcare Cost and Utilization Project User Support; ICD-9-CM, International Classification of Diseases, Ninth Revision, Clinical Modification; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NEDS, Nationwide Emergency Department Sample.

Table A5. NEDS Sampling Stratifiers

Stratifier	Values
Region	1: Northeast 2: Midwest 3: South 4: West
Trauma	0: Not a trauma center 1: Trauma center level I 2: Trauma center level II 3: Trauma center level III Collapsed categories used for sampling strata with small sample sizes 4: Non-trauma or trauma center level III (beginning in the 2011 NEDS) 7: Trauma center level II or III (beginning in the 2018 NEDS) 8: Trauma center level I or II (in all years of the NEDS) 9: Trauma center level I, II or III (only in the 2006–2010 NEDS)
Urban-Rural	1: Large metropolitan 2: Small metropolitan 3: Micropolitan 4: Nonurban residual Collapsed categories used for strata with small sample sizes 6: Any urban-rural location (used in the South in 2014) 7: Small metropolitan and micropolitan (used in the South in 2011–2015) 8: Metropolitan (large and small) 9: Nonmetropolitan (micropolitan and nonurban location)
Teaching	0: Metropolitan nonteaching 1: Metropolitan teaching 2: Nonmetropolitan teaching and nonteaching
Control	0: All (used for combining public, voluntary, and private) 1: Public—government, non-Federal 2: Voluntary—private, nonprofit 3: Proprietary—private, investor owned/for profit 4: Private (used for combining private voluntary and proprietary)

Abbreviation: NEDS, Nationwide Emergency Department Sample.

Table A6. Size of NEDS Target Universe, Sampling Frame, and Sample, 2024

Category	Description	Number of Hospital-Owned EDs, 2024	Number of ED visits, 2024
Target Universe	EDs in community, non-rehabilitation U.S. hospitals that reported total ED visits in the AHA Annual Survey Database	4,356	143,722,590
Sampling Frame	EDs in the 40 States and the District of Columbia that provide information on ED visits that result and do not result in admission	3,024	100,917,927
2024 NEDS	20 percent sample of target universe drawn from the sampling frame	939	33,534,546

Abbreviations: ED, emergency department; NEDS, Nationwide Emergency Department Sample.

Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Emergency Department Sample, 2024.

Table A7. Number and Percent of ED Visits by Discharge Status, NEDS 2024

Type of ED Visit Based on Discharge Status from the ED	Number of ED Visits	ED Visits, %
ED visit in which the patient was treated and released	118,764,528	82.63
ED visit in which the patient was admitted to the same hospital	21,917,910	15.25
ED visit in which the patient was transferred to another short-term hospital	2,657,805	1.85
ED visit in which the patient died in the ED	222,080	0.15
ED visit in which patient was not admitted to the same hospital, destination unknown	159,672	0.11
ED visit in which the patient was discharged alive, destination unknown (but not admitted)	594	<0.01
Total	143,722,590	100

Abbreviation: ED, emergency department; NEDS, Nationwide Emergency Department Sample.

Source: Agency for Healthcare Research and Quality, Healthcare Cost and Utilization Project, Nationwide Emergency Department Sample, 2024.

Appendix B: Partner-Specific Restrictions

Table B1 enumerates the types of restrictions applied to the 2024 Nationwide Emergency Department Sample. Restrictions include the following types:

- Confidentiality of hospitals
- Confidentiality of records
- Limited reporting of diagnosis codes for medical misadventures and adverse effects
- Missing discharges for specific populations of patients

Table B1. Partner-Specific Restrictions

Confidentiality of Hospitals

Limitations on sampling to ensure hospital confidentiality
• For a subset of Partners
  ○ Prior to collapsing strata: If there is a "unique" hospital in the State, it is excluded from sampling. *Unique* is defined as the only hospital in the State universe for a stratum. For example, if there is only one rural, nonteaching, trauma level III hospital in a State, then it is excluded from the sampling frame.
  ○ After sampling: Stratifier data elements are set to missing if the stratum had fewer than two hospitals in the universe of the State's hospitals.

Confidentiality of Records
Limitations on selected data elements to ensure patient confidentiality • Age (AGE) values greater than 90 are set to 90 for all NEDS records. • At least one Partner requires that ages in years (AGE) be set to the midpoints of age ranges. • At least one Partner requires that admission month (AMONTH) be set to missing on all records.
Limited Reporting of Diagnosis Codes for Medical Misadventures and Adverse Effects
At least one Partner removes diagnosis codes for medical misadventures and adverse effects from the data files supplied to HCUP.
Missing Information for Specific Populations of Patients

• ED visits related to HIV
  ○ At least one Partner excludes records for HIV patients from the files provided to HCUP. Therefore, these records are not included in the NEDS.
  ○ Alternatively, at least one Partner includes records for HIV patients in the data provided to HCUP but removes the diagnosis codes identifying HIV.
 	
• ED visits related to mental health and substance use disorders
  ○ At least one Partner restricts the release of select information for ED visits related to mental health disorders. Mental health diagnosis codes are reported, but these records will have a higher percentage of missing values for the following data elements than other conditions: patient location (PL_NCHS2), national income quartile of the patient's residence (ZIPINC_QRTL), admission month (AMONTH), and discharge quarter (DQTR).

- At least one Partner restricts the release of select information for ED visits related to mental health and substance use disorders. Related diagnosis codes are reported, but these records have a perturbed value of the ZIP Code used to assign the patient location (PL_NCHS2) and national income quartile of the patient's residence (ZIPINC_QRTL) and will be missing admission month (AMONTH), and discharge quarter (DQTR).

- At least one Partner excludes records for patients treated in two types of alternate level of care units: skilled nursing and swing bed. Therefore, these records are not included in the NEDS.

- At least one Partner masks the type of abortion (e.g., spontaneous, legally induced) by setting all abortion-specific diagnosis and procedure codes to "unspecified" abortions.

Abbreviations: HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample.

Appendix C: NEDS Data Elements and Codes

Table C1. Data Elements in the 2024 NEDS Core File

Type of Data Element	HCUP Data Element	Coding Notes
Admission timing	AWEEKEND	Admission on weekend: (0) admission on Monday through Friday, (1) admission on Saturday or Sunday
	AMONTH	Admission month coded from (1) January to (12) December
Age at admission	AGE	Age in years coded 0–90 years. Any ages greater than 90 were set to 90.
Diagnosis information	I10_DX1 – I10_DX40	ICD-10-CM diagnoses, with external cause of morbidity codes at the end of the array
	I10_NDX	Number of diagnoses coded on the original record received from Partner organizations
	I10_INJURY	ICD-10-CM initial injury diagnosis[a] reported: (0) no injury diagnoses reported, (1) injury is reported in first-listed diagnosis, (2) injury is reported in a diagnosis other than the first-listed diagnosis
	I10_MULTINJURY	Multiple ICD-10-CM initial injury diagnoses[a] reported: (0) one or no injury diagnosis reported, (1) more than one injury diagnosis reported, regardless of position
	I10_INJURY_CUT	External cause of morbidity codes indicating injury by cutting or piercing: (0) no injury by cutting or piercing, (1) injury by cutting or piercing
	I10_INJURY_DROWN	External cause of morbidity codes indicating injury by drowning or submersion: (0) no injury by drowning or submersion, (1) injury by drowning or submersion
	I10_INJURY_FALL	External cause of morbidity codes indicating injury by falling: (0) no injury by falling, (1) injury by falling
	I10_INJURY_FIRE	External cause of morbidity codes indicating injury by fire, flame, or hot object: (0) no injury by fire, flame, or hot object, (1) injury by fire, flame, or hot object
	I10_INJURY_FIREARM	External cause of morbidity codes indicating injury by firearm: (0) no injury by firearm, (1) injury by firearm
	I10_INJURY_MACHINERY	External cause of morbidity codes indicating injury by machinery: (0) no injury by machinery, (1) injury by machinery

Type of Data Element	HCUP Data Element	Coding Notes
	I10_INJURY_MVT	External cause of morbidity codes indicating injury involving motor vehicle traffic, including the occupant of a car, motorcyclist, pedal cyclist, pedestrian, or unspecified person: (0) no injury involving motor vehicle traffic, (1) injury involving motor vehicle traffic
	I10_INJURY_NATURE	External cause of morbidity codes indicating injury involving natural or environmental causes, including bites and stings: (0) no injury involving natural or environmental causes, (1) injury involving natural or environmental causes
	I10_INJURY_OVEREXERTION	External cause of morbidity codes indicating injury by overexertion: (0) no injury by overexertion, (1) injury by overexertion
	I10_INJURY_POISON	External cause of morbidity codes indicating injury by poisoning: (0) no injury by poisoning, (1) injury by poisoning
	I10_INJURY_STRUCK	External cause of morbidity codes indicating injury involving being struck by or against something: (0) no injury involving being struck by or against, (1) injury involving being struck by or against
	I10_INJURY_SUFFOCATION	External cause of morbidity codes indicating injury by suffocation: (0) no injury by suffocation, (1) injury by suffocation
	I10_INTENT_ASSAULT	External cause of morbidity codes indicating injury by assault: (0) no injury by assault, (1) injury by assault
	I10_INTENT_SELF_HARM	External cause of morbidity codes indicating intended self harm: (0) not intended self harm, (1) intended self harm
	I10_INTENT_UNINTENTIONAL	External cause of morbidity codes indicating injury was unintentional: (0) no unintentional injury, (1) unintentional injury
Discharge timing	DQTR	Discharge quarter coded: (1) January–March, (2) April–June, (3) July–September, (4) October–December
	YEAR	Calendar year of ED visits

Type of Data Element	HCUP Data Element	Coding Notes
Disposition of patient from the ED	DISP_ED	Disposition from ED: (1) routine; (2) transfer to short-term hospital; (5) other transfers, including skilled nursing facility, intermediate care, and another type of facility; (6) home health care; (7) against medical advice; (9) admitted as an inpatient to this hospital; (20) died in ED; (21) discharged/transferred to court/law enforcement; (98) not admitted, destination unknown; (99) discharged alive, destination unknown (but not admitted)
	DIED_VISIT	Died in ED: (0) did not die, (1) died in the ED, (2) died in the hospital
ED event	EDevent	Type of ED event: (1) ED visit in which the patient is treated and released, (2) ED visit in which the patient is admitted to the same hospital, (3) ED visit in which the patient is transferred to another short-term hospital, (9) ED visit in which the patient died in the ED, (98) ED visits in which patient was not admitted, destination unknown, (99) ED visit in which patient was discharged alive, destination unknown (but not admitted)
Sex of patient	FEMALE	Indicates sex: (0) male, (1) female
Race and ethnicity of patient	RACE	***Not available in the 2024 NEDS.***
Urban-rural location of the patient's residence	PL_NCHS2	Urban-rural designation for patient's county of residence: (21) Metropolitan counties (22) Non-metropolitan counties (including micropolitan and rural counties) *A similar data element PL_NCHS is available from 2013-2022 and PL_NCHS2006 from 2006-2012.*
National quartile for median household income of patient's ZIP Code	ZIPINC_QRTL	Median household income quartiles for patient's ZIP Code. Specific thresholds change by year and can be found at https://hcup-us.ahrq.gov/db/vars/zipinc_qrtl/nedsnote.jsp
Payer information	PAY1	Expected primary payer, uniform: (1) Medicare, (2) Medicaid, (3) private including HMO, (4) self-pay, (5) no charge, (6) other
	PAY2	Expected secondary payer, uniform: (1) Medicare, (2) Medicaid, (3) private including HMO, (4) self-pay, (5) no charge, (6) other

Type of Data Element	HCUP Data Element	Coding Notes
Total ED charges	TOTCHG_ED_2024	Total hospital charge for treat-and-release ED visits that (TOTCHG_ED_2024) includes two separate adjustments to the hospital charge for treat-and-release ED visits in the Western and Midwest regions. The adjustment is specific to the West and Midwest because the sampling of hospital-owned emergency departments in those regions are most impacted by the change in available data and practice patterns can vary substantially by region. TOTCHG_ED_2024 is missing for ED visits that result in an admission to the same hospital (identified by HCUPFILE="SID"). *Prior to data year 2023, total charges for ED services are included in the data element TOTCHG_ED. In data year 2023, the data element is TOTCHG_ED_2023.*
HCUP source file	HCUPFILE	Source of HCUP record: (SEDD) from SEDD file, (SID) from SID file
Discharge weight	DISCWT	Discharge weight used to calculate national estimates. Weights ED visits to AHA universe.
NEDS hospital identifier, synthetic	HOSP_ED	Unique HCUP NEDS hospital number—links to NEDS Hospital Weights file, but not to other HCUP databases. *The information on Census region, which was identified in the first digit, is excluded starting from data year 2023.*
NEDS stratum	NEDS_STRATUM	Stratum used to sample hospitals, based on geographic region, trauma, location/teaching status, and control. Stratum information is also contained in the Hospital Weights File. *Starting in data year 2023, the coding of NEDS_STRATUM is a sequential number. Prior to data year 2023, the digits in NEDS_STRATUM included information on geographic region, control, location/teaching status, and trauma designation.*
Record identifier, synthetic	KEY_ED	Unique HCUP NEDS record number—links to NEDS Supplemental Files but not to other HCUP databases. *The information on Census region is excluded starting from data year 2023. Prior to data year 2023, the first digit of KEY_ED identified the Census region.*

Abbreviations: ED, emergency department; HCUP, Healthcare Cost and Utilization Project; HMO, health maintenance organization; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification; NEDS, Nationwide Emergency Department Sample; SEDD, State Emergency Department Databases; SID, State Inpatient Databases.

Notes: For data years prior to 2024, refer to the NEDS Description of Data Elements page on the HCUP-US website or to previous versions of the Introduction to the NEDS.

[a] Injuries are identified by diagnosis codes in the Clinical Classifications Software Refined for ICD-10-CM categories of INJ001-INJ027 and INJ032. Injuries are limited to the initial encounter with a 7th character of A, B, C, or missing.

Table C2. Data Elements in the 2024 NEDS Supplemental ED File

Type of Data Element	HCUP Data Element	Coding Notes
CPT procedure information	CPT1–CPT50	CPT procedures performed in the ED
	CPTCCS1–CPTCCS50	Clinical Classifications Software category for all CPT procedures
	NCPT	Number of procedures coded on the original record. A maximum of 50 CPT codes are retained on the NEDS.
NEDS hospital identifier, synthetic	HOSP_ED	Unique HCUP NEDS hospital number—links to NEDS Hospital Weights File but not to other HCUP databases. *The information on Census region, which was identified in the first digit, is excluded starting from data year 2023.*
Record identifier, synthetic	KEY_ED	Unique HCUP NEDS record number—links to NEDS Supplemental Files but not to other HCUP databases. *The information on Census region, which was identified in the first digit, is excluded starting from data year 2023.*

Abbreviations: CPT, Current Procedural Terminology; ED, emergency department; HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample.

Notes: For data years prior to 2024, refer to the NEDS Description of Data Elements page on the HCUP-US website or to previous versions of the Introduction to the NEDS.

Table C3. Data Elements in the 2024 NEDS Supplemental Inpatient File

Type of Data Element	HCUP Data Element	Coding Notes
Disposition of patient from the hospital	DISP_IP	Disposition from hospital admission: (1) routine; (2) transfer to short-term hospital; (5) other transfers, including skilled nursing facility, intermediate care, and another type of facility; (6) home health care; (7) against medical advice; (20) died in hospital; (99) discharged alive, destination unknown
Diagnosis-related group (DRG)	DRG	DRG in use on discharge date
	DRG_NoPOA	DRG assignment made without the use of the present on admission flags for the diagnoses
	DRGVER	Grouper version in use on discharge date
	MDC	Major diagnostic category (MDC) in use on discharge date
	MDC_NoPOA	MDC in use on discharge date, calculated without the use of the present on admission flags for the diagnoses
Length of hospital inpatient stay	LOS_IP	Length of stay, edited
Total charges for inpatient stay	TOTCHG_IP	***Not available in the 2024 NEDS.***
ICD-10-PCS procedure information	I10_PR_IP1 – I10_PRI_IP15	ICD-10-PCS procedures coded on ED admissions. Procedure may have been performed in the ED or during the hospital stay.
	I10_NPR_IP	Number of procedures coded on the original record.
Data elements derived from the HCUP Software Tools for ICD-10-PCS Procedures	PCLASSn	Procedure Classes Refined for ICD-10-PCS procedure codes
	PCLASS_VERSION	Version of the Procedure Classes Refined for ICD-10-PCS procedure codes
	PRCCSR_APPROACH_aaannn[1]	Indication that at least one ICD-10-PCS procedure on the record is included in the Clinical Classification Software Refined (CCSR) aaannn and the procedure approach: (OA) ICD-10-PCS codes in this CCSR category are reported on the record and at least one reported procedure code is open approach; (MI) ICD-10-PCS codes in this CCSR category are reported on the record, no reported procedures are open approach, and at least one reported procedure code is minimally invasive; (NC) ICD-10-PCS codes in this CCSR category are reported on the record, but none are classified as either an open approach or a minimally invasive approach; (ZZ) ICD-10-PCS procedure codes in this CCSR category are not reported on the record.

[1] Where aaa denotes the clinical domain and nnn denotes the CCSR number within the clinical domain.

Type of Data Element	HCUP Data Element	Coding Notes
	PRCCSR_VERSION	Version of CCSR for ICD-10-PCS procedure codes
NEDS hospital identifier, synthetic	HOSP_ED	Unique HCUP NEDS hospital number—links to NEDS Hospital Weights File but not to other HCUP databases. *The information on Census region is excluded starting from data year 2023. Prior to data year 2023, the first digit of HOSP_ED identified the Census region.*
Record identifier, synthetic	KEY_ED	Unique HCUP NEDS record number—links to NEDS Supplemental Files but not to other HCUP databases. *The information on Census region is excluded starting from data year 2023. Prior to data year 2023, the first digit of KEY_ED identified the Census region.*

Abbreviations: ED, emergency department; HCUP, Healthcare Cost and Utilization Project; ICD-10-PCS, International Classification of Diseases, Tenth Revision, Procedure Coding System; NEDS, Nationwide Emergency Department Sample

Notes: For data years prior to 2024, refer to the NEDS Description of Data Elements page on the HCUP-US website or to previous versions of the Introduction to the NEDS.

Table C4. Data Elements in the 2024 NEDS Hospital Weights File

Type of Data Element	HCUP Data Element	Coding Notes
Discharge counts	N_DISC_U	Number of AHA universe ED visits in the stratum
	S_DISC_U	Number of sampled ED visits in the sampling stratum
	TOTAL_EDvisits	Total number of ED visits for this hospital in the NEDS
Weights	DISCWT	Discharge weight used to calculate national estimates. Weights ED visits to AHA universe.
	HOSPWT	Weight to hospital-owned EDs in AHA universe (i.e., total U.S.)
Discharge year	YEAR	Discharge year
Hospital counts	N_HOSP_U	Number of AHA universe hospital-owned EDs in the stratum
	S_HOSP_U	Number of sampled hospital-owned EDs in the stratum
NEDS hospital identifier, synthetic	HOSP_ED	Unique HCUP NEDS hospital number—links to NEDS Hospital Weights file, but not to other HCUP databases. *The information on Census region, which was identified in the first digit, is excluded starting from data year 2023.*
Hospital characteristics	HOSP_URCAT4	Hospital urban-rural location: (1) large metropolitan areas with at least 1 million residents; (2) small metropolitan areas with less than 1 million residents; (3) micropolitan areas; (4) not metropolitan or micropolitan. Collapsed categories used prior to data year 2023: (6) collapsed category of any urban-rural location; (7) collapsed category of small metropolitan and micropolitan; (8) metropolitan, collapsed category of large and small metropolitan; (9) nonmetropolitan, collapsed category of micropolitan and rural
	HOSP_CONTROL	Control/ownership of hospital: (1) government, non-Federal, public, (2) private, nonprofit, voluntary, (3) private, invest-own. Collapsed categories used prior to data year 2023: (0) government or private, collapsed category, (4) private, collapsed category
	HOSP_REGION	***Not available in the 2024 NEDS.***
	HOSP_TRAUMA	Trauma center level: (0) nontrauma center, (1) trauma level I, (2) trauma level II, (3) trauma level III. Collapsed categories used prior to data year 2023: (4) nontrauma or trauma level III, collapsed category beginning in the 2011 NEDS, (8) trauma level I or II, collapsed category, (9) trauma level I, II, or III, collapsed category in the 2006–2010 NEDS. Children's hospitals with trauma centers are classified with adult/pediatric trauma centers.
	HOSP_UR_TEACH	Teaching status of hospital: (0) metropolitan nonteaching, (1) metropolitan teaching, (2) nonmetropolitan

Type of Data Element	HCUP Data Element	Coding Notes
	NEDS_STRATUM	Stratum used to sample EDs, includes geographic region, trauma, location/teaching status, and control. *Starting in data year 2023, the coding of NEDS_STRATUM is a sequential number. Prior to data year 2023, the digits in NEDS_STRATUM included information geographic region, control, location/teaching status, and trauma designation.*

Abbreviations: AHA, American Hospital Association; ED, emergency department; HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample

For data years prior to 2024, refer to the NEDS Description of Data Elements page on the HCUP-US website or to previous versions of the Introduction to the NEDS.

Table C5. Data Elements in the 2024 NEDS Diagnosis and Procedure Groups File

Type of Data Element	HCUP Data Element	Coding Notes
Chronic Condition Indicator Refined (CCIR)	CCIR1-CCIR30	Indication that a diagnosis is a chronic condition or not a chronic condition, identified by the AHRQ CCIR for ICD-10-CM diagnosis codes
	CCIR_VERSION	Version of CCIR for ICD-10-CM diagnoses
Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses	DXCCSR_aaannn[2]	Indication that at least one ICD-10-CM diagnosis on the record is included in CCSR AAAnnn
	DXCCSR_Default_DX1	Default CCSR for principal/first-listed ICD-10-CM diagnosis
	DXCCSR_VERSION	Version of CCSR for ICD-10-CM diagnoses
Elixhauser Comorbidity Software Refined for ICD-10-CM	CMR_aaa[3]	Comorbidity measures (aaa) identified by the AHRQ Elixhauser Comorbidity Software Refined for ICD-10-CM diagnosis codes
	CMR_VERSION	Version of the Elixhauser Comorbidity Measure Refined for ICD-10-CM
NEDS identifiers, synthetic	HOSP_ED	Unique HCUP NEDS hospital number—links to NEDS Hospital Weights File but not to other HCUP databases. *The information on Census region, which was identified in the first digit, is excluded starting from data year 2023.*
	KEY_ED	Unique HCUP NEDS record number—links to NEDS Core and Supplemental Files but not to other HCUP databases. *The information on Census region is excluded starting from data year 2023. Prior to data year 2023, the first digit of KEY_ED identified the Census region.*

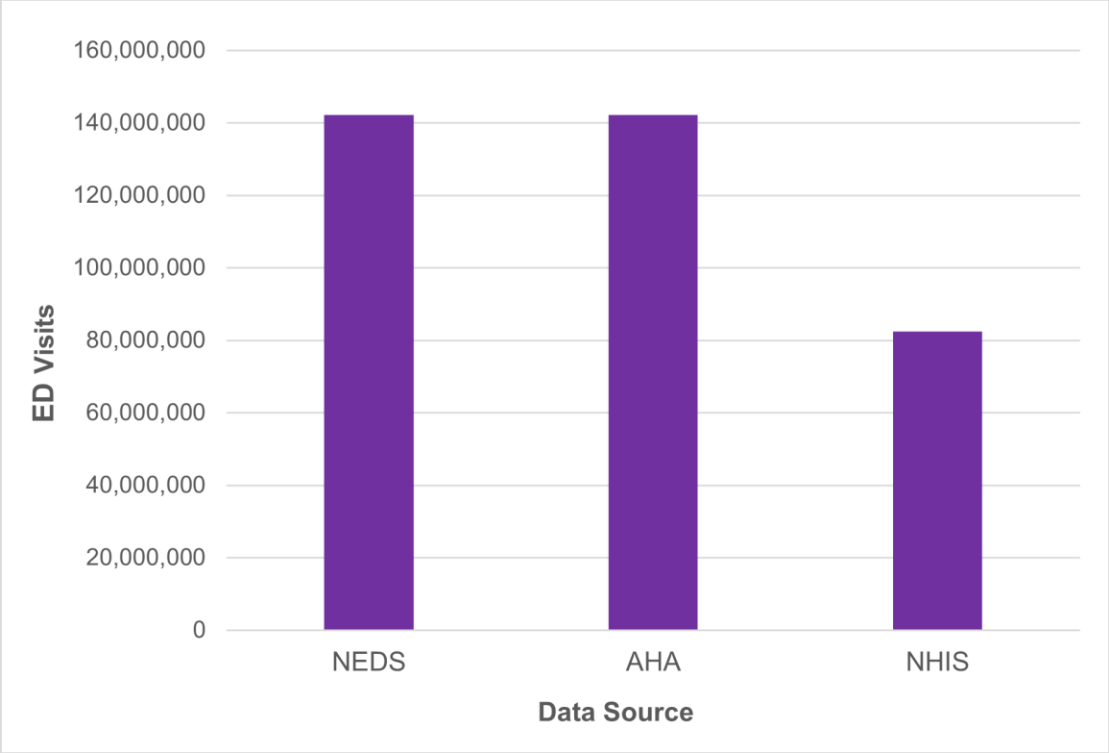
Abbreviations: AHA, American Hospital Association; ED, emergency department; HCUP, Healthcare Cost and Utilization Project; NEDS, Nationwide Emergency Department Sample

For data years prior to 2024, refer to the NEDS Description of Data Elements page on the HCUP-US website or to previous versions of the Introduction to the NEDS.

[2] Where aaa denotes the body system and nnn denotes the CCSR number within the body system.
[3] Where aaa denotes the specific comorbidity measure.

Appendix D: Comparisons of the NEDS With Other Sources of ED Data

Figure D1. Number of Emergency Department (ED) Visit in the U.S., by Data Source, 2024



Abbreviations: NEDS, Nationwide Emergency Department Sample; AHA, American Hospital Association Annual Survey Database; NHIS, National Health Interview Survey

Table D1. Number and Percent of Emergency Department (ED) Visits in the U.S., by Census Region and Data Source, 2024

Region	NEDS[1]		AHA		NHIS[2]	
	Number of Visits (weighted)	Percent of Visits	Number of Visits	Percent of Visits	Number of Visits	Percent of Visits
Northeast	26,746,780	18.6	26,746,780	18.6	14,522,352	16.7
Midwest	32,041,511	22.3	32,041,511	22.3	17,261,756	20.3
South	58,494,272	40.7	58,494,272	40.7	34,536,718	41.2
West	26,440,027	18.4	26,440,027	18.4	18,588,820	21.8
Total U.S.	143,722,590	100.0	143,722,590	100.0	84,909,646	100.0

Abbreviations: NEDS, Nationwide Emergency Department Sample; AHA, American Hospital Association Annual Survey Database; NHIS, National Health Interview Survey.

The data element indicating census region (HOSP_REGION) is not included in the 2024 NEDS.

[1] NEDS weighted counts by geographic region exactly match the AHA counts because the AHA data were used as control totals for the NEDS discharge weights.

[2] NHIS estimates were calculated using the values provided in the survey (0, 1, 2, 3, 4+). For the upper range of visits in the survey (4 or more ED visits), 4 ED visits were used for the estimate.

Table D2. Distribution of Hospital-Owned Emergency Departments (ED) by Number of Visits, NEDS and AHA, 2024

Volume of ED Visits	NEDS		AHA	
	Number of EDs (weighted)	Percent of EDs	Number of EDs	Percent of EDs
Less than 10,000 visits	1,422	32.6	1,502	34.5
10,000 - 19,999 visits	684	15.7	723	16.6
20,000 - 29,999 visits	546	12.5	483	11.1
30,000 - 39,999 visits	400	9.2	394	9.0
40,000 - 49,999 visits	259	5.9	263	6.0
50,000 or more visits	1,045	24.0	991	22.8
All Hospital-based EDs	4,356	100.0	4,356	100.0

Abbreviations: NEDS, Nationwide Emergency Department Sample; AHA, American Hospital Association Annual Survey Database.

Table D3. Number of and Percent of ED Visits Resulting in Inpatient Admission in the U.S., by Census Region, NEDS, 2024

Region	Number of ED Visits (weighted)	Number of ED Visits Resulting in Admission (weighted)	Percent of ED Visits Resulting in Admission
Northeast	26,746,780	4,629,142	17.3
Midwest	32,041,511	4,403,810	13.7
South	58,494,272	9,256,421	15.8
West	26,440,027	3,628,538	13.7
Total U.S.	**143,722,590**	**21,907,910**	**15.3**

Abbreviations: NEDS, Nationwide Emergency Department Sample.

The data element indicating Census region (HOSP_REGION) is not included in the 2024 NEDS.

Table D4. Number of Injuries by Type of Injury-Related ED Visit, NEDS and NEISS-AIP, 2024

Type of Injury-Related- ED Visit	NEDS (All Injuries)[a]		NEDS (Initial Encounter for Injuries)[b]		NEISS-AIP[c]	
	Number of Visits (weighted)	95% CI	Number of Visits (weighted)	95% CI	Number of Visits (weighted)	95% CI
Total number of ED visits for nonfatal injuries	27,292,884	(26,013,456 – 28,572,313)	26,592,180	(25,356,956 – 27,827,404)	31,674,123	(27,430,000 – 35,920,000)
Treated and released from ED	23,461,105	(22,350,696 – 24,571,514)	22,889,650	(21,817,249 – 23,962,050)	26,009,138	(22,540,000 – 29,480,000)
Admitted to the same hospital	3,012,306	(2,819,352 – 3,205,260)	2,897,219	(2,711,244 – 3,083,193)	3,831,349	(2,910,000 – 4,750,000)
Transferred	542,622	(511,225 – 574,019)	535,440	(504,531 – 566,350)	743,485	(603,965 – 883,004)
Other[d]	276,852	(255,077 – 298,627)	269,871	(248,714 – 291,028)	1,090,152	(833,514 – 1,350,000)

Abbreviations: NEDS, Nationwide Emergency Department Sample; NEISS-AIP, National Electronic Injury Surveillance System All-Injury Program; CI, confidence interval.

[a] Injuries are identified by diagnosis codes in the Clinical Classifications Software Refined for ICD-10-CM categories of INJ001-INJ027 and INJ032.

[b] Initial encounters are limited to ICD-10-CM diagnoses with a 7th character of A, B, C, or missing.

[c] Data from the Web-based Injury Statistics Query and Reporting System (WISQARS™) (WISQARS Fatal and Nonfatal Injury Reports). Includes nonfatal, all-cause injuries. Patients who died on arrival to the ED or during treatment in the ED are excluded. Queried on October 1, 2026.

[d] The types of ED visits included under Other differ by data source. For the NEISS-AIP, “Other” includes left against medical advice, sent for observations, and unknown destination. For the NEDS, “Other” only includes left against medical advice.