

STATISTICAL BRIEF #174

June 2014

Overview of Emergency Department Visits in the United States, 2011

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Introduction

Emergency departments (EDs) provide a significant source of medical care in the United States, with over 131 million total ED visits occurring in 2011.¹ Over the past decade, the increase in ED utilization has outpaced growth of the general population, despite a national decline in the total number of ED facilities.^{2,3} In 2009, approximately half of all hospital inpatient admissions originated in the ED.⁴ In particular, EDs were the primary portal of entry for hospital admission for uninsured and publicly insured patients (privately insured patients were more likely to be directly admitted to the hospital from a doctor's office or clinic).⁵

ED utilization reflects the greater health needs of the surrounding community and may provide the only readily available care for individuals who cannot obtain care elsewhere.⁶ Many ED visits are "resource sensitive" and potentially preventable, meaning that access to high-quality, community-based health care can prevent the need for a portion of ED visits.

This HCUP Statistical Brief presents data on ED visits in the United States in 2011. Patient and hospital characteristics for two types of ED visits are provided: ED visits with admission to the same hospital and ED visits resulting in discharge, which includes patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition. The most frequent conditions treated by patient age group also are presented for both types of ED visits. All differences between estimates noted in the text are statistically significant at the .0005 level or better.

¹ HCUPnet. 2011 National Statistics, All ED Visits.
<http://hcupnet.ahrq.gov/HCUPnet.jsp>.
Accessed May 7, 2014.

² Tang N, Stein J, Hsia RY, Maselli JH, Gonzales R. Trends and characteristics of US emergency department visits, 1997–2007. *Journal of the American Medical Association*. 2010;304(6):664–70.

³ Goodell S, DeLia D, Cantor JC. Emergency Department Utilization and Capacity. 2009, Robert Wood Johnson Foundation Policy Brief No. 17. Princeton, NJ: Robert Wood Johnson Foundation.
http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2009/rwjf43566. Accessed May 7, 2014.

⁴ Morganti-Gonzalez K, Baufman S, Blanchard J, Abir M, Iyer N, Smith A, et al. The Evolving Role of Emergency Departments in the United States. RAND RR 280-ACEP. Santa Monica, CA: Rand Corp; May 2013.

⁵ Ibid. Note: excludes live births.

⁶ Tang et al., 2010.

Highlights

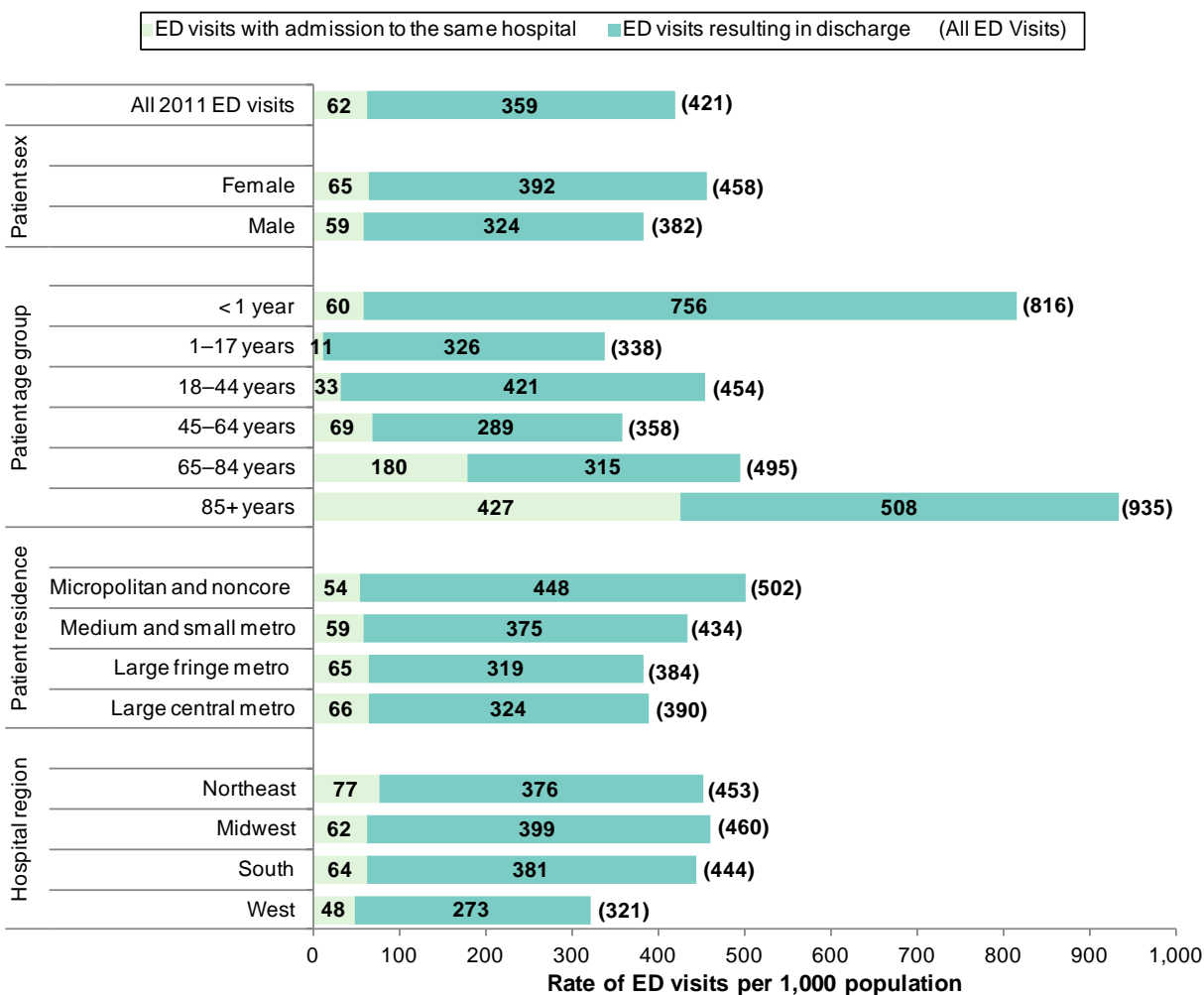
- In 2011, there were about 421 visits to the emergency department (ED) for every 1,000 individuals in the population.
- More than five times as many individuals who visited an ED were discharged as were admitted to the same hospital.
- Among patients younger than 18 years, the most common reasons for admission to the hospital after an ED visit were acute bronchitis (infants younger than 1 year), asthma (patients aged 1–17 years), and pneumonia (infants and patients aged 1–17 years).
- For adults aged 45–84 years, septicemia (infection in the bloodstream) was the most frequent reason for admission to the hospital after an ED visit.
- Medicare was the primary payer for more than half of ED visits that resulted in admission to the same hospital.
- The most common reasons for ED visits resulting in discharge were fever and otitis media (infants and patients aged 1–17 years), superficial injury (all age groups except infants), open wounds of the head, neck, and trunk (patients aged 1–17 years and adults aged 85+ years), nonspecific chest pain (adults aged 45 years and older), and abdominal pain and back pain (all adult age groups except those aged 85+ years).
- Rural areas had a higher rate of ED visits resulting in discharge compared with urban areas.

Findings

Emergency department visits by selected patient and hospital characteristics, 2011

In 2011, rates of ED visits varied by the patient's sex, age group, residence, and hospital region (Figure 1).

Figure 1. Rate of emergency department visits by the patient's sex, age group, residence, and hospital region, 2011



Note: "ED visits resulting in discharge" includes patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2011

- **In 2011, more than five times as many individuals who visited the ED were discharged as were admitted to the same hospital.**

Overall, in 2011 there were 421 ED visits per 1,000 population. More than five times as many individuals who visited the ED were discharged (359 per 1,000 population) as were admitted to the same hospital (62 per 1,000 population).

- **Overall, females had about a 20 percent higher rate of ED visits than males.**

Females had a higher overall rate of ED visits than males (458 versus 382 per 1,000 population). The rate of ED visits that resulted in discharge was over 20 percent higher for females than males (392 versus 324 per 1,000 population).

- **Infants younger than 1 year and adults aged 85 years and older had the highest rate of ED visits, but the older adults were far more likely to be admitted to the same hospital.**

Infants and adults aged 85 years and older had the highest rate of ED visits overall (816 and 935 per 1,000 population, respectively) and the highest rate of ED visits that resulted in discharge (756 and 508 per 1,000 population, respectively). Adults aged 65–84 years and adults aged 85 years and older had the highest rates of ED visits with admission to the same hospital (180 and 427 per 1,000 population, respectively).

Among infants younger than 1 year and patients aged 1–17 years and 18–44 years, fewer than 10 percent of all ED visits resulted in admission to the same hospital (7.4 percent, 3.3 percent, and 7.3 percent, respectively). The proportion of ED visits with admission to the same hospital increased as age increased among the following groups: 45–64 years (19.3 percent), 65–84 years (36.4 percent), and 85 years and older (45.7 percent).

- **Rural areas had the highest rate of ED visits resulting in discharge.**

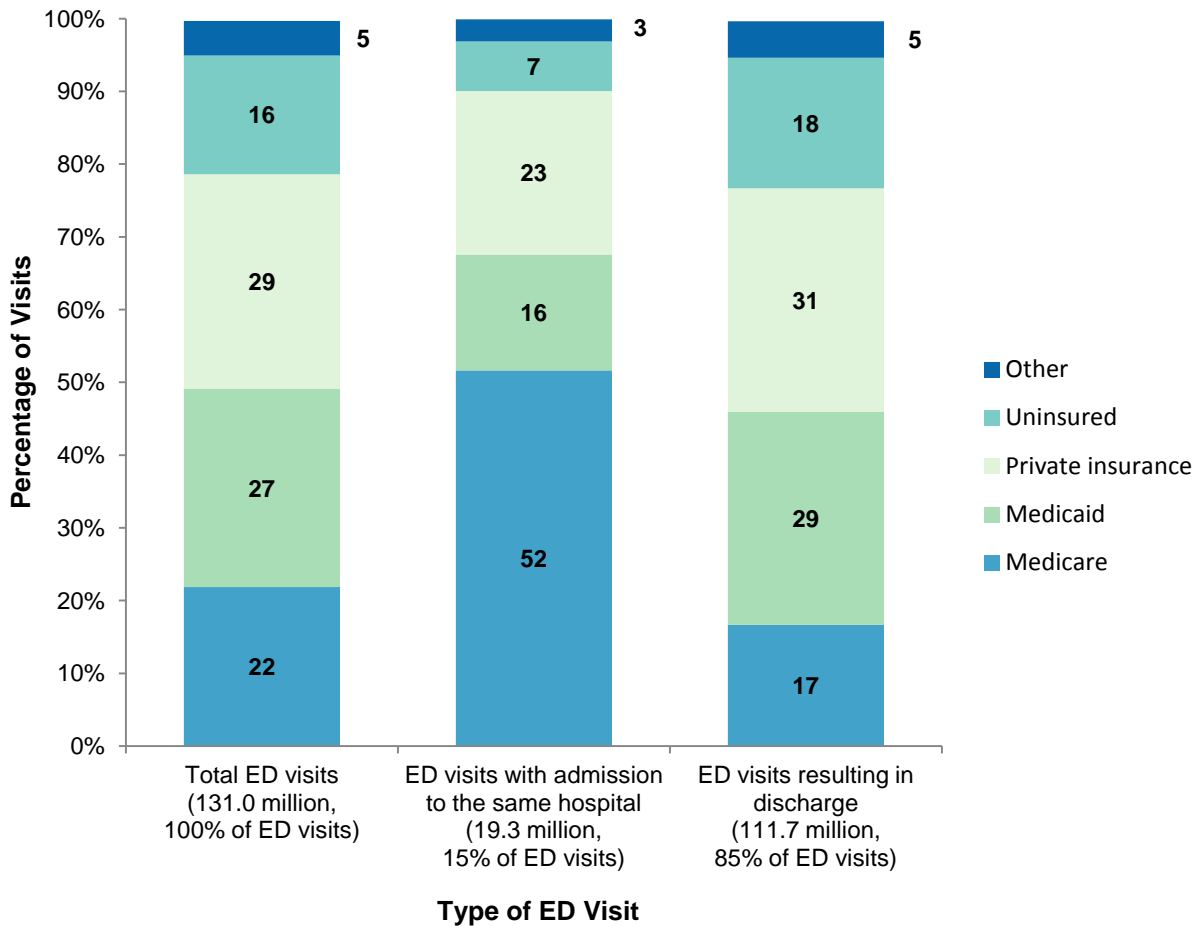
Rural areas (micropolitan and noncore areas) had the highest rate of ED visits that resulted in discharge in 2011 (448 per 1,000 population) compared with urban areas: medium and small metropolitan areas (375), large metropolitan counties (319), and large metropolitan cities (324). ED visits with admission to the same hospital did not differ substantially by patient residence.

- **Western States had the lowest rate of ED visits.**

Western States had the lowest rate of ED visits overall (321 per 1,000 population) compared with the other three U.S. regions: South (444), Midwest (460), and Northeast (453). The lower ED visit rate in the West occurred for ED visits with admission to the same hospital (48 per 1,000 population) and ED visits resulting in discharge (273 per 1,000 population).

The proportions of ED visits that were attributable to each expected primary payer are provided in Figure 2.

Figure 2. Proportions of emergency department visits by expected primary payer, 2011



Note: "ED visits resulting in discharge" includes patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2011

- **Among all ED visits in 2011, private insurance and Medicaid were the most common expected primary payers.**

Of the 131 million total ED visits in 2011, 29 percent were billed to private insurance, 27 percent to Medicaid, and 22 percent to Medicare. For 16 percent of all ED visits, there was no insurance coverage.

- **For ED visits with admission to the same hospital, Medicare was the most common primary payer.**

Medicare was billed for 52 percent of the 19.3 million ED visits that resulted in admission to the same hospital in 2011. Private insurance was the second most common primary expected payer, billing for 23 percent of all ED visits that resulted in hospital admission, followed by Medicaid, which was billed for 16 percent of these ED visits. Approximately 7 percent of ED visits with admission to the same hospital were not covered by any insurance.

■ For ED visits resulting in discharge, nearly one-fifth were uninsured.

Fully 18 percent of the 111.7 million ED visits that resulted in discharge had no insurance coverage. Private insurance and Medicaid were the most common primary payers for these ED visits (31 percent and 29 percent, respectively).

Reasons for emergency department visits by patient age group, 2011

Tables 1 and 2 provide the most common principal conditions identified in 2011 for admission to the same hospital after an ED visit (Table 1) and ED visits resulting in discharge (Table 2) by patient age group.

Table 1. Top five principal conditions for admission to the same hospital after an emergency department visit, by age group, 2011

Principal condition ^a	Number and rank ^b of ED visits with admission to the same hospital, by age group											
	<1 year		1–17 years		18–44 years		45–64 years		65–84 years		85+ years	
	n	Rank	n	Rank	n	Rank	n	Rank	n	Rank	n	Rank
Total ED visits with admission to the same hospital	238,317		799,637		3,734,009		5,679,839		6,421,521		2,449,425	
Acute bronchitis	52,200	1										
Pneumonia (except that caused by tuberculosis and sexually transmitted diseases)	17,600	2	69,400	2			203,500	3	328,000	3	149,400	3
Urinary tract infections	11,900	3									125,400	4
Fever of unknown origin	7,900	4										
Hemolytic jaundice and perinatal jaundice	7,700	5										
Asthma			76,900	1								
Appendicitis and other appendiceal conditions			59,200	3								
Mood disorders			37,400	4	226,300	1						
Skin and subcutaneous tissue infections			33,300	5	133,700	3	161,800	5				
Diabetes mellitus with complications					134,200	2						
Schizophrenia and other psychotic disorders					120,400	4						
Biliary tract disease					116,300	5						
Septicemia (except in labor)							237,500	1	392,700	1	167,500	2
Nonspecific chest pain							233,200	2				
Chronic obstructive pulmonary disease and bronchiectasis							198,500	4	309,000	4		
Congestive heart failure, nonhypertensive									350,100	2	190,500	1
Cardiac dysrhythmias									278,600	5		
Fracture of neck of femur (hip)											105,600	5

^a Principal conditions are based on the first-listed diagnosis on the hospital discharge record and are classified using AHRQ's Clinical Classifications Software (CCS). Two general CCS "other" conditions are not reported in the table for infants aged <1 year: other perinatal conditions (26,200 ED visits) and other upper respiratory infections (8,200 ED visits). "Other" CCS categories include miscellaneous, otherwise unclassifiable diagnoses that may be difficult to interpret as a group.

^b Rank of the principal condition by number of ED visits within each age group

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NIS), 2011

- **The five most common reasons for admission to the same hospital after an ED visit constituted between 18.2 percent and 40.8 percent of the ED visits, depending on the patient's age group.**

In 2011, the five most common principal conditions accounted for 40.8 percent of all infant admissions to the same hospital after an ED visit. The five top-ranked reasons constituted about one-third of the admissions after an ED visit among patients aged 1–17 years (34.5 percent) and adults aged 85 years and older (30.1 percent). The most frequent principal conditions accounted for one-fourth or less of the admissions after an ED visit among adults aged 18–44 years (19.6 percent), 45–64 years (18.2 percent), and 65–84 years (25.8 percent).

- **Pneumonia and other respiratory conditions were top-ranked reasons for admission to the same hospital after an ED visit for all age groups except those aged 18–44 years.**

In 2011, pneumonia was either the second or third most common reason for admission to the same hospital after an ED visit for all age groups except adults aged 18–44 years (pneumonia was the ninth most common condition in this age group, data not shown).

Other respiratory conditions also were common for most age groups. Acute bronchitis was the most common reason for admission to the same hospital after an ED visit for infants, and asthma was the most common diagnosis for patients aged 1–17 years. Chronic obstructive pulmonary disease and bronchiectasis was the fourth most common reason for admission to the same hospital after an ED visit for adults aged 45–64 years and 65–84 years.

- **Septicemia and cardiac conditions were top reasons for admission to the same hospital after an ED visit among adults aged 45 years and older.**

Septicemia was the most common reason for admission to the same hospital after an ED visit among adults aged 45–64 years and 65–84 years. Septicemia also was the second most common diagnosis among adults aged 85 years and older.

Congestive heart failure was the top-ranked reason for admission to the same hospital after an ED visit among adults aged 85 years and older and the second most common reason among adults aged 65–84 years. Other cardiac conditions also were common: nonspecific chest pain was the second most common reason for admission to the same hospital after an ED visit among adults aged 45–64 years, and cardiac dysrhythmias were the fifth most common reason among those aged 65–84 years.

- **Mood disorders were a common type of diagnosis among younger patients admitted to the same hospital after an ED visit.**

A mood disorders diagnosis was the most common reason for admission to the same hospital after an ED visit among adults aged 18–44 years. Schizophrenia and other psychotic disorders also were common among this age group, ranking fourth among reasons for admission to the same hospital. Mood disorders were the fourth most common type of diagnosis among patients aged 1–17 years.

Table 2. Top five principal conditions for emergency department visits resulting in discharge, by age group, 2011

Principal condition ^a	Number and rank ^b of ED visits resulting in discharge, by age group											
	<1 year		1–17 years		18–44 years		45–64 years		65–84 years		85+ years	
	n	Rank	n	Rank	n	Rank	n	Rank	n	Rank	n	Rank
Total ED visits resulting in discharge^c	3,021,782		22,819,322		47,788,338		23,953,917		11,220,150		2,915,116	
Fever of unknown origin	269,900	1	842,400	5								
Otitis media and related conditions	266,200	2	1,266,500	2								
Acute bronchitis	181,000	3										
Viral infections	145,600	4										
Nausea and vomiting	121,300	5										
Superficial injury, contusion			1,575,900	1	2,178,700	3	1,066,500	5	565,800	2	213,400	1
Open wounds of head, neck, and trunk			1,142,600	3							96,200	4
Sprains and strains			1,061,100	4	3,181,700	1	1,350,800	2				
Abdominal pain					2,958,300	2	1,197,600	4	425,200	3		
Spondylosis, intervertebral disc disorders, other back problems					1,827,600	4	1,200,600	3	368,000	4		
Headache, including migraine					1,770,000	5						
Nonspecific chest pain							1,525,200	1	643,000	1	117,200	3
Urinary tract infections									359,900	5	127,100	2
Open wounds of extremities											82,800	5

^a Principal conditions are based on the first-listed diagnosis on the ED visit record and are classified using AHRQ's Clinical Classifications Software (CCS). General CCS "other" conditions are not reported in the table and include the following conditions by age group: other upper respiratory infections (<1 year: 540,700 ED visits; 1–17 years: 2,550,600 ED visits; 18–44: 1,926,500 ED visits); other perinatal conditions (<1 year: 151,400 ED visits); other injuries and conditions due to external causes (1–17 years: 1,075,500 ED visits; 85+ years: 126,200 ED visits). "Other" CCS categories include miscellaneous, otherwise unclassifiable diagnoses that may be difficult to interpret as a group.

^b Rank of the principal condition by number of ED visits within each age group

^c "ED visits resulting in discharge" include patients who were stabilized in the ED and then discharged home, transferred to another hospital, or any other disposition.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NIS), 2011

■ **The five most common reasons for ED visits resulting in discharge constituted between 21.1 percent and 32.6 percent of the ED visits, depending on the patient's age group.**

In 2011, the five top-ranked principal conditions accounted for 32.6 percent of all ED visits for infants that resulted in discharge. The five most common reasons constituted about one-fourth of ED visits among patients aged 1–17 years (25.8 percent), adults aged 18–44 years (24.9 percent), and adults aged 45–64 years (26.5 percent). The most frequent principal conditions accounted for about one-fifth of ED visits that resulted in discharge among adults aged 65–84 years (21.1 percent) and adults aged 85 years and older (21.8 percent).

■ **Fever and otitis media were common principal conditions diagnosed during ED visits resulting in discharge among patients younger than 18 years.**

Fever of unknown origin was the most common diagnosis for ED visits that resulted in discharge among infants younger than 1 year. Fever also was the fifth most common condition among patients aged 1–17 years. Otitis media and related conditions (ear infections) was the second most frequent reason for ED visits resulting in discharge among infants and patients aged 1–17 years.

- **Injuries—including contusions, open wounds, and sprains—were common reasons for ED visits resulting in discharge among all age groups except infants.**

Superficial injury was the most common reason for ED visits resulting in discharge among patients aged 1–17 years and adults aged 85 years and older. Superficial injury also was among the top five reasons for ED visits resulting in discharge among other adult age groups, ranking second among adults aged 65–84 years, third among adults aged 18–44 years, and fifth among adults aged 45–64 years.

Other injury-related conditions also were commonly observed during ED visits resulting in discharge. Open wounds of the head, neck, and trunk were frequent reasons for ED visits that resulted in discharge among patients aged 1–17 years and adults aged 85 years and older. Sprains and strains were common among patients aged 1–17 years, adults aged 18–44 years (where it was the top-ranked condition), and adults aged 45–64 years. Open wounds of extremities were the fifth most common type of diagnosis among adults aged 85 years and older.

- **Nonspecific chest pain was a top-ranked principal condition for ED visits resulting in discharge among adults aged 45 years and older.**

Nonspecific chest pain was the most common reason for ED visits that resulted in discharge for adults aged 45–64 years and 65–84 years. Nonspecific chest pain was the third most common diagnosis among adults aged 85 years and older.

- **Abdominal pain and back problems were among the five most frequent reasons for ED visits resulting in discharge among all adult age groups except those aged 85 years and older.**

Abdominal pain was one of the most common reasons for adult ED visits that resulted in discharge, ranking as the second most common reason among adults aged 18–44 years, ranking fourth among adults aged 45–64 years, and ranking third among adults aged 65–84 years.

Spondylosis, intervertebral disc disorders, and other back problems also were a common type of diagnosis for adult ED visits resulting in discharge, ranking fourth among adults aged 18–44 years and 65–84 years and ranking third among adults aged 45–64 years.

Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) Nationwide Emergency Department Sample (NEDS), 2011. The statistics were generated from HCUPnet, a free, online query system that provides users with *immediate access* to the largest set of publicly available, all-payer national, regional, and State-level hospital care databases from HCUP.⁷

Many statistical tests were conducted for this Statistical Brief. Thus, to decrease the number of false-positive results, we reduced the significance level to .0005 for individual tests.

Definitions

Diagnoses, ICD-9-CM, and Clinical Classifications Software (CCS)

The *principal diagnosis* is that condition established after study to be chiefly responsible for the patient's admission to the hospital. *Secondary diagnoses* are concomitant conditions that coexist at the time of admission or develop during the stay.

ICD-9-CM is the International Classification of Diseases, Ninth Revision, Clinical Modification, which assigns numeric codes to diagnoses. There are approximately 14,000 ICD-9-CM diagnosis codes.

CCS categorizes ICD-9-CM diagnoses into a manageable number of clinically meaningful categories.⁸ This "clinical grouper" makes it easier to quickly understand patterns of diagnoses. CCS categories identified as "Other" typically are not reported; these categories include miscellaneous, otherwise unclassifiable diagnoses that may be difficult to interpret as a group.

Types of hospitals included in HCUP

HCUP is based on data from community hospitals, which are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). HCUP data include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care, rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Community hospitals included in the Nationwide Emergency Department Sample (NEDS) have hospital-based emergency departments and no more than 90 percent of their ED visits resulting in admission.

Unit of analysis

The unit of analysis is the emergency department (ED) encounter, not a person or patient. This means that a person who is seen in the ED multiple times in one year will be counted each time as a separate "encounter" in the ED.

Location of patients' residence

Place of residence is based on the urban-rural classification scheme for U.S. counties developed by the National Center for Health Statistics (NCHS). For this Statistical Brief, we collapsed the NCHS categories into either urban or rural according to the following:

Urban:

- Large Central Metropolitan: includes metropolitan areas with 1 million or more residents
- Large Fringe Metropolitan: includes counties of metropolitan areas with 1 million or more residents
- Medium and Small Metropolitan: includes areas with 50,000 to 999,999 residents.

⁷ Agency for Healthcare Research and Quality. HCUPnet web site. <http://hcupnet.ahrq.gov/>. Accessed May 7, 2014.

⁸ HCUP Clinical Classifications Software (CCS). Healthcare Cost and Utilization Project (HCUP). U.S. Agency for Healthcare Research and Quality, Rockville, MD. Updated April 2014. <http://www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp>. Accessed May 7, 2014.

Rural:

- Micropolitan and Noncore: includes nonmetropolitan counties (i.e., counties with no town greater than 50,000 residents).

Payer

Payer is the expected primary payer for the hospital stay. To make coding uniform across all HCUP data sources, payer combines detailed categories into general groups:

- Medicare: includes patients covered by fee-for-service and managed care Medicare
- Medicaid: includes patients covered by fee-for-service and managed care Medicaid
- Private Insurance: includes Blue Cross, commercial carriers, and private health maintenance organizations (HMOs) and preferred provider organizations (PPOs)
- Uninsured: includes an insurance status of "self-pay" and "no charge"
- Other: includes Worker's Compensation, TRICARE/CHAMPUS, CHAMPVA, Title V, and other government programs.

Hospital stays billed to the State Children's Health Insurance Program (SCHIP) may be classified as Medicaid, Private Insurance, or Other, depending on the structure of the State program. Because most State data do not identify SCHIP patients specifically, it is not possible to present this information separately.

When more than one payer is listed for a hospital discharge, the first-listed payer is used.

Region

Region is one of the four regions defined by the U.S. Census Bureau:

- Northeast: Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, New York, New Jersey, and Pennsylvania
- Midwest: Ohio, Indiana, Illinois, Michigan, Wisconsin, Minnesota, Iowa, Missouri, North Dakota, South Dakota, Nebraska, and Kansas
- South: Delaware, Maryland, District of Columbia, Virginia, West Virginia, North Carolina, South Carolina, Georgia, Florida, Kentucky, Tennessee, Alabama, Mississippi, Arkansas, Louisiana, Oklahoma, and Texas
- West: Montana, Idaho, Wyoming, Colorado, New Mexico, Arizona, Utah, Nevada, Washington, Oregon, California, Alaska, and Hawaii

About HCUP

The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of health care databases and related software tools and products developed through a Federal-State-Industry partnership and sponsored by the Agency for Healthcare Research and Quality (AHRQ). HCUP databases bring together the data collection efforts of State data organizations, hospital associations, private data organizations, and the Federal government to create a national information resource of encounter-level health care data (HCUP Partners). HCUP includes the largest collection of longitudinal hospital care data in the United States, with all-payer, encounter-level information beginning in 1988. These databases enable research on a broad range of health policy issues, including cost and quality of health services, medical practice patterns, access to health care programs, and outcomes of treatments at the national, State, and local market levels.

HCUP would not be possible without the contributions of the following data collection Partners from across the United States:

Alaska State Hospital and Nursing Home Association

Arizona Department of Health Services

Arkansas Department of Health

California Office of Statewide Health Planning and Development

Colorado Hospital Association

Connecticut Hospital Association

Florida Agency for Health Care Administration

Georgia Hospital Association
Hawaii Health Information Corporation
Illinois Department of Public Health
Indiana Hospital Association
Iowa Hospital Association
Kansas Hospital Association
Kentucky Cabinet for Health and Family Services
Louisiana Department of Health and Hospitals
Maine Health Data Organization
Maryland Health Services Cost Review Commission
Massachusetts Center for Health Information and Analysis
Michigan Health & Hospital Association
Minnesota Hospital Association
Mississippi Department of Health
Missouri Hospital Industry Data Institute
Montana MHA - An Association of Montana Health Care Providers
Nebraska Hospital Association
Nevada Department of Health and Human Services
New Hampshire Department of Health & Human Services
New Jersey Department of Health
New Mexico Department of Health
New York State Department of Health
North Carolina Department of Health and Human Services
North Dakota (data provided by the Minnesota Hospital Association)
Ohio Hospital Association
Oklahoma State Department of Health
Oregon Association of Hospitals and Health Systems
Oregon Health Policy and Research
Pennsylvania Health Care Cost Containment Council
Rhode Island Department of Health
South Carolina Budget & Control Board
South Dakota Association of Healthcare Organizations
Tennessee Hospital Association
Texas Department of State Health Services
Utah Department of Health
Vermont Association of Hospitals and Health Systems
Virginia Health Information
Washington State Department of Health
West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About Statistical Briefs

HCUP Statistical Briefs are descriptive summary reports presenting statistics on hospital inpatient and emergency department use and costs, quality of care, access to care, medical conditions, procedures, patient populations, and other topics. The reports use HCUP administrative health care data.

About the NEDS

The HCUP Nationwide Emergency Department Database (NEDS) is a unique and powerful database that yields national estimates of emergency department (ED) visits. The NEDS was constructed using records from both the HCUP State Emergency Department Databases (SEDD) and the State Inpatient Databases (SID). The SEDD capture information on ED visits that do not result in an admission (i.e., 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 NEDS was created to enable analyses of ED utilization patterns and support public health professionals, administrators, policymakers, and

clinicians in their decisionmaking regarding this critical source of care. The NEDS is produced annually beginning in 2006.

About HCUPnet

HCUPnet is an online query system that offers instant access to the largest set of all-payer health care databases that are publicly available. HCUPnet has an easy step-by-step query system that creates tables and graphs of national and regional statistics as well as data trends for community hospitals in the United States. HCUPnet generates statistics using data from HCUP's Nationwide Inpatient Sample (NIS), the Kids' Inpatient Database (KID), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For more information about HCUP, visit <http://www.hcup-us.ahrq.gov/>.

For additional HCUP statistics, visit HCUPnet, our interactive query system, at <http://hcupnet.ahrq.gov/>.

For information on other hospitalizations in the United States, refer to the following HCUP Statistical Briefs located at <http://www.hcup-us.ahrq.gov/reports/statbriefs/statbriefs.jsp>:

- Statistical Brief #166, Overview of Hospital Stays in the United States, 2011
- Statistical Brief #168, Costs for Hospital Stays in the United States, 2011
- Statistical Brief #162, Most Frequent Conditions in U.S. Hospitals, 2011
- Statistical Brief #165, Most Frequent Procedures Performed in U.S. Hospitals, 2011

For a detailed description of HCUP, more information on the design of the Nationwide Emergency Department Sample (NEDS), and methods to calculate estimates, please refer to the following publications:

Introduction to the HCUP Nationwide Emergency Department Sample, 2010. Online. November 2012. U.S. Agency for Healthcare Research and Quality. <http://hcup-us.ahrq.gov/db/nation/neds/NEDS2010Introductionv3.pdf>. Accessed May 7, 2014.

Introduction to the HCUP State Emergency Department Databases. Online. August 2013. U.S. Agency for Healthcare Research and Quality. http://hcup-us.ahrq.gov/db/state/seddist/Introduction_to_SEDD.pdf. Accessed May 7, 2014.

Suggested Citation

Weiss AJ (Truven Health Analytics), Wier LM (Truven Health Analytics), Stocks C (AHRQ), Blanchard J (RAND). Overview of Emergency Department Visits in the United States, 2011. HCUP Statistical Brief #174. June 2014. Agency for Healthcare Research and Quality, Rockville, MD. <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb174-Emergency-Department-Visits-Overview.pdf>.

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AHRQ welcomes questions and comments from readers of this publication who are interested in obtaining more information about access, cost, use, financing, and quality of health care in the United States. We also invite you to tell us how you are using this Statistical Brief and other HCUP data and tools, and to share suggestions on how HCUP products might be enhanced to further meet your needs. Please e-mail us at hcup@ahrq.gov or send a letter to the address below:

Irene Fraser, Ph.D., Director
Center for Delivery, Organization, and Markets
Agency for Healthcare Research and Quality
540 Gaither Road
Rockville, MD 20850