

Overview of Emergency Department Visits Related to Injuries, by Cause of Injury, 2017

STATISTICAL BRIEF #266 November 2020

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Introduction

Injuries are common and can have many causes, such as falls, cuts, motor vehicle accidents, bites, poisoning, and hot objects. In 2017, the Centers for Disease Control and Prevention estimated unintentional falls were the leading cause of injuries treated in the emergency department (ED) for all age groups except ages 10–24 years, for which being struck by or against something was the leading cause of ED visits related to injuries.¹ If severe or untreated, injuries can result in death. In 2018, unintentional injuries were the leading cause of death among people aged 1–44 years.² However, the majority of injuries are nonfatal, and many are treated in EDs. In 2014, the rate of ED visits related to injuries was approximately 82 per 1,000 population, with less than 10 percent of these visits resulting in the patient being admitted to the hospital.³

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents statistics on ED visits related to injuries using the 2017 Nationwide Emergency Department Sample (NEDS). The number of ED visits related to each cause of injury is presented, along with the percentage of those visits that resulted in the patient being admitted to the same hospital or transferred to another hospital. The population rate of ED visits related to injuries is presented by select population characteristics for all injury causes and for the five most common specific causes of injury. Finally, the distribution of primary expected payer for ED visits related to injuries is provided for all injury causes and for the five most common specific causes of injury. Because of the large sample size of the NEDS data, small differences can be statistically significant. Thus, only differences greater than or equal to 10 percent are noted in the text.

Highlights

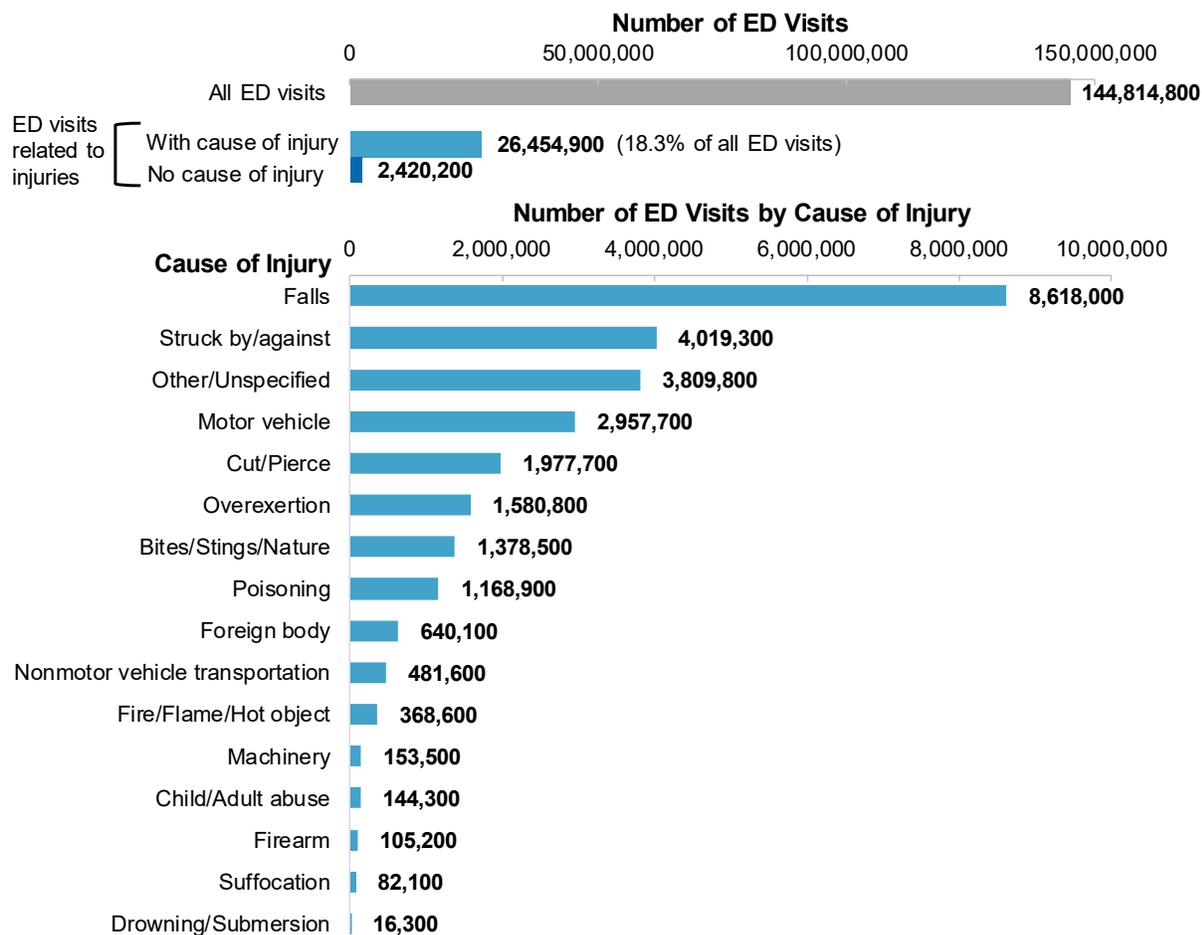
- Falls were the most common cause of injuries treated in the emergency department (ED) in 2017, accounting for approximately one-third of the 26.5 million ED visits related to injuries for which a cause of injury was reported.
- Overall, 10 percent of ED visits related to injuries for all injury causes were admitted or transferred to another hospital, but the percentage was more than 30 percent for ED visits related to injuries caused by suffocation, firearms, and poisoning (77.6, 41.9, and 33.6 percent, respectively).
- Population rates of ED visits related to injuries were highest for the oldest adults (65+ years), among individuals residing in the lowest income communities, and among individuals residing in rural areas.
- Population rates of ED visits related to injuries caused by being cut/pierced were nearly twice as high for males compared with females. Rates were nearly twice as high for ED visits related to injuries caused by motor vehicle accidents in the lowest income communities compared with the highest income communities.
- Private insurance was the most common expected payer for ED visits related to injuries caused by motor vehicle accidents (51.8 percent). Medicare was the most common expected payer for ED visits related to injuries caused by falls (37.9 percent).

Findings

Overall emergency department (ED) visits related to injuries, by cause of injury, 2017

Figure 1 presents the total number of ED visits related to injuries by the cause of injury in 2017.

Figure 1. Number of ED visits related to injuries, by cause of injury, 2017



Abbreviation: ED, emergency department

Note: Some of the 26.5 million ED visits related to injuries for which a cause of injury was reported in 2017 included more than one injury cause. For this analysis, the same ED visit may be counted more than once for each injury cause. The number of ED visits was rounded to the nearest hundred.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2017

- **In 2017, 1 in 5 ED visits in the United States involved an injury.**

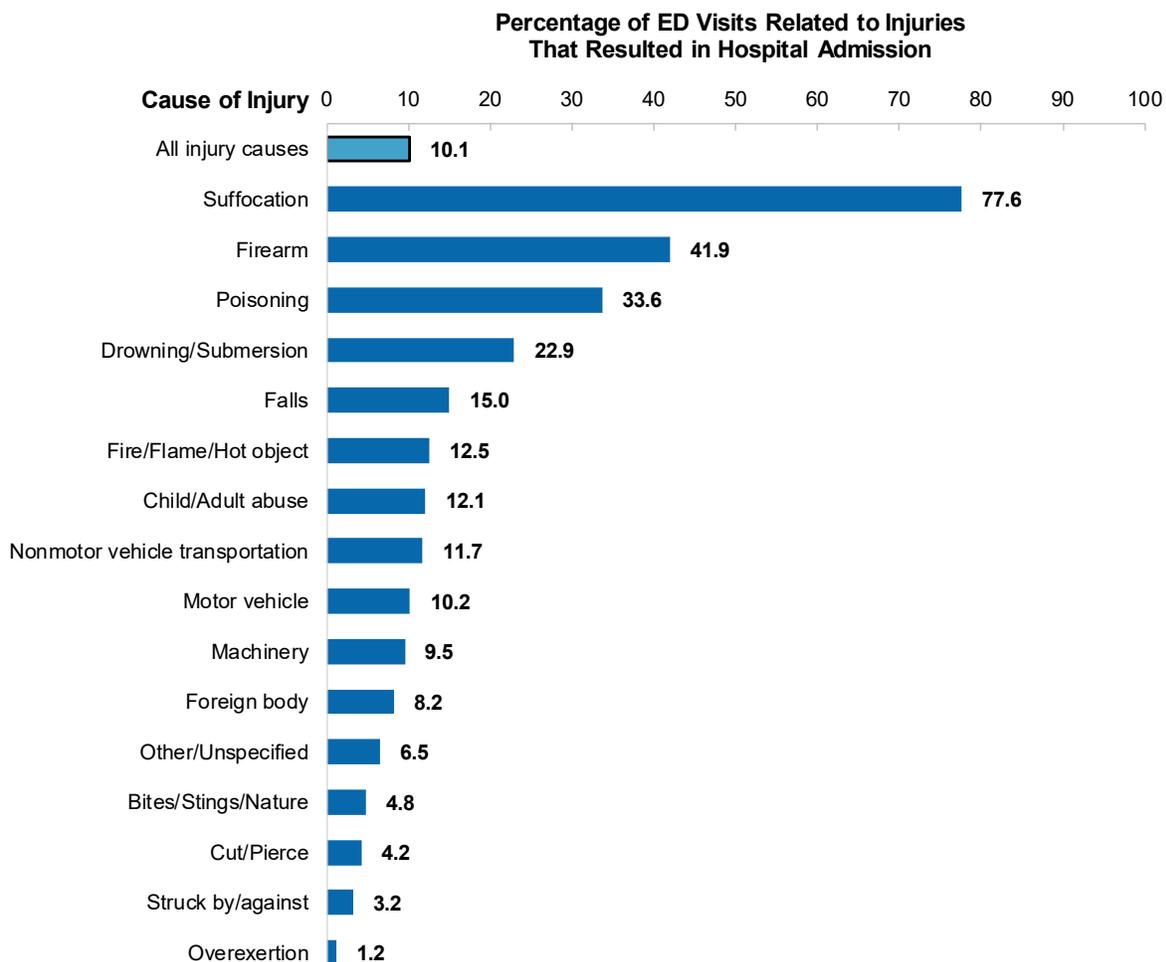
Of the 144.8 million total ED visits in the United States in 2017, 28.9 million (19.9 percent) involved an injury. Of these, the majority (26.5 million, 91.6 percent) had at least one cause of injury reported. The remainder of the analysis in this Statistical Brief is focused on these 26.5 million ED visits (18.3 percent of all ED visits).

- **One-third of ED visits related to injuries in 2017 involved falls.**

Among ED visits related to injuries in 2017, falls were the most frequent cause of injury, with more than 8.6 million ED visits, representing 32.6 percent of the 26.5 million total ED visits related to injuries. Being struck by or against something was the second most common cause of injury (15.2 percent of ED visits related to injuries). Drowning/submersion and suffocation were the least frequent injury causes (0.1 and 0.3 percent of ED visits related to injuries, respectively).

Figure 2 presents the percentage of ED visits related to injuries that resulted in patients being admitted (including those admitted to the same hospital or transferred to another hospital for admission), by the cause of injury in 2017.

Figure 2. Percentage of ED visits related to injuries that resulted in hospital admission, by cause of injury, 2017



Abbreviation: ED, emergency department

Notes: The same ED visit may be counted more than once for each injury cause. Admissions include those ED visits admitted to the same hospital and those transferred to another hospital for admission.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2017

- **More than three-fourths of ED visits related to suffocation resulted in the patient being admitted to the hospital.**

Across all injury causes, the majority of ED visits (89.9 percent) were treated and released. However, more than one-third of ED visits related to three specific causes of injury resulted in the patient being admitted to the hospital: suffocation (77.6 percent), firearm injuries (41.9 percent), and poisoning (33.6 percent). For all other injury causes, fewer than one-fourth of ED visits resulted in the patient being admitted.

Characteristics of ED visits related to injuries, by cause of injury, 2017

Table 1 presents the population rate of ED visits related to injuries, for all injury causes and for the five most common specific causes of injury, by population characteristics in 2017. The five most common specific injury causes account for approximately 70 percent of the 26.5 million ED visits related to injuries for which a cause of injury was reported.

Table 1. Rate of ED visits related to injuries per 100,000 population, by most common specific injury causes, and by population characteristics, 2017

Characteristic	All injury causes	Falls	Struck by/ against	Motor vehicle	Cut/ pierce	Over-exertion
Number	26,454,900	8,618,000	4,019,300	2,957,700	1,977,700	1,580,800
Rate per 100,000 population	8,122.0	2,645.8	1,234.0	908.1	607.2	485.3
Age						
0–17 years	8,493.5	2,757.0	1,790.3	479.9	498.9	475.1
18–29 years	9,091.3	1,359.1	1,686.5	1,680.8	983.5	643.5
30–44 years	7,709.9	1,468.8	1,242.7	1,163.5	764.3	630.3
45–64 years	6,599.4	2,127.4	796.7	828.4	509.7	422.1
65+ years	9,589.5	6,165.1	662.2	524.2	332.0	258.0
Sex						
Male	8,424.5	2,359.8	1,465.9	897.0	785.2	486.8
Female	7,827.4	2,923.1	1,008.8	918.5	434.4	483.9
Community-level income						
Quartile 1 (lowest)	9,997.8	2,967.8	1,550.5	1,205.1	724.4	588.8
Quartile 2	8,527.2	2,751.2	1,289.3	941.6	642.9	527.7
Quartile 3	7,261.6	2,458.0	1,080.4	800.6	552.3	443.7
Quartile 4 (highest)	6,138.3	2,240.4	930.0	621.8	470.0	352.6
Location of patient's residence						
Metro	7,756.9	2,529.4	1,188.8	899.7	570.2	460.1
Rural adjacent	10,359.0	3,325.8	1,519.3	992.1	816.8	657.6
Rural remote	9,682.9	3,252.7	1,388.2	842.8	821.3	585.1

Abbreviation: ED, emergency department

Notes: The same ED visit may be counted more than once for each different injury cause. Community-level income was missing for less than 2% of ED visits; location of patient's residence was missing for less than 1% of ED visits. The number of ED visits was rounded to the nearest hundred.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2017

■ **The population rate of ED visits related to injuries varied by cause of injury and characteristics of the population.**

Across ages, the highest population rate of ED visits related to injuries for all injury causes was among the youngest age groups (aged 0–17 years and 18–29 years) and the oldest age group (aged 65+ years). Children and younger adults (aged 0–17 and 18–29 years) had the highest rate of ED visits related to injuries caused by being struck by or against something. Younger adults (aged 18–29 years) also had the highest rate of ED visits related to injuries caused by motor vehicle accidents and being cut or pierced by something. Younger and middle-aged adults (aged 18–29 and 30–44 years) had the highest rate of ED visits related to injuries caused by overexertion. Finally, the oldest adults (aged 65+ years) had the highest rate of ED visits related to injuries caused by falls.

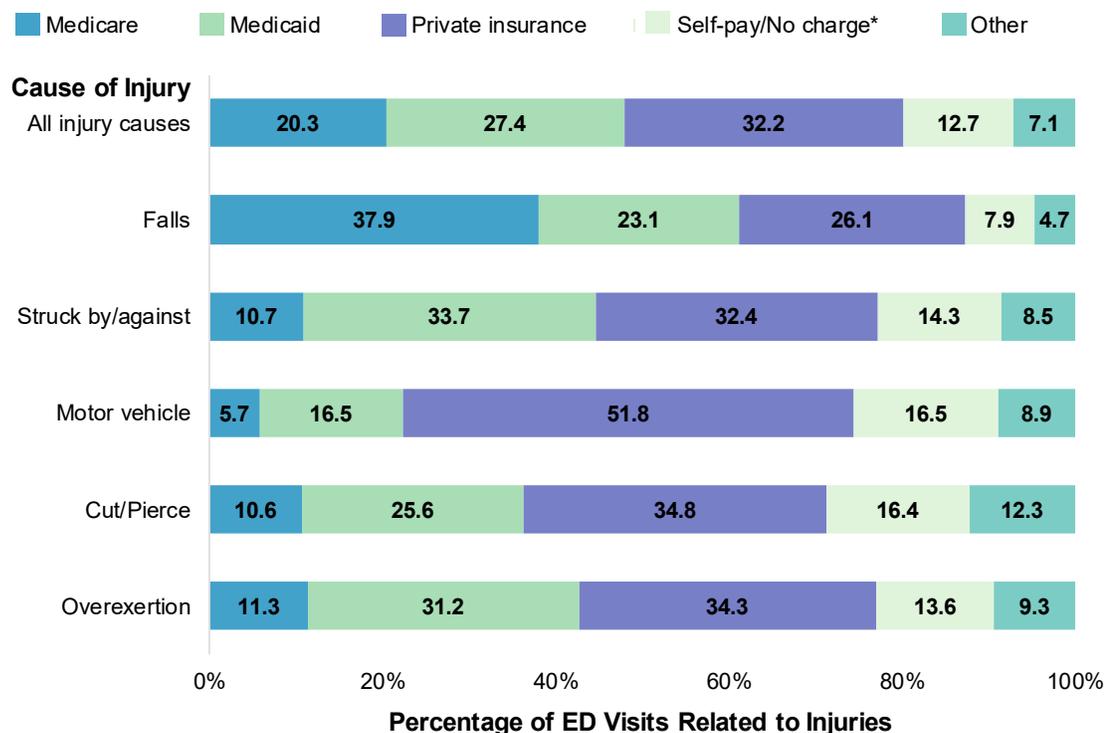
Males and females had similar population rates of ED visits related to injuries for all injury causes. However, males had higher rates of ED visits related to injuries caused by being struck by or against something and being cut or pierced by something, whereas females had higher rates related to falls.

Individuals residing in the lowest income communities had the highest population rate of ED visits related to injuries for all injury causes compared with those residing in higher income communities. Those residing in the lowest income communities also had the highest rate of ED visits related to injuries caused by four of the five most common causes of injury (excluding falls), with the rate of ED visits related to motor vehicle accidents occurring at nearly double the rate in the lowest versus the highest income communities.

Individuals residing in rural-adjacent and rural-remote areas had higher population rates of ED visits related to injuries for all injury causes compared with those residing in metropolitan areas. Those residing in rural-adjacent and rural-remote areas also had higher rates of ED visits related to injuries caused by four of the five most common causes of injury (excluding motor vehicle accidents), with the largest differential for ED visits related to being cut or pierced by something.

Figure 3 presents the distribution of primary expected payer for ED visits related to injuries, for all injury causes and for the five most common specific causes of injury, in 2017.

Figure 3. Distribution of primary expected payer of ED visits related to injuries, by most common specific injury cause, 2017



Abbreviation: ED, emergency department

Notes: The same ED visit may be counted more than once for each different injury cause. Expected payer was missing for less than 1% of ED visits.

* Self-pay/No charge: includes self-pay, no charge, charity, and no expected payment.

Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), Nationwide Emergency Department Sample (NEDS), 2017

■ **The share of ED visits related to injuries varied by cause of injury and primary expected payer.**

Private insurance accounted for the largest share of ED visits related to injuries for all injury causes (32.2 percent), followed by Medicaid (27.4 percent), Medicare (20.3 percent), self-pay/no charge (12.7 percent), and other (7.1 percent).

The largest share of ED visits related to injuries across the five most common specific injury causes differed for each primary expected payer, as follows:

- Private insurance: motor vehicle accidents (51.8 percent)
- Medicaid: struck by/against (33.7 percent) and overexertion (31.2 percent)
- Medicare: falls (37.9 percent)
- Self-pay/No charge: motor vehicle accidents (16.5 percent) and cut/pierce (16.4 percent)
- Other: cut/pierce (12.3 percent)

References

¹ Centers for Disease Control and Prevention. National Estimates of the 10 Leading Causes of Nonfatal Injuries Treated in Hospital Emergency Departments, United States – 2017. www.cdc.gov/injury/wisqars/pdf/leading_causes_of_nonfatal_injury_2017-508.pdf. Accessed June 4, 2020.

² Centers for Disease Control and Prevention. 10 Leading Causes of Death by Age Group, United States – 2018. www.cdc.gov/injury/images/lc-charts/leading_causes_of_death_by_age_group_2018_1100w850h.jpg. Accessed June 4, 2020.

³ Moore BJ, Stocks C, Owens PL. Trends in Emergency Department Visits, 2006–2014. HCUP Statistical Brief #227. September 2017. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb227-Emergency-Department-Visit-Trends.pdf. Accessed April 9, 2020.

About Statistical Briefs

Healthcare Cost and Utilization Project (HCUP) Statistical Briefs provide basic descriptive statistics on a variety of topics using HCUP administrative healthcare data. Topics include hospital inpatient, ambulatory surgery, and emergency department use and costs, quality of care, access to care, medical conditions, procedures, and patient populations, among other topics. The reports are intended to generate hypotheses that can be further explored in other research; the reports are not designed to answer in-depth research questions using multivariate methods.

Data Source

The estimates in this Statistical Brief are based upon data from the HCUP 2017 Nationwide Emergency Department Sample (NEDS). Supplemental sources included population denominator data for use with HCUP databases, derived from information available from the U.S. Census Bureau and Claritas, a vendor that produces population estimates and projections based on data from the U.S. Census Bureau.^{a,b}

Definitions

Diagnoses, ICD-10-CM, and Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses For emergency department (ED) visits that are treated and released, the *first-listed diagnosis* represents the condition, symptom, or problem identified in the medical record to be chiefly responsible for the emergency department (ED) services provided. In cases where the first-listed diagnosis is a symptom or problem, a diagnosis has not been established (confirmed) by the provider. For ED visits that result in an inpatient admission, the first-listed diagnosis is the *principal diagnosis*, the condition established after study to be chiefly responsible for the patient's admission to the hospital. *Secondary diagnoses* are conditions that coexist at the time of the ED visit or inpatient admission, that require or affect patient care treatment received or management, or that develop during the inpatient stay. *All-listed diagnoses* include the first-listed (principal) diagnosis plus the secondary conditions.

ICD-10-CM is the International Classification of Diseases, Tenth Revision, Clinical Modification. In October 2015, ICD-10-CM replaced the International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM) diagnosis coding system for most inpatient and outpatient medical encounters. There are over 70,000 ICD-10-CM diagnosis codes.

The CCSR aggregates ICD-10-CM diagnosis codes into a manageable number of clinically meaningful categories.^c The CCSR is intended to be used analytically to examine patterns of healthcare in terms of

^a Barrett M, Coffey R, Levit K. Population Denominator Data Sources and Data for Use with HCUP Databases (Updated with 2018 Population Data). HCUP Methods Series Report #2019-02. October 24, 2019. U.S. Agency for Healthcare Research and Quality. www.hcup-us.ahrq.gov/reports/methods/2019-02.pdf. Accessed February 3, 2020.

^b Claritas. Claritas Demographic Profile by ZIP Code. <https://claritas360.claritas.com/mybestsegments/>. Accessed February 3, 2020.

^c Agency for Healthcare Research and Quality. HCUP Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses. Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality. Updated January 2020. www.hcup-us.ahrq.gov/toolsoftware/ccsr/ccs_refined.jsp. Accessed February 27, 2020.

cost, utilization, and outcomes; rank utilization by diagnoses; and risk-adjust by clinical condition. The CCSR capitalizes on the specificity of the ICD-10-CM coding scheme and allows ICD-10-CM codes to be classified in more than one category. Approximately 10 percent of diagnosis codes are associated with more than one CCSR category because the diagnosis code documents either multiple conditions or a condition along with a common symptom or manifestation. ICD-10-CM coding definitions for each CCSR category presented in this Statistical Brief can be found in the *CCSR reference file*, available at www.hcup-us.ahrq.gov/toolsoftware/ccsr/ccs_refined.jsp#download.

Case definition

ED visits related to injuries were defined using any-listed ICD-10-CM diagnosis code in the following CCSR, as listed in Table 2.

Table 2. Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses defining emergency department visits related to injuries

CCSR	Description of CCSR
INJ001	Fracture of head and neck, initial encounter
INJ002	Fracture of the spine and back, initial encounter
INJ003	Fracture of torso, initial encounter
INJ004	Fracture of the upper limb, initial encounter
INJ005	Fracture of the lower limb (except hip), initial encounter
INJ006	Fracture of the neck of the femur (hip), initial encounter
INJ007	Dislocations, initial encounter
INJ008	Traumatic brain injury (TBI); concussion, initial encounter
INJ009	Spinal cord injury (SCI), initial encounter
INJ010	Internal organ injury, initial encounter
INJ011	Open wounds of head and neck, initial encounter
INJ012	Open wounds to limbs, initial encounter
INJ013	Open wounds of trunk, initial encounter
INJ014	Amputation of a limb, initial encounter
INJ015	Amputation of other body parts, initial encounter
INJ016	Injury to blood vessels, initial encounter
INJ017	Superficial injury; contusion, initial encounter
INJ018	Crushing injury, initial encounter
INJ019	Burn and corrosion, initial encounter
INJ020	Effect of foreign body entering opening, initial encounter
INJ021	Effect of other external causes, initial encounter
INJ022	Poisoning by drugs, initial encounter
INJ023	Toxic effects, initial encounter
INJ024	Sprains and strains, initial encounter
INJ025	Injury to nerves, muscles and tendons, initial encounter
INJ026	Other specified injury, initial encounter
INJ027	Other unspecified injury, initial encounter
INJ032	Maltreatment/abuse

Abbreviations: CCSR, Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification

Mechanism or cause of the injury was identified and defined based on the ICD-10-CM external cause of injury matrix developed by the Centers for Disease Control and Prevention (CDC), version updated December 2019. This coding is available on the CDC website at

www.cdc.gov/nchs/injury/injury_tools.htm. Certain ICD-10-CM diagnosis codes that begin with the letter T are included in the definition of an injury and an external cause. Most of these T codes are poisoning by drugs, medicaments, and biological substances. Other T codes include asphyxiation; effects of foreign body entering through natural orifice; and adult and child abuse, neglect, and other maltreatment.

Of the 144.8 million ED visits in 2017, 28.9 million indicated an injury. Of these, 26.5 million (91.6 percent) included at least one external cause of injury code and 2.4 million (8.4 percent) did not include any external cause of injury codes. Some ED visits related to injuries included more than one code identifying the external cause of injury; thus, more than one cause of injury may be documented for a single ED visit. Of the 26.5 million ED visits related to injuries with at least one external cause of injury code, 25.1 million (94.9 percent) had only one external cause code and 1.3 million (5.1 percent) had more than one external cause code. The analysis in this Statistical Brief included all codes that identified an external cause of injury; thus, the same ED visit may be counted more than once.

Injury causes from the CDC's ICD-10-CM external cause of injury matrix were grouped into a smaller number of categories for reporting in this Statistical Brief, as shown in Table 3.

Table 3. CDC external cause of injury categories and grouping in this Statistical Brief

Original CDC categories for cause of injury	Grouped causes for this Statistical Brief
Cut/Pierce	Cut/Pierce
Drowning/Submersion	Drowning/Submersion
Falls	Falls
Fire/Flame	Fire/Flame/Hot object
Hot object/substance	
Firearm	Firearm
Machinery	Machinery
MVT–Occupant	Motor vehicle
MVT–Motorcyclist	
MVT–Pedal cyclist	
MVT–Pedestrian	
MVT–Other	
MVT–Unspecified	
Motor vehicle–Nontraffic	
Pedal cyclist, other	Nonmotor vehicle transportation
Pedestrian, other	
Other land transport	
Other transport	
Bites and stings, nonvenomous	Bites/Stings/Nature
Bites and stings, venomous	
Natural/environmental, other	
Overexertion	Overexertion
Poisoning: Drug	Poisoning
Poisoning: Nondrug	
Struck by/against	Struck by/against
Suffocation	Suffocation
Other specified, child/adult abuse	Child/Adult abuse
Other specified, foreign body	Foreign body
Other specified, classifiable	Other/Unspecified
Other specified, not elsewhere classifiable	
Unspecified	

Abbreviations: CDC, Centers for Disease Control and Prevention; MVT, motor vehicle traffic

Source of CDC external cause of injury mechanism classification: Hedegaard H, Johnson RL, Garnett MF, Thomas KE. The International Classification of Diseases 10th Revision, Clinical Modification (ICD-10-CM) External Cause-of-Injury Framework for Categorizing Mechanism and Intent of Injury. Table A. Basic structure of the 2014 proposed ICD-10-CM external cause-of-injury matrix for categorizing mechanism and intent of injury. National Health Statistics Reports #136. December 30, 2019. www.cdc.gov/nchs/data/nhsr/nhsr136-508.pdf. Accessed July 20, 2020.

Types of hospitals included in the HCUP Nationwide Emergency Department Sample

The Nationwide Emergency Department Sample (NEDS) is based on ED data from community acute care hospitals, which are defined as short-term, non-Federal, general, and other specialty hospitals available to the public. Included among community hospitals are pediatric institutions and hospitals that are part of academic medical centers. Excluded are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Hospitals included in the NEDS have EDs, and no more than 90 percent of their ED visits result in admission.

Unit of analysis

The unit of analysis is the ED visit, not a person or patient. This means that a person who is seen in the ED multiple times in 1 year will be counted each time as a separate visit in the ED.

Location of patients' residence

Place of residence is based on the rural-urban continuum codes (RUCC) for U.S. counties developed by the United States Department of Agriculture (USDA).^d For this Statistical Brief, we collapsed the RUCC codes into the following three categories:

Metropolitan (metro) area:

- Counties in metro areas of 1 million population or more
- Counties in metro areas of 250,000 to 1 million population
- Counties in metro areas of fewer than 250,000 population

Rural-adjacent to metro area:

- Urban population of 20,000 or more, adjacent to a metro area
- Urban population of 2,500 to 19,999, adjacent to a metro area
- Completely rural or less than 2,500 urban population, adjacent to a metro area

Rural-remote area:

- Urban population of 20,000 or more, not adjacent to a metro area
- Urban population of 2,500 to 19,999, not adjacent to a metro area
- Completely rural or less than 2,500 urban population, not adjacent to a metro area

Community-level income

Community-level income is based on the median household income of the patient's ZIP Code of residence. Quartiles are defined so that the total U.S. population is evenly distributed. Cut-offs for the quartiles are determined annually using ZIP Code demographic data obtained from Claritas, a vendor that produces population estimates and projections based on data from the U.S. Census Bureau.^e The value ranges for the income quartiles vary by year. Patients in the first quartile are designated as having *low* income, and patients in the upper three quartiles are designated as having *not low* income. The income quartile is missing for patients who are homeless or foreign.

Expected payer

To make coding uniform across all HCUP data sources, the primary expected payer for the ED visit combines detailed categories into general groups:

- Medicare: includes fee-for-service and managed care Medicare
- Medicaid: includes fee-for-service and managed care Medicaid
- Private insurance: includes commercial nongovernmental payers, regardless of the type of plan (e.g., private health maintenance organizations [HMOs], preferred provider organizations [PPOs])
- Self-pay/No charge: includes self-pay, no charge, charity, and no expected payment
- Other payers: includes other Federal and local government programs (e.g., TRICARE, CHAMPVA, Indian Health Service, Black Lung, Title V) and Workers' Compensation

ED visits that were expected to be billed to the State Children's Health Insurance Program (SCHIP) are included under Medicaid.

For this Statistical Brief, when more than one payer is listed for an ED visit, the first-listed payer is used.

^d United States Department of Agriculture. Rural-Urban Continuum Codes. www.ers.usda.gov/data-products/rural-urban-continuum-codes/. Accessed February 27, 2020.

^e Claritas. Claritas Demographic Profile by ZIP Code. <https://claritas360.claritas.com/mybestsegments/>. Accessed February 3, 2020.

ED visits resulting in admission or transfer

Disposition of the patient at discharge from the ED was used to identify ED visits resulting in admission or transferred to another facility. ED visits resulting in admission to the same hospital were those patients initially seen in the ED who were then admitted to the specific hospital associated with that ED. ED visits that were transferred to another facility included those patients who were transferred to another acute care facility.

About HCUP

The Healthcare Cost and Utilization Project (HCUP, pronounced "H-Cup") is a family of healthcare 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, and private data organizations (HCUP Partners) and the Federal government to create a national information resource of encounter-level healthcare data. 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 healthcare 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 Department of Health and Social Services	Nevada Department of Health and Human Services
Alaska State Hospital and Nursing Home Association	New Hampshire Department of Health & Human Services
Arizona Department of Health Services	New Jersey Department of Health
Arkansas Department of Health	New Mexico Department of Health
California Office of Statewide Health Planning and Development	New York State Department of Health
Colorado Hospital Association	North Carolina Department of Health and Human Services
Connecticut Hospital Association	North Dakota (data provided by the Minnesota Hospital Association)
Delaware Division of Public Health	Ohio Hospital Association
District of Columbia Hospital Association	Oklahoma State Department of Health
Florida Agency for Health Care Administration	Oregon Association of Hospitals and Health Systems
Georgia Hospital Association	Oregon Office of Health Analytics
Hawaii Lauima Data Alliance	Pennsylvania Health Care Cost Containment Council
Hawaii University of Hawai'i at Hilo	Rhode Island Department of Health
Illinois Department of Public Health	South Carolina Revenue and Fiscal Affairs Office
Indiana Hospital Association	South Dakota Association of Healthcare Organizations
Iowa Hospital Association	Tennessee Hospital Association
Kansas Hospital Association	Texas Department of State Health Services
Kentucky Cabinet for Health and Family Services	Utah Department of Health
Louisiana Department of Health	Vermont Association of Hospitals and Health Systems
Maine Health Data Organization	Virginia Health Information
Maryland Health Services Cost Review Commission	Washington State Department of Health
Massachusetts Center for Health Information and Analysis	West Virginia Department of Health and Human Resources, West Virginia Health Care Authority
Michigan Health & Hospital Association	Wisconsin Department of Health Services
Minnesota Hospital Association	Wyoming Hospital Association
Mississippi State Department of Health	
Missouri Hospital Industry Data Institute	
Montana Hospital Association	
Nebraska Hospital Association	

About the NEDS

The HCUP Nationwide Emergency Department Sample (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., patients who were treated in the ED and then released from the ED, or patients who were transferred to another hospital); the SID contain information on patients initially seen in the ED 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 decision making regarding this critical source of care. The NEDS is produced annually beginning in 2006. Over time, the sampling frame for the NEDS has changed; thus, the number of States contributing to the NEDS varies from year to year. The NEDS is intended for national estimates only; no State-level estimates can be produced. The unweighted sample size for the 2017 NEDS is 33,506,645 (weighted, this represents 144,814,803 ED visits).

For More Information

For other information on inpatient stays and emergency department visits related to injuries, refer to the HCUP Statistical Briefs located at www.hcup-us.ahrq.gov/reports/statbriefs/sb_injurypoisoning.jsp and www.hcup-us.ahrq.gov/reports/statbriefs/sb_injuries.jsp.

For additional HCUP statistics, visit:

- HCUP Fast Stats at www.hcup-us.ahrq.gov/faststats/landing.jsp for easy access to the latest HCUP-based statistics for healthcare information topics
- HCUPnet, HCUP's interactive query system, at www.hcupnet.ahrq.gov/

For more information about HCUP, visit www.hcup-us.ahrq.gov/.

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

Agency for Healthcare Research and Quality. Overview of the Nationwide Emergency Department Sample (NEDS). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated December 2019. www.hcup-us.ahrq.gov/nedsoverview.jsp. Accessed February 3, 2020.

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