HEALTHCARE COST AND UTILIZATION PROJECT

Agency for Healthcare Research and Quality

STATISTICAL BRIEF #180

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Overview of Hospital Stays in the United States, 2012

Audrey J. Weiss, Ph.D. and Anne Elixhauser, Ph.D.

Introduction

Hospital inpatient care constitutes almost one-third of all health care expenditures in the United States.[1] Overall, hospitalizations affect a large proportion of Americans directly and represent a significant impact to the U.S economy. Although general population growth and a higher prevalence of chronic health conditions suggest that hospital utilization may increase over time, particularly among some groups, greater use of chronic disease management programs and emphasis on outpatient treatment may result in a declining trend in hospital stays.

This Statistical Brief presents data from the Healthcare Cost and Utilization Project (HCUP) on characteristics of inpatient stays in U.S. community hospitals in 2012. The distribution of type of hospital stay (surgical, medical, and maternal or neonatal) is presented for different characteristics (patient age, primary payer, and hospital region). Changes in hospital utilization and costs from 2003 to 2012 are provided, along with changes in hospital utilization by primary payer and patient age. All differences between mean estimates noted in the text are statistically significant at the 0.0005 level or better. Differences between proportions noted in the text differ by at least 10 percent.

Highlights

- In 2012, there were 36.5 million hospital stays in the United States, with an average length of stay of 4.5 days and an average cost of $10,400 per stay.
- The rate of hospitalization decreased by an average of 0.3 percent per year from 2003 to 2008 and by an average of 1.9 percent per year from 2008 to 2012. Between 2003 and 2012, average inflation-adjusted hospital costs increased by 1.8 percent per year.
- About 56 percent of hospital stays in 2012 were medical, 21.8 percent were surgical, and 22.2 percent were maternal or neonatal.
- Females had a higher rate of hospitalization in 2012 than did males, but males had a longer average length of stay and higher average cost per stay.
- In 2012, patients residing in low income communities had a higher rate of hospitalization, a longer length of stay, and lower average hospital costs compared with patients in higher income communities.
- The rate of hospital stays in 2012 was lower in the Pacific and Mountain divisions than in the other Census divisions. Patients hospitalized in the Northeast had the longest length of stay and patients in the West had the highest average hospital costs.
- From 2003 to 2012, the share of hospital stays billed to private insurance decreased from 36.6 to 30.6 percent.

[1] Gonzalez JM. National Health Care Expenses in the U.S. Civilian Noninstitutionalized Population, 2011. MEPS Statistical Brief No. 425. Rockville, MD: Agency for Healthcare Research and Quality, 2013. http://meps.ahrq.gov/data_files/publications/st425/stat425.pdf. Accessed March 28, 2014.

Findings

Characteristics of hospital stays, 2012
Table 1 presents utilization and cost data for hospital inpatient stays in 2012 by selected patient and hospital characteristics.

Table 1. Number and rate of hospital stays, length of stay, and costs by patient, payer, community income, and hospital characteristics, 2012

Characteristic	Hospital stays			Mean length of stay, days	Costs	
	Number, thousands	Percent	Rate per 1,000 population		Mean cost per stay, $	Aggregate, millions $
All hospital stays	36,500	100	116.2	4.5	10,400	377,455
Patient age, years						
< 1	4,300	11.7	1,070.9	3.8	5,000	21,101
1–17	1,500	4.0	21.1	3.9	9,900	14,635
18–44	9,000	24.7	78.9	3.6	7,600	68,425
45–64	9,000	24.7	108.8	4.9	12,900	116,075
65–84	9,700	26.7	260.9	5.2	13,000	126,573
85+	3,000	8.2	502.0	5.2	10,200	30,512
Patient sex						
Male	15,400	42.3	99.9	4.8	11,700	180,587
Female	21,000	57.7	132.0	4.3	9,400	196,833
Primary payer[a]						
Medicare	14,300	39.1	n/a	5.2	12,200	174,609
Medicaid	7,600	20.9	n/a	4.3	8,100	61,679
Private insurance	11,200	30.6	n/a	3.8	9,700	107,807
Uninsured	2,000	5.6	n/a	4.0	8,800	18,056
Community income[b]						
Low	10,900	30.0	136.8	4.6	9,700	105,981
Not low	24,700	67.8	106.1	4.4	10,600	262,789
Hospital region						
Northeast	7,000	19.1	125.2	4.9	10,800	75,146
Midwest	8,200	22.6	122.4	4.3	10,200	84,140
South	14,100	38.7	120.4	4.5	9,300	131,635
West	7,200	19.6	97.2	4.2	12,300	86,533

[a] Population rates are not available by primary payer.

[b] Patients in the first quartile are designated as *low* income, and patients in the upper three quartiles are designated as *not low* income.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **In 2012, there were about 36.5 million hospital stays with an average length of stay of 4.5 days and an average cost of $10,400 per stay.**

  In 2012, there were approximately 36.5 million hospital stays in the United States, representing a hospitalization rate of 116.2 stays per 1,000 population. Across all types of stays, the average length of a hospital stay was 4.5 days. Aggregate hospital costs were $377.5 billion, and the average cost per stay was $10,400.

- **Hospital utilization and costs varied substantially in relationship to patient and hospital characteristics.**

  The rate of hospitalization was highest among infants, which included hospital births (newborns), at 1,070.9 stays per 1,000 population. With the exception of infants, the hospitalization rate increased with age from 21.1 stays per 1,000 population among 1–17 year olds to 502.0 stays per 1,000 population among those aged 85 years and older.

  Adults aged 18–44 years had the shortest average length of stay (3.6 days), followed by infants and children up to 17 years of age (3.8 to 3.9 days). Among adults, lengths of stay were longer as patient age increased, with adults aged 65 years and older having the longest average length of stay (5.2 days). Average cost per stay was lowest for infants ($5,000) and highest for adults aged 45–84 years ($12,900 to $13,000).

  Females had a higher rate of hospitalization (132.0 stays per 1,000 population) than males (99.9 stays per 1,000 population). The average length of a hospital stay was shorter for females than for males (4.3 vs. 4.8 days), and the average cost of a hospital stay was lower for females than for males ($9,400 vs. $11,700). It is important to note that maternal stays for females admitted for pregnancy and delivery were included in this analysis. Analyses excluding maternal and neonatal (newborn) stays showed the same relative differences between males and females (data not shown). Excluding maternal and neonatal conditions and compared with males, females had a higher rate of hospitalization (93.9 vs. 86.9 stays per 1,000 population), a shorter average length of stay (4.8 vs. 5.0 days), and lower average cost per stay ($11,400 vs. $12,800).

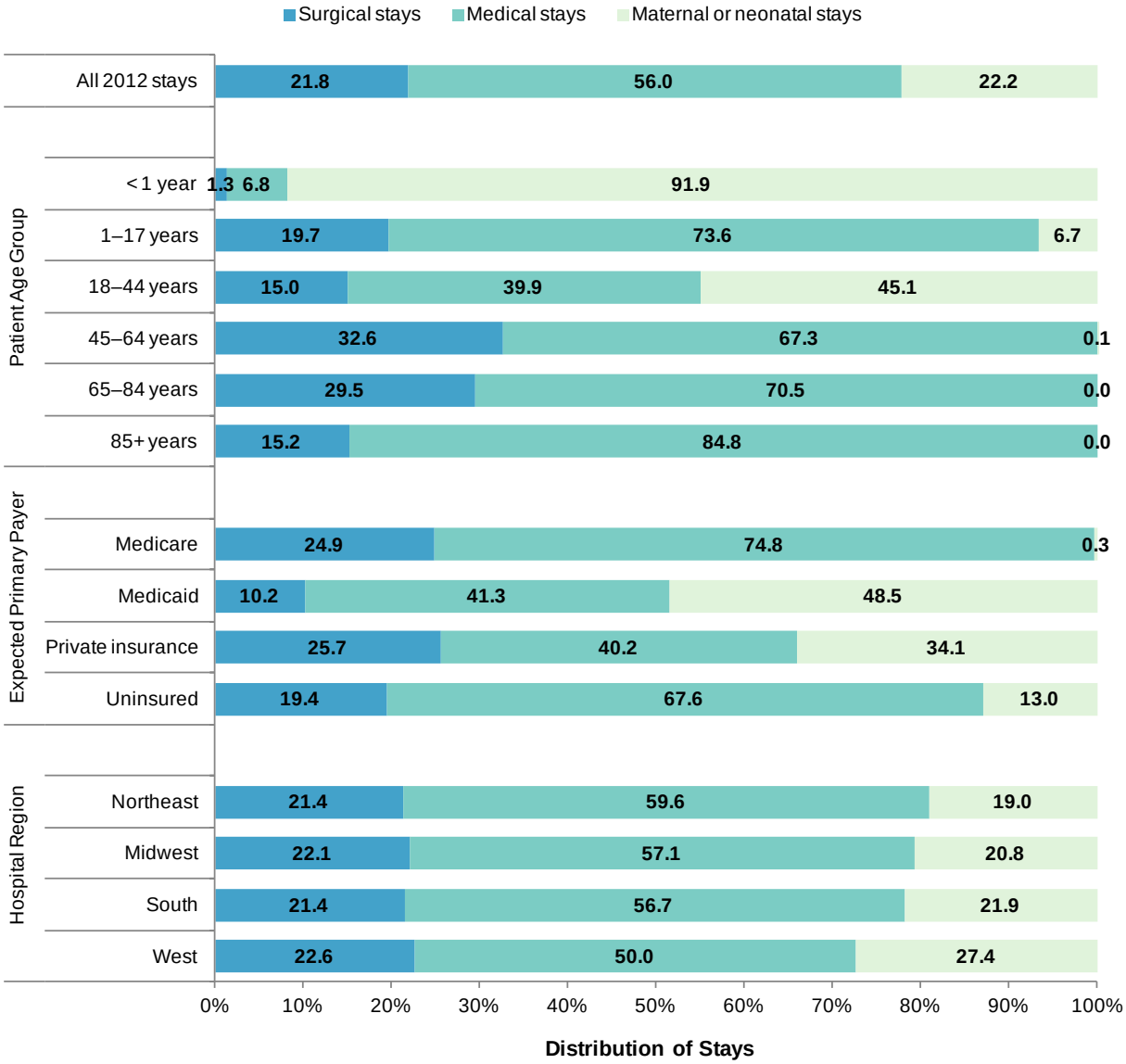
  Medicare paid for the largest number of hospitalizations (14.3 million stays), followed by private insurance (11.2 million stays) and Medicaid (7.6 million stays). About 2 million hospital stays were for patients without insurance. Patients covered by Medicare experienced the longest average length of stay (5.2 days), and privately insured patients had the shortest average length of stay (3.8 days). Average cost per stay was highest for Medicare hospitalizations ($12,200) and lowest for Medicaid hospital stays ($8,100).

  Communities with low income levels had a higher rate of hospitalization than did communities with higher income levels (136.8 vs. 106.1 stays per 1,000 population). Compared with patients from higher income communities, patients from low income communities had a longer average length of stay (4.6 vs. 4.4 days) and lower average hospital costs ($9,700 vs. $10,600).

  The West had a lower rate of hospitalization (97.2 stays per 1,000 population) compared with the other regions (range: 120.4 to 125.2 stays per 1,000 population). The Northeast had the longest average length of stay at 4.9 days, and the West and Midwest had the shortest average lengths of stay (4.2 and 4.3 days, respectively). The West had the highest average hospital cost ($12,300) and the South had the lowest average hospital cost ($9,300).

Figure 1 provides the distribution of hospital stays by patient age, primary payer, and hospital region, comparing each subgroup by type of stay—surgical, medical, and maternal or neonatal.

Figure 1. Distribution of inpatient stays by patient age group, primary payer, hospital region, and type of stay, 2012



Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **Medical stays constituted the largest proportion of hospitalizations.**

  Overall, medical stays constituted the largest proportion of hospital stays, representing 56.0 percent of all hospitalizations. Maternal/neonatal stays and surgical stays each constituted approximately 22 percent of hospitalizations. More than two-thirds of hospitalizations were medical stays for the second youngest and three oldest age groups: 1–17 years (73.6 percent), 45–64 years (67.3 percent), 65–84 years (70.5 percent), and 85+ years (84.8 percent). Medical stays also constituted a high proportion of stays among patients covered by Medicare (74.8 percent) and among the uninsured (67.6 percent).

- **Maternal or neonatal stays constituted the largest proportion of hospitalizations among infants, younger adults, and patients covered by Medicaid.**

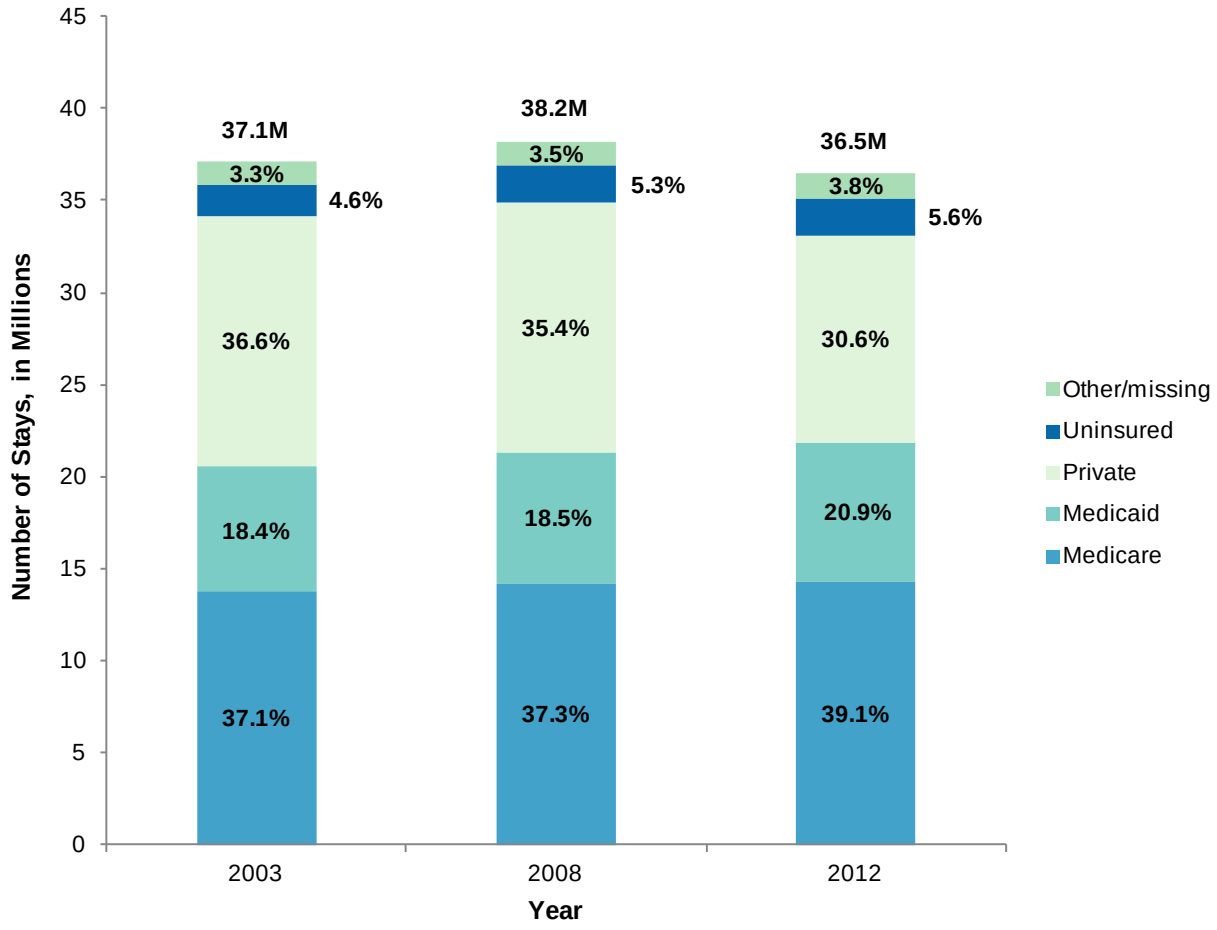
  Neonatal stays constituted 91.9 percent of hospital stays among infants aged < 1 year. Nearly half of stays among patients aged 18–44 years (45.1 percent) and those covered by Medicaid (48.5 percent) were for maternal conditions.

- **In the West, the proportion of maternal or neonatal stays was higher and the proportion of medical stays lower relative to the distribution within other U.S. regions.**

  In the West maternal or neonatal stays accounted for more than one-quarter of all hospitalizations (27.4 percent) versus around 20 percent for the other regions (range: 19.0–21.9 percent). In addition, the West had a lower proportion of medical stays (50.0 percent) compared with the other regions (range: 56.7–59.6 percent).

Figure 2 presents the distribution of hospital stays by primary payer for 2012 and for 2 prior years (2003 and 2008), covering a 10-year time period.

Figure 2. Distribution of inpatient stays by primary payer, 2003, 2008, and 2012



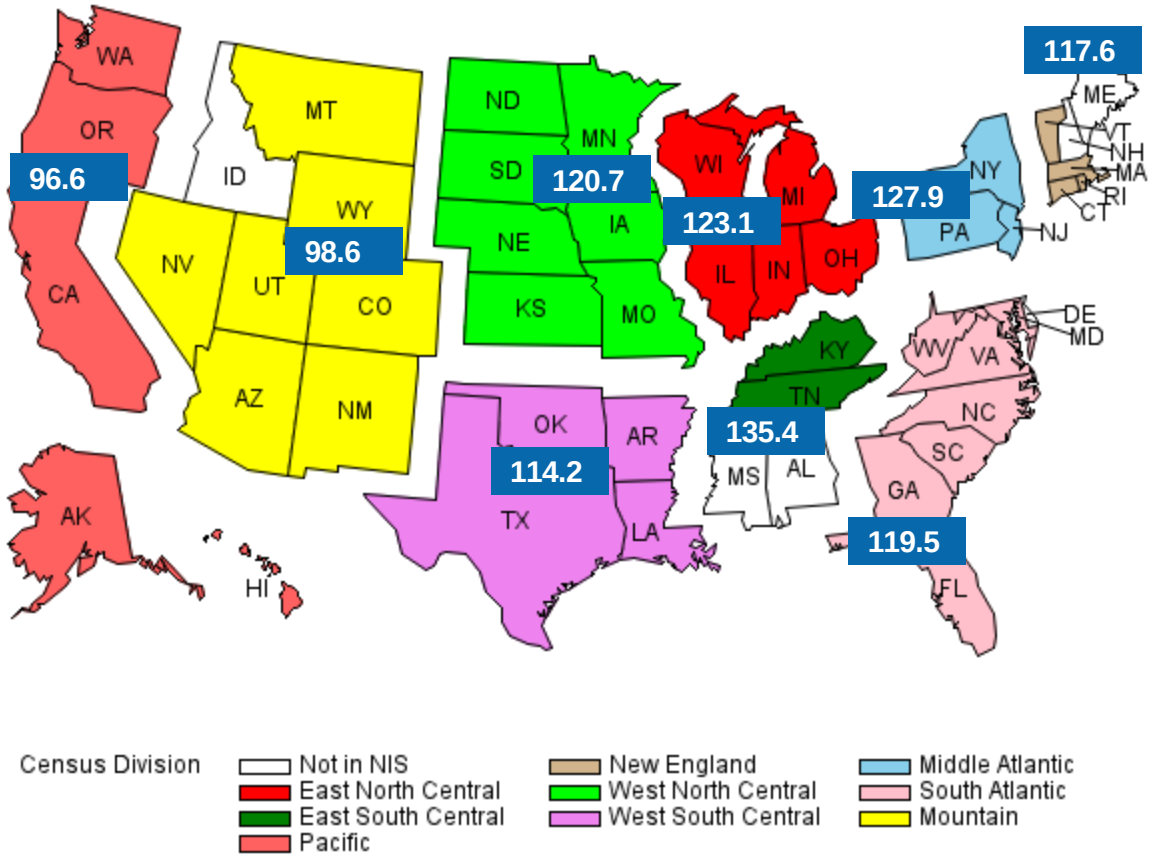
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **The share of hospital costs billed to private insurance decreased between 2003 and 2012.**

  Between 2003 and 2012, the number of hospital stays billed to private insurance decreased from 13.6 to 11.2 million stays, representing a decrease from 36.6 to 30.6 percent of all hospitalizations. During this same time period, the share of stays billed to Medicaid increased from 6.8 to 7.6 million stays (an increase from 18.4 percent to 20.9 percent of all hospitalizations).

Figure 3 presents the rate of hospital inpatient stays across the nine U.S. Census divisions in 2012.

Figure 3. Rate of inpatient stays per 1,000 population by U.S. Census division, 2012



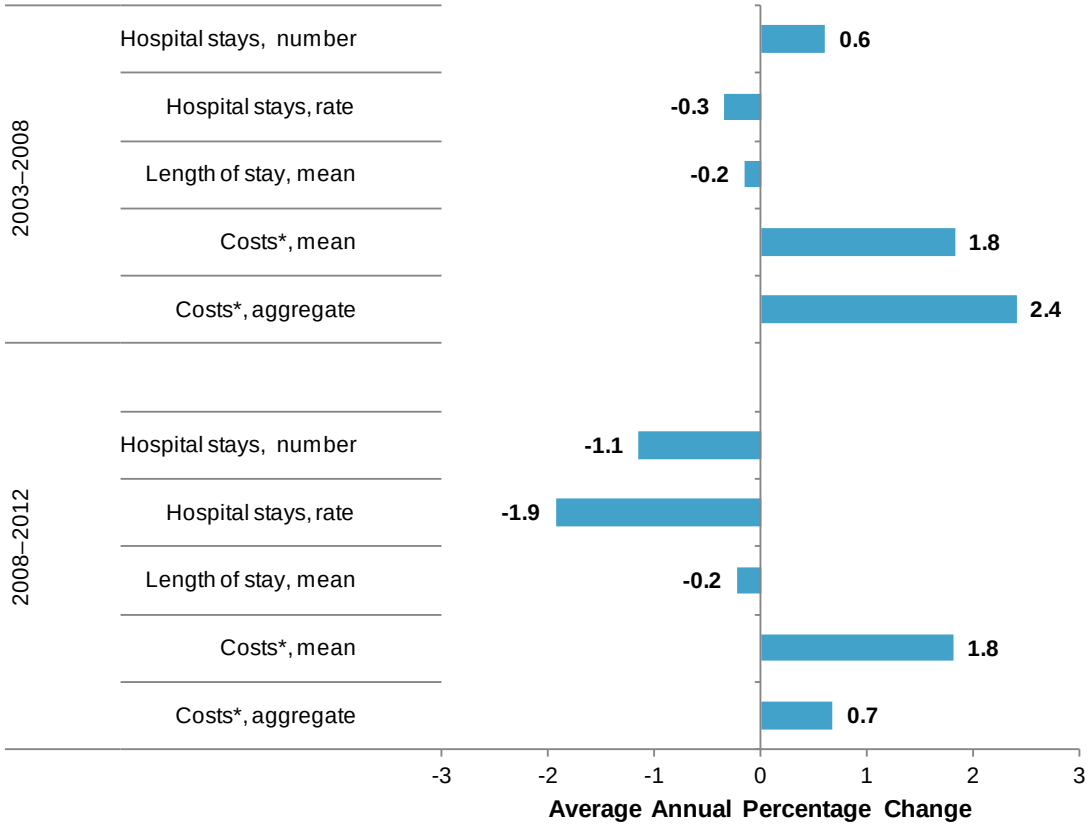
Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2012

- **The Pacific and Mountain divisions had the lowest rates of inpatient stays.**

  The lowest hospitalization rates were in the Pacific and Mountain divisions (96.6 and 98.6 stays per 1,000 population, respectively). The West South Central division had a lower hospitalization rate (114.2 stays per 1,000 population) than did the East South Central and Middle Atlantic divisions (135.4 and 127.9 stays per 1,000 population, respectively).

Changes in utilization and costs of hospital stays, 2003–2012
Figure 4 presents overall changes in utilization and costs associated with hospital inpatient stays.

Figure 4. Average annual percentage change in hospital inpatient utilization and inflation-adjusted costs, 2003–2008 and 2008–2012



* Growth in mean and aggregate hospital costs was calculated using inflation-adjusted costs.

Note: Data from 2008 were used as end points in both the 2003–2008 and the 2008–2012 analyses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **Hospital costs increased while the rate of hospitalization and mean length of stay decreased over the decade from 2003 to 2012.**

  The number of hospital stays increased 0.6 percent annually from 2003 to 2008, whereas the number of stays decreased an average of 1.1 percent annually between 2008 and 2012.

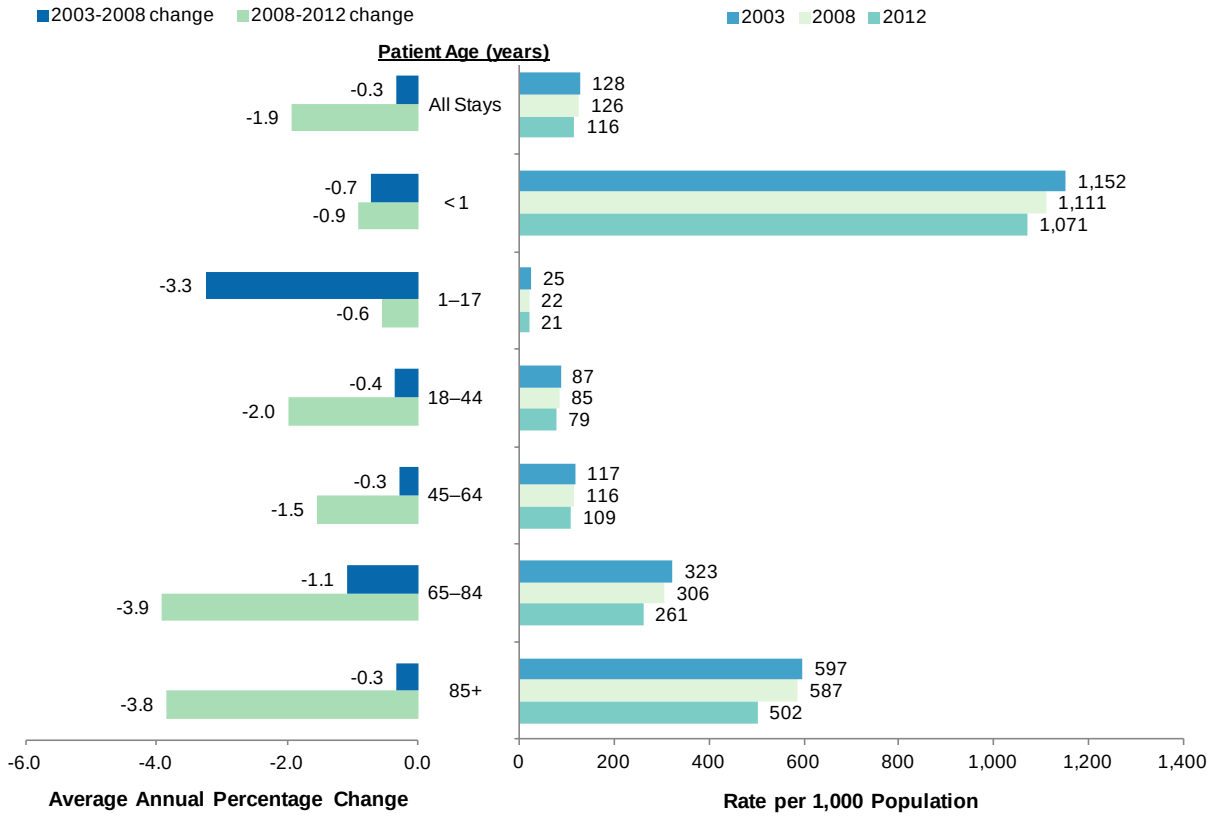
  The overall rate of hospitalization decreased over time, with an average annual decrease of 0.3 percent between 2003 and 2008 and an average annual decrease of 1.9 percent between 2008 and 2012.

  The length of a hospital stay decreased on average 0.2 percent per year between 2003 and 2012.

  Finally, mean inflation-adjusted hospital costs grew at a relatively steady rate, averaging 1.8 percent per year during both time periods. Aggregate inflation-adjusted hospital costs grew an average of 2.4 percent per year between 2003 and 2008 but slowed to a 0.7 percent average increase per year between 2008 and 2012.

Figure 5 presents the rate of stays by patient age for 2003, 2008, and 2012, along with the average annual percentage change for two consecutive 5-year time periods (2003–2008 and 2008–2012).

Figure 5. Rate of inpatient stays and change over time by patient age, 2003–2012



Note: Data from 2008 were used as end points in both the 2003–2008 and the 2008–2012 analyses.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), National (Nationwide) Inpatient Sample (NIS), 2003, 2008, 2012

- **The rate of hospitalization decreased between 2003 and 2012 overall and across patient subgroups.**

  Between 2003 and 2012 the rate of hospitalization decreased from 128 stays per 1,000 population in 2003 to 116 stays per population in 2012. This decrease in the hospitalization rate occurred for all age groups. The rate of decrease was generally greater from 2008 to 2012 than from 2003 to 2008, with the exception of patients aged 1–17 years, who experienced a faster decline in hospitalization rate from 2003 to 2008.

  From 2008 through 2012, the rate of hospitalization decreased at the highest rate—almost 4 percent per year—for those aged 65 years and older.

Data Source

The estimates in this Statistical Brief are based upon data from the Healthcare Cost and Utilization Project (HCUP) 2012 National Inpatient Sample (NIS). Historical data were drawn from the 2003 and 2008 Nationwide Inpatient Sample (NIS). 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.[2]

The 2012 NIS was redesigned to optimize national estimates. The redesign incorporates two critical changes:

- Revisions to the sample design—the NIS is now a *sample of discharge records from all HCUP-participating hospitals*, rather than a sample of hospitals from which all discharges were retained.

- Revisions to how hospitals are defined—the NIS now uses the *definition of hospitals and discharges supplied by the statewide data organizations* that contribute to HCUP, rather than the definitions used by the American Hospital Association (AHA) Annual Survey of Hospitals.

The new sampling strategy is expected to result in more precise estimates than did the previous NIS design by reducing sampling error: for many estimates, confidence intervals under the new design are about half the length of confidence intervals under the previous design. The change in sample design for 2012 necessitates recomputation of prior years' NIS data to enable analysis of trends that uses the same definitions of discharges and hospitals.

This is the first Statistical Brief that reports data from the 2012 NIS.

Many hypothesis tests were conducted for this Statistical Brief. Thus, to decrease the number of false-positive results, we reduced the significance level to 0.0005 for individual tests.

Definitions

Diagnoses, ICD-9-CM, major diagnostic categories (MDCs), and diagnosis-related groups (DRGs)
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 and procedures. There are approximately 14,000 ICD-9-CM diagnosis codes and approximately 4,000 ICD-9-CM procedure codes.

MDCs assign ICD-9-CM principal diagnosis codes to one of 25 general diagnosis categories. For this report, maternal hospital stays were identified using MDC 14 (pregnancy, childbirth, and the puerperium) and neonatal hospital stays were identified using MDC 15 (newborns and other neonates with conditions originating during the perinatal period).

DRGs comprise a patient classification system that categorizes patients into groups that are clinically coherent and homogeneous with respect to resource use. DRGs group patients according to diagnosis, type of treatment (procedure), age, and other relevant criteria. Each hospital stay has one assigned DRG. For this report, surgical stays were defined as *valid O.R. procedures* on the basis of DRG coding principles. Stays other than maternal/neonatal stays or surgical stays were considered medical stays.

Types of hospitals included in the HCUP National (Nationwide) Inpatient Sample
The National (Nationwide) Inpatient Sample (NIS) 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). The NIS includes obstetrics and gynecology, otolaryngology, orthopedic,

[2] Agency for Healthcare Research and Quality. HCUPnet Web site. http://hcupnet.ahrq.gov/. Accessed September 11, 2014.

cancer, pediatric, public, and academic medical hospitals. Excluded are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. Beginning in 2012, long-term acute care hospitals are also excluded. However, if a patient received long-term care, rehabilitation, or treatment for psychiatric or chemical dependency conditions in a community hospital, the discharge record for that stay will be included in the NIS.

Unit of analysis
The unit of analysis is the hospital discharge (i.e., the hospital stay), not a person or patient. This means that a person who is admitted to the hospital multiple times in 1 year will be counted each time as a separate discharge from the hospital.

Costs and charges
Total hospital charges were converted to costs using HCUP Cost-to-Charge Ratios based on hospital accounting reports from the Centers for Medicare & Medicaid Services (CMS).[3] *Costs* reflect the actual expenses incurred in the production of hospital services, such as wages, supplies, and utility costs; *charges* represent the amount a hospital billed for the case. For each hospital, a hospital-wide cost-to-charge ratio is used. Hospital charges reflect the amount the hospital billed for the entire hospital stay and do not include professional (physician) fees. For the purposes of this Statistical Brief, costs are reported to the nearest hundred.

Annual costs were inflation adjusted using the Gross Domestic Product (GDP) from the U.S. Department of Commerce, Bureau of Economic Analysis (BEA), with 2012 as the index base.[4] That is, all costs are expressed in 2012 dollars.

Average annual percentage change
Average annual percentage change is calculated using the following formula:

$$\text{Average annual percentage change} = \left[\left(\frac{\text{End value}}{\text{Beginning value}}\right)^{\frac{1}{\text{change in years}}} - 1\right] \times 100.$$

Median community-level income
Median community-level income is the median household income of the patient's ZIP Code of residence. Income levels are separated into quartiles with cut-offs determined using ZIP Code demographic data obtained from the Nielsen Company. 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.

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

[3] Agency for Healthcare Research and Quality. HCUP Cost-to-Charge Ratio (CCR) Files. Healthcare Cost and Utilization Project (HCUP). 2001–2011. Rockville, MD: Agency for Healthcare Research and Quality. Updated August 2014. http://www.hcup-us.ahrq.gov/db/state/costtocharge.jsp. Accessed September 11, 2014.

[4] U.S. Bureau of Economic Analysis. National Income and Product Account Tables, Table 1.1.4 Price Indexes for Gross Domestic Product. http://www.bea.gov/iTable/iTable.cfm?RegID=9&step=1#reqid=9&step=1&isuri=1. Accessed March 20, 2014.

State data do not identify patients in SCHIP 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 Revenue and Fiscal Affairs Office
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 NIS

The HCUP National (Nationwide) Inpatient Sample (NIS) is a national (nationwide) database of hospital inpatient stays. The NIS is nationally representative of all community hospitals (i.e., short-term, non-Federal, nonrehabilitation hospitals). The NIS is a sample of hospitals and includes all patients from each hospital, regardless of payer. It is drawn from a sampling frame that contains hospitals comprising more than 95 percent of all discharges in the United States. The vast size of the NIS allows the study of topics at the national and regional levels for specific subgroups of patients. In addition, NIS data are standardized across years to facilitate ease of use.

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 National (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 #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 and more information on the design of the National (Nationwide) Inpatient Sample (NIS), please refer to the following database documentation:

Agency for Healthcare Research and Quality. Overview of the National (Nationwide) Inpatient Sample (NIS). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated July 2014. http://www.hcup-us.ahrq.gov/nisoverview.jsp. Accessed September 11, 2014.

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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