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STATISTICAL BRIEF #229

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Characteristics of Homeless Individuals Using Emergency Department Services in 2014

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Introduction

Homeless people are more likely than members of the general public to use emergency department (ED) services. Compared with the general population, homeless individuals are 3 times more likely to use an ED at least once in a year.¹ Nearly three out of four inpatient stays by homeless individuals began in the ED, compared with half of stays for nonhomeless patients.² Various factors may contribute to this outcome. Prior research has shown that homeless individuals experience acute physical disorders at 3 to 6 times the rates experienced by nonhomeless individuals.³ It has also been shown that homeless individuals have high rates of mental illness^{2,4,5,6} and high rates of hospitalization.⁷ Because of barriers to access to care—such as lack of insurance and transportation—as well as poor continuity of care, homeless people frequently use EDs as their primary or only source of health care.^{8,9} When they do seek medical care, it is usually at teaching hospitals.¹⁰

¹ Kushel MB, Vittinghoff E, Haas JS. Factors associated with the health care utilization of homeless persons. *Journal of the American Medical Association*. 2001;285(2):200–6.

² Karaca Z (AHRQ), Wong H (AHRQ), Mutter R (AHRQ). Characteristics of Homeless and Non-Homeless Individuals Using Inpatient and Emergency Department Services, 2008. Statistical Brief #152. March 2013. Agency for Healthcare Research and Quality, Rockville, MD. www.hcup-us.ahrq.gov/reports/statbriefs/sb152.pdf. Accessed August 8, 2017.

³ Wright JD. Poor people, poor health: the health status of the homeless. *Journal of Social Issues*. 1990;46(4):49–64.

⁴ Wright NM, Tompkins CN. How can health services effectively meet the health needs of homeless people? *British Journal of General Practice*. 2006;56(525):286–93.

⁵ Bassuk EL, Buckner JC, Perloff JN, Bassuk SS. Prevalence of mental health and substance use disorders among homeless and low-income housed mothers. *American Journal of Psychiatry*. 1998;155(11):1561–4.

⁶ Sadowski LS, Kee RA, VanderWeele TJ, Buchanan D. Effect of a housing and case management program on emergency department visits and hospitalizations among chronically ill homeless adults: a randomized trial. *Journal of the American Medical Association*. 2009;301(17):1771–8.

⁷ Martell JV, Seitz RS, Harada JK, Kobayashi J, Sasaki VK, Wong C. Hospitalization in an urban homeless population: the Honolulu Urban Homeless Project. *Annals of Internal Medicine*. 1992;116(4):299–303.

⁸ Kushel MB, Perry S, Bangsberg D, Clark R, Moss AR. Emergency department use among the homeless and marginally housed: results from a community-based study. *American Journal of Public Health*. 2002 May;92(5):778–84.

Highlights

- More than three-fourths of all ED visits by homeless individuals were to teaching hospitals.
- In teaching hospitals, Medicaid was the most common payer for ED visits by homeless individuals (47.1 percent of treat-and-release ED visits and 72.1 percent of ED visits resulting in hospital admission).
- In nonteaching hospitals, more than 40 percent of ED visits by homeless individuals were uninsured.
- Among treat-and-release ED visits, alcohol-related disorders, screening and history of mental disorders and substance abuse, and mood disorders were the three most common conditions by homeless individuals with a mental or substance use disorder.
- Among ED visits resulting in hospital admission, schizophrenia and other psychotic disorders, mood disorders, and alcohol-related disorders were the three most common conditions by homeless individuals with a mental or substance use disorder.
- More than half of ED visits resulting in hospital admission for Black homeless individuals with a mental or substance use disorder were attributable to schizophrenia.
- More than one-third of ED visits resulting in admission to nonteaching hospitals for White and Hispanic homeless individuals with a mental or substance use disorder were attributable to mood disorders.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents patient characteristics, insurance coverage, and a clinical profile of ED visits among homeless individuals during 2014 in eight States (Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York, and Wisconsin). Homelessness is directly reported by the hospitals; there is an indicator for each discharge from inpatient hospitals or hospital-affiliated EDs regarding a patient's homelessness status. Data used for this analysis include ED visits that resulted in admission to inpatient care at the same hospital, as well as treat-and-release ED visits that resulted in discharge from the ED, which includes patients who were routinely discharged, who were transferred to another type of healthcare facility, who were discharged against medical advice, or who died in the ED. Homeless individuals' demographic information, expected primary payer, and prevalence of a mental or substance use disorder are summarized for Black, Hispanic, and White individuals by hospital teaching status.

⁹ Morris DM, Gordon JA. The role of the emergency department in the care of homeless and disadvantaged populations. *Emergency Medicine Clinics of North America*. 2006;24(4):839–48.

¹⁰ Bowdler JE, Barrell LM. Health needs of homeless persons. *Public Health Nursing*. 1987;4(3):135–40.

Findings

Patient characteristics of ED visits among homeless individuals in teaching and nonteaching hospitals, 2014

Table 1 shows variations among ED visits in homeless individuals' age, sex, race/ethnicity, and expected primary payer by type of ED visit and hospital type.

Table 1. Demographic profile of ED visits by homeless individuals, 2014

Patient characteristic	Treat-and-release ED visits		ED visits resulting in hospital admission	
	Teaching hospital	Nonteaching hospital	Teaching hospital	Nonteaching hospital
Total number of ED visits ^a	73,600	25,600	110,200	4,900
Age, %				
Under 18	2.0	4.4	8.0	0.3
18–29	17.5	22.3	18.4	13.8
30–44	28.6	27.0	22.9	23.0
45–64	47.7	41.9	33.1	53.8
65 and older	4.2	4.4	17.6	9.1
Sex, %				
Male	73.0	69.5	49.3	75.1
Race/ethnicity, %				
White	56.0	72.1	18.1	74.5
Black	24.7	12.2	35.5	14.0
Hispanic	13.1	8.8	29.7	8.9
Expected primary payer, %				
Medicare	15.6	11.7	21.7	21.7
Medicaid	47.1	28.8	72.1	28.4
Private	3.9	6.7	1.7	5.6
Uninsured	28.1	49.2	3.8	41.0
Other	5.2	3.5	0.7	3.3

Abbreviation: ED, emergency department

^a Total numbers of ED visits are rounded to the nearest hundred

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2014 State Inpatient Databases (SID) and 2014 State Emergency Department Databases (SEDD) from eight States (Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York, and Wisconsin)

- **In 2014, the majority—86 percent—of ED visits by homeless individuals were made to teaching hospitals.**

There were 99,200 total treat-and-release ED visits by homeless individuals from eight States (73,600 visits at teaching hospitals plus 25,600 visits at nonteaching hospitals).

There were 115,100 total ED visits resulting in hospital admission by homeless individuals in eight States (110,200 visits admitted to teaching hospitals plus 4,900 visits admitted to nonteaching hospitals).

- **The proportion of ED visits by homeless individuals differed between teaching and nonteaching hospitals across age cohorts.**

In 2014, the largest proportion of ED visits by homeless patients was among individuals aged 45-64 years.

In 2014, among ED visits by homeless patients that resulted in admission to a teaching hospital, 8.0 percent were made by homeless individuals aged less than 18 years old, compared with 0.3 percent admitted to a nonteaching hospital.

- **In 2014, the majority of ED visits by homeless patients were made by male individuals.**

Males accounted for 73.0 and 69.5 percent of treat-and-release ED visits by homeless individuals in teaching and nonteaching hospitals, respectively.

Male individuals made 49.3 percent of ED visits by homeless patients that resulted in admission to a teaching hospital and 75.1 percent of ED visits by homeless patients that resulted in admission to a nonteaching hospital.

- **The proportion of ED visits by homeless individuals differed between teaching and nonteaching hospitals across racial/ethnic cohorts.**

In 2014, the majority of treat-and-release ED visits by homeless patients were made by White individuals in both teaching and nonteaching hospitals.

In 2014, about 72 percent of ED visits by homeless patients that resulted in admission to a teaching hospital were by non-White individuals.

- **In 2014, among homeless individuals, Medicaid was the most common expected primary source of payment for ED visits at teaching hospitals but no insurance coverage was most common among ED visits at nonteaching hospitals.**

Among ED visits by homeless individuals at teaching hospitals, Medicaid provided coverage for 47.1 percent of treat-and-release ED visits and 72.1 percent of ED visits that resulted in a hospital admission.

Among ED visits by homeless individuals at nonteaching hospitals, there was no insurance coverage for 49.2 percent of treat-and-release ED visits and for 41.0 percent of ED visits resulting in a hospital admission.

Mental and substance use diagnoses among ED visits by homeless individuals, 2014

Table 2 presents the clinical profile of ED visits by homeless individuals with a mental or substance use disorder.

Table 2. Clinical profile of emergency department visits by homeless individuals with a mental or substance use disorder, 2014

Patient Clinical characteristics	Treat-and-release ED visits		ED visits resulting in hospital admission	
	Teaching hospital	Nonteaching hospital	Teaching hospital	Nonteaching hospital
Total number of ED visits with a mental or substance use disorder	44,700	14,900	26,100	2,100
Subcategories of mental and substance use disorders,^a %				
Adjustment disorders	0.6	0.4	1.2	1.4
Anxiety disorders	12.4	13.8	0.8	1.4
Attention deficit, conduct, and disruptive behavior disorders	1.6	1.3	0.8	— ^b
Delirium, dementia, and amnestic and other cognitive disorders	0.4	0.6	1.1	0.8
Developmental disorders	1.0	0.6	0.0	— ^b
Disorders usually diagnosed in infancy, childhood, or adolescence	0.2	0.1	0.2	— ^b
Impulse control disorders	0.1	— ^b	0.7	— ^b
Mood disorders	25.1	22.3	25.9	38.9
Personality disorders	0.8	0.6	0.3	— ^b
Schizophrenia and other psychotic disorders	10.1	7.0	38.4	25.7
Alcohol-related disorders	46.0	34.0	19.5	24.7
Substance-related disorders	21.9	16.8	10.3	6.1
Suicide and intentional self-inflicted injury	8.0	9.1	0.0	0.2
Screening and history of mental health and substance abuse	37.4	57.4	— ^b	— ^b
Miscellaneous disorders	0.4	0.4	0.7	— ^b

Abbreviation: ED, emergency department

Notes: Total numbers of ED visits with a mental or substance use disorder are rounded to the nearest hundred.

^a Disease categories are based on the Clinical Classification Software (CCS)—a diagnosis and procedure categorization scheme based on the International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM). Percentages in the table are based on principal diagnosis codes at inpatient facilities. The HCUP SEDD do not differentiate between the principal diagnosis codes and other diagnosis codes. Therefore, we used all diagnosis codes reported for each treat-and-release ED visit when creating broader CCS disease categories.

^b Statistics are not reported whenever there are fewer than 11 observations in a particular cell.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2014 State Inpatient Databases (SID) and 2014 State Emergency Department Databases (SEDD) from eight States (Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York and Wisconsin)

■ **In 2014, the majority of treat-and-release ED visits among homeless individuals involved a mental or substance use disorder.**

For ED treat-and-release visits among homeless individuals, nearly 60 percent of ED visits at both teaching (44,700 out of 73,600, or 60.7 percent) and nonteaching hospitals (14,900 out of 25,600, or 58.2 percent) involved a mental or substance use disorder.

- **In 2014, alcohol-related disorders, mood disorders, and screening and history of mental and substance abuse were the three most common conditions among treat-and-release ED visits by homeless individuals with a mental or substance use disorder.**

In teaching hospitals, alcohol-related disorders were the most prevalent conditions (46.0 percent) followed by screening and history of mental health and substance abuse (37.4 percent) and mood disorders (25.1 percent) among treat-and-release ED visits by homeless individuals with a mental or substance use disorder.

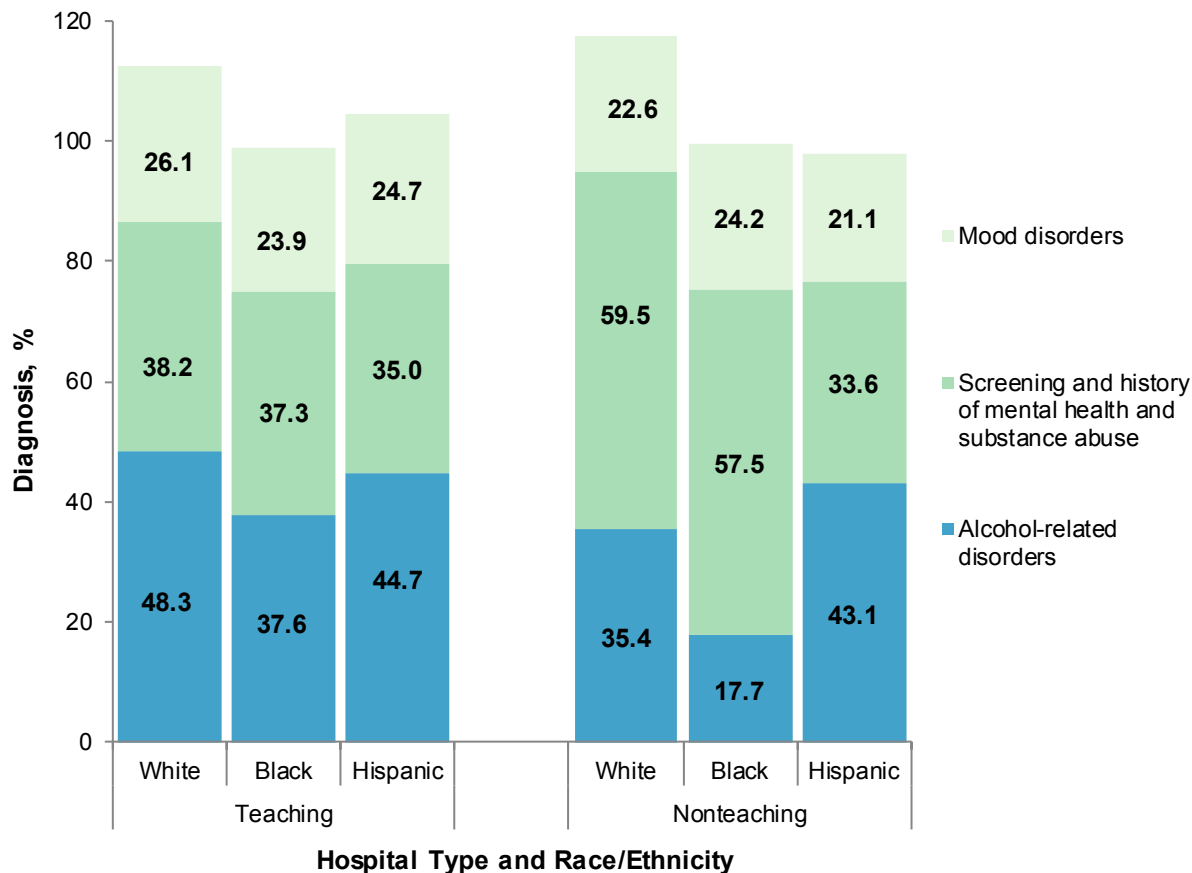
In nonteaching hospitals, screening and history of mental health and substance abuse was the most prevalent condition (57.4 percent) followed by alcohol-related disorders (34.0 percent) and mood disorders (22.3 percent) among treat-and-release ED visits by homeless individuals with a mental or substance use disorder.

- **In 2014, alcohol-related disorders, mood disorders, and schizophrenia and other psychotic disorders were the three most common conditions among ED visits resulting in hospital admission by homeless individuals with a mental or substance use disorder.**

Schizophrenia and other psychotic disorders (38.4 percent), mood disorders (25.9 percent), and alcohol-related disorders (19.5 percent) were the most common mental and substance use disorders among ED visits by homeless individuals resulting in admission to teaching hospitals. These disorders also ranked in the top three at nonteaching hospitals, but the leading diagnosis was mood disorders (38.9 percent).

Figure 1 shows racial/ethnic differences in the distribution of the three most common mental and substance use disorders among treat-and-release ED visits by homeless individuals.

Figure 1. Common mental and substance use disorders among treat-and-release ED visits by homeless individuals, 2014



Note: Disease categories are based on the Clinical Classification Software (CCS)—a diagnosis and procedure categorization scheme based on the International Classification of Diseases, 9th Revision, Clinical Modification. The first-listed diagnosis for treat-and-release ED records may not reflect the principal reason for the visit, as it does for inpatient stays. Therefore, we used all diagnosis codes reported for each treat-and-release ED visit when creating broader CCS disease categories. Thus, the percentages can add to more than 100 percent because a record may have more than one mental health and substance use disorder listed.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2014 State Inpatient Databases (SID) and 2014 State Emergency Department Databases (SEDD) from eight States (Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York, and Wisconsin)

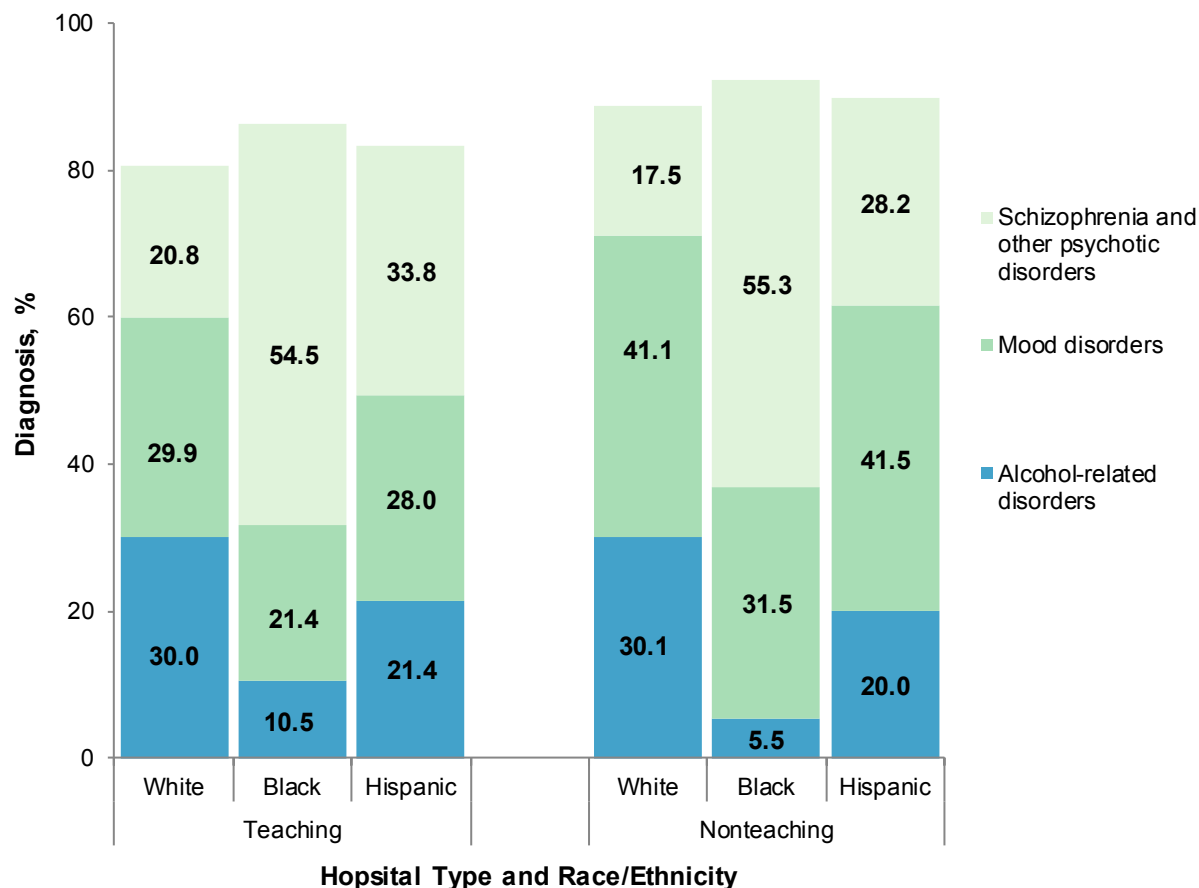
- **The proportions of treat-and-release ED visits by homeless individuals with a mental or substance use disorder that were for mood disorders, screening and history of mental health and substance use, and alcohol-related disorders differed between teaching and nonteaching hospitals across racial/ethnic cohorts.**

In teaching hospitals, alcohol-related disorders were the most common conditions across all racial/ethnic cohorts among treat-and-release ED visits by homeless individuals with a mental or substance use disorder (48.3, 37.6 and 44.7 percent respectively for White, Black, and Hispanic homeless individuals).

In nonteaching hospitals, screening and history of mental health and substance abuse was the most common condition among treat-and-release ED visits by White and Black homeless individuals with a mental or substance use disorder (59.5 and 57.5 percent, respectively). In comparison, alcohol-related disorders were the most common conditions for Hispanics (43.1 percent).

Figure 2 shows racial/ethnic differences in the distribution of the three most common mental and substance use disorders among ED visits by homeless individuals that resulted in hospital admission.

Figure 2. Common mental and substance use disorders among ED visits resulting in hospital admission by homeless individuals, 2014



Note: Disease categories are based on the Clinical Classification Software—a diagnosis and procedure categorization scheme based on the International Classification of Diseases, 9th Revision, Clinical Modification. The percentages are based on principal diagnosis codes on the inpatient record.

Source: Agency for Healthcare Research and Quality (AHRQ), Center for Delivery, Organization, and Markets, Healthcare Cost and Utilization Project (HCUP), 2014 State Inpatient Databases (SID) and 2014 State Emergency Department Databases (SEDD) from eight States (Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York, and Wisconsin).

- **In 2014, more than half of ED visits resulting in hospital admission for Black homeless individuals with a mental or substance use disorder were attributable to schizophrenia.**

Among ED visits by Black homeless individuals with a mental or substance use disorder, 54.5 and 55.3 percent of visits were for schizophrenia and other psychotic disorders for those admitted to teaching and nonteaching hospitals, respectively.

- **In 2014, more than one-third of ED visits resulting in admission to nonteaching hospitals by White and Hispanic homeless individuals with a mental or substance use disorder were attributable to mood disorders.**

In nonteaching hospitals, mood disorders were the most common conditions among ED visits resulting in hospital admission for White and Hispanic homeless individuals with a mental or substance use disorder (41.1 and 41.5 percent, respectively).

About Statistical Briefs

HCUP Statistical Briefs provide basic descriptive statistics on a variety of topics using HCUP administrative health care 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 Healthcare Cost and Utilization Project (HCUP) State Inpatient Databases (SID) and State Emergency Department Databases (SEDD) for 2014. Eight States were included in the analysis: Arizona, Florida, Georgia, Maryland, Massachusetts, Missouri, New York, and Wisconsin.

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. *All-listed diagnoses* include the principal diagnosis plus these additional secondary conditions.

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 diagnosis codes into a manageable number of clinically meaningful categories.¹¹ 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.

In this analysis, mental and substance use conditions are based on clinical classification of the principal diagnosis for visits that resulted in inpatient stays and are based on all-listed diagnoses for records where the patient was discharged from the emergency department.

Case definition

Homelessness is directly reported by the hospitals. There is an indicator for each discharge from inpatient hospitals or hospital-affiliated emergency departments regarding the patient's homelessness status.

Types of hospitals included in HCUP State Inpatient Databases

This analysis used State Inpatient Databases (SID) limited to 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). Community hospitals include obstetrics and gynecology, otolaryngology, orthopedic, cancer, pediatric, public, and academic medical hospitals. Excluded for this analysis are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals. However, if a patient received long-term care, rehabilitation, or treatment for a psychiatric or chemical dependency condition in a community hospital, the discharge record for that stay was included in the analysis.

¹¹ Agency for Healthcare Research and Quality. HCUP Clinical Classifications Software (CCS) for ICD-9-CM. Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated October 2016. www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Accessed January 31, 2017

Types of hospitals included in HCUP State Emergency Department Databases

This analysis used State Emergency Department Databases (SEDD) limited to data from community hospitals with a hospital-based emergency department. Community hospitals are defined as short-term, non-Federal, general, and other hospitals, excluding hospital units of other institutions (e.g., prisons). Community hospitals include specialty, pediatric, public, and academic medical hospitals. Excluded for this analysis are long-term care facilities such as rehabilitation, psychiatric, and alcoholism and chemical dependency hospitals.

Unit of analysis

The unit of analysis for inpatient data 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. Inpatient stays include those admitted through the emergency department (ED).

The unit of analysis for ED data 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. ED visits exclude those for patients admitted to the hospital, including patients transferred to other hospitals.

Payer

Payer is the expected 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.

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

Teaching hospitals

Teaching hospital status was based on variables provided by American Hospital Association (AHA) Annual Survey, 2014. A hospital is defined as a teaching hospital if one of the following conditions holds:

- The hospital is a member of the Council of Teaching Hospital of the Association of American Medical Colleges (COTH).
- The participating site is recognized for one or more programs accredited by the Accreditation Council for Graduate Medical Education.
- The ratio of interns and residents to beds is 0.25 or higher.

Reporting of race and ethnicity

Data on Hispanic ethnicity are collected differently among the States and also can differ from the census methodology of collecting information on race (White, Black, Asian/Pacific Islander, American Indian/Alaska Native, Other [including mixed race]) separately from ethnicity (Hispanic, non-Hispanic). State data organizations often collect Hispanic ethnicity as one of several categories that include race. Therefore, for multistate analyses, HCUP creates the combined categorization of race and ethnicity for data from States that report ethnicity separately. This Statistical Brief reports race/ethnicity only for the following categories: non-Hispanic White, non-Hispanic Black, and Hispanic.

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, and private data organizations (HCUP Partners) and the Federal government to create a national information resource of encounter-level health care 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 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 Department of Health and Social Services
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
District of Columbia 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
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 State Department of Health
Missouri Hospital Industry Data Institute
Montana Hospital Association
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 Office of Health Analytics
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 Department of Health and Human Resources, West Virginia Health Care Authority
Wisconsin Department of Health Services
Wyoming Hospital Association

About the SID

The HCUP State Inpatient Databases (SID) are hospital inpatient databases from data organizations participating in HCUP. The SID contain the universe of the inpatient discharge abstracts in the participating HCUP States, translated into a uniform format to facilitate multistate comparisons and analyses. Together, the SID encompass more than 95 percent of all U.S. community hospital discharges. The SID can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market-area variation analyses, and to identify State-specific trends in inpatient care utilization, access, charges, and outcomes.

About the SEDD

The HCUP State Emergency Department Databases (SEDD) include information from hospital-owned emergency departments (EDs) from data organizations participating in HCUP, translated into a uniform format to facilitate multistate comparisons and analyses. The SEDD capture information on ED visits that do not result in an admission to the same hospital (i.e., patients who are treated in the ED and then discharged, transferred to another hospital, left against medical advice, or died). The SEDD contain a core set of clinical and nonclinical information on all patients, including individuals covered by Medicare, Medicaid, or private insurance, as well as those who are uninsured. The SEDD can be used to investigate questions unique to one State, to compare data from two or more States, to conduct market-area variation analyses, and to identify State-specific trends in injury surveillance, emerging infections, and other conditions treated in the ED.

About HCUP Fast Stats

HCUP Fast Stats (www.hcup-us.ahrq.gov/faststats/landing.jsp) is an interactive, online tool that provides easy access to the quarterly HCUP-based statistics for select State and national health information topics. HCUP Fast Stats uses side-by-side comparisons of visual statistical displays, trend figures, or simple tables to convey complex information at a glance. Topics currently available in HCUP Fast Stats include State Trends in Hospital Use by Payer; National Hospital Utilization and Costs; and Opioid-Related Hospital Use, National and State. HCUP Fast Stats presents statistics using data from HCUP's National (Nationwide) Inpatient Sample (NIS), the Nationwide Emergency Department Sample (NEDS), the State Inpatient Databases (SID), and the State Emergency Department Databases (SEDD).

For More Information

For more information on hospital utilization among individuals with low income, including homeless individuals, refer to the HCUP Statistical Briefs located at www.hcup-us.ahrq.gov/reports/statbriefs/sb_lowincome.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 health information topics
- HCUPnet, HCUP's interactive query system, at 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 State Inpatient Databases (SID) or State Emergency Department Databases (SEDD), please refer to the following database documentation:

Agency for Healthcare Research and Quality. Overview of the State Inpatient Databases (SID). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated June 2016. www.hcup-us.ahrq.gov/sidoverview.jsp. Accessed January 31, 2017.

Agency for Healthcare Research and Quality. Overview of the State Emergency Department Databases (SEDD). Healthcare Cost and Utilization Project (HCUP). Rockville, MD: Agency for Healthcare Research and Quality. Updated June 2016. www.hcup-us.ahrq.gov/seddoverview.jsp. Accessed January 31, 2017.

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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:

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