OSHPD
Office of Statewide Health Planning and Development

Emergency Department (ED) and Ambulatory Surgery (AS) Data Dictionary

Public Use File

For Data Years:
January – December 2010 – File Structure Revised 10/2013
January – December 2011 – File Structure Revised 10/2013
January – December 2012 – New File Specifications
January – December 2013
January – December 2014

File Formats Available:
Comma-Delimited Text File (.txt)
Comma-Delimited Text File with Labels (.txt)
SAS (Ver 9.3) File (.sas7bat)
SAS (Ver 9.3) Proc Format Program (to associate labels with SAS File)

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[1] Appendicesnot listed are not applicable to Public ED and/or AS data sets.

INTRODUCTION

General Information

The California Office of Statewide Health Planning and Development (OSHPD) provides public data sets of emergency care data collected from hospital emergency departments and also of ambulatory surgery data collected from general acute care hospitals and licensed freestanding ambulatory surgery clinics in California. Each record within the data set consists of one outpatient encounter, also known as a service visit. Data collected for these encounters include demographic, clinical, payer, and facility information.

Emergency Department (ED) data include encounters from hospitals licensed to provide emergency medical services. Reportable ED encounters include only those patients who had a *face-to-face contact with a provider*. If a patient left without being seen, the patient did not have a face-to-face encounter with a provider and therefore the ED encounter was not reported. A provider is defined as the person who has primary responsibility for assessing and treating the condition of a patient at a given contact and exercises independent judgment in the care of the patient. If the ED encounter resulted in a same-hospital admission, the ED encounter would be combined with the inpatient record. A separate ED record would not be reported for that scenario. When analyzing ED records, you may want to include these direct admissions, which are identified in the hospital's inpatient data as having the ED at the same hospital as the source of admission.

Ambulatory Surgery (AS) data include encounters from general acute care hospitals and licensed freestanding ambulatory surgery clinics, during which *at least one ambulatory surgery procedure* is performed. A freestanding ambulatory surgery clinic is defined as a surgical clinic licensed by the California Department of Public Health (CDPH). Many facilities that are called ambulatory surgery centers are not required to be licensed as surgical clinics, and do not report data to the Office. An ambulatory surgery procedure is defined as those procedures performed on an outpatient basis in the general operating rooms, ambulatory surgery rooms, endoscopy units, or cardiac catheterization laboratories of a hospital or a freestanding ambulatory surgery clinic. If a procedure was done elsewhere (such as in a radiology unit), no ambulatory surgery record is required to be filed. If a hospital-based AS encounter resulted in a same-hospital admission, the AS encounter would be combined with the inpatient record. A separate AS record would not be reported for that scenario. When analyzing hospital-based AS records, you may want to include the AS direct admissions, which are identified in the hospital's inpatient data as having Ambulatory Surgery at the same hospital as the source of admission.

For more information see the documentation provided by the MIRCal (data submission) system: www.oshpd.ca.gov/HID/MIRCal/EDASManual.html.

The public data is released yearly by OSHPD once it has been screened by the automated reporting software (MIRCal) and corrected by the individual facilities. Because of the file size, the .txt version of the data is divided into three separate files based on the geographic location of the facility.

Excluded and Masked Variables

The masking strategy used for the Public Use Files has been revised to protect patient confidentiality, minimize the risk of disclosure of protected health information, and preserve the file's clinical information. See the "What's New" section and Appendix B – Risk Mitigation Specification for the masking specifications and Appendix E – Counts of Unique Records for Emergency Department or Ambulatory Surgery.

Modification and Exception Reports

Some facilities have been granted "modifications" to standard data reporting requirements because they were unable to complete specific fields as required or were determined to be out of compliance at the time of reporting. Exceptions are reported for facilities with records that were initially flagged as wrong but were actually reported correctly. See Appendix C – Modifications and Exceptions for a listing of Emergency Department or Ambulatory Surgery facilities and affected variables.

Consolidation Facility Listing

Appendix D – Facility Status shows facility consolidated status and status changes (openings, closing, ownership changes) by year of data collection. When multiple facility locations operate under one hospital license, the licensed entity is considered a consolidated provider. These types of facilities can report patient-level data as either separate entities, or aggregated as one consolidated provider.

Importing Notes

There are several fields that, although they appear to contain numeric data, should be treated as text (character). This is particularly important when working with ICD-9-CM (diagnosis) and CPT (procedure) codes. Diagnosis and procedure codes are stored without decimals and many contain leading zeros. For example, the ICD-9-CM code for Salmonella Gastroenteritis is “003.0” (implied decimal following the third digit from the left). If not formatted as text, the leading zeros will be dropped and the code will appear as an invalid diagnosis code of “30”.

File Format

The Public Use File is offered in two versions: SAS (.sas7bdat, created with SAS version 9.3) and comma-delimited (.txt). To assist SAS file users, the facility name variable (oshpd_name) has been added to the files and a “proc” format file is available to associate labels with variables.

For TXT file users, in addition to the “Code” format, a “Label” formatted file is available. In the “Label” file, alphanumeric values have been replaced by more descriptive “English” values. For example, for the variable “sev_code”, the descriptive label “MS-DRG assignment is based on the presence of MCC” replaced the code value “1”. In either version of the TXT file, for three variables (oshpd_id, MDC, MSDRG), the original variables, with “code” values, were retained and “label” variables were added (oshpd_name, mdc_name, msdrg_name). On the TXT files, the length of each field and the length of each record will vary according to the data reported. A header row identifying each data element is provided in sequence order on the first record.

Note that facility and MS-DRG codes and their associated labels potentially change across years and that year-specific code-label crosswalks must be used.

The attributes for each data field are provided on the following pages. Note that the variable length may differ across the Code/Label version of the file.

What's New

Revisions to the Public Use File to Protect Patient Confidentiality

Beginning in 2013, with the release of 2012 data, the Public Use File has been modified to protect patient confidentiality, minimize the risk of disclosure of confidential patient data, and preserve the file's clinical information.

These demographic and date variables were removed:

- Service Quarter
- Service Year
- Age in Years (at date service)
- Age Range (20 categories)
- Age Range (5 categories)
- Ethnicity
- Gender
- Patient County
- Race

One variable was modified: the 5-digit Patient ZIP Code was replaced with a 3-digit Patient ZIP Code.

A masking rule was applied: First, Principal Diagnosis, Principal Procedure, and Principal E-Codes were examined for a single occurrence of one of those codes for a given hospital/clinic. If, for the given hospital/clinic, a single instance of either a Principal Diagnosis or Principal Procedure were found, the Principal codes were preserved, but the secondary diagnoses, secondary procedures and all E-Codes in the record were masked (*). If, for the given facility, a single instance of a Principal E-Code was found, all E-Codes on the record were masked (*). For each record that is the only record for a facility for a report year, all data elements other than the hospital ID, name, and service year were masked (*).

No other masking of data elements was applied. In the 2012 ED and AS files, 2.2 and 8.4 percent, respectively, of the encounter records had secondary variables masked. See Appendix B – Risk Mitigation Specification for the masking specifications and Appendix E – Counts of Unique Records for Emergency Department or Ambulatory Surgery.

Files Split by Facility County, Not Service Date

Because of their size, previous .txt public use files were split into two six-month period files. To minimize the risk of disclosure based on service period, files are divided by the geographic location of the facility, not service date:

- Los Angeles
- Southern: Imperial, Orange, Riverside, San Bernardino, San Diego, Santa Barbara, Ventura
- Northern: Alameda, Alpine, Amador, Butte, Calaveras, Colusa, Contra Costa, Del Norte, El Dorado, Fresno, Glenn, Humboldt, Inyo, Kern, Kings, Lake, Lassen, Madera, Marin, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Napa, Nevada, Placer, Plumas, Sacramento, San Benito, San Francisco, San Joaquin, San Luis Obispo, San Mateo, Santa Clara, Santa Cruz, Shasta, Sierra, Siskiyou, Solano, Sonoma, Stanislaus, Sutter, Tehama, Trinity, Tulare, Tuolumne, Yolo, Yuba.

California Clinic Licensing Law – Data From Non-Licensed Clinics Not Accepted

On September 19, 2007, the Third District Court of Appeals issued its decision in the Capen vs. Shewry lawsuit holding that all clinics that are owned by a physician or group of physicians are excluded from licensure by CDPH (see The California clinic licensing law pursuant to Section 1200, et seq. of the California Health and Safety Code). According to the decision, physician-owned clinics are subject to oversight by the Medical Board of California, which reviews certain "outpatient surgery settings" which use anesthesia. CDPH has interpreted the decision as stripping it of the authority to license or regulate any physician-owned surgical clinic, including the authority to issue licenses that physicians request voluntarily. Licensed freestanding Ambulatory Surgery Clinics are required to report encounter data to OSHPD; non-licensed clinics are not. Non-licensed clinics were allowed to report data through MIRCal through 2011. Starting in 2012, data from non-licensed clinics has not been accepted.

FILE DOCUMENTATION

Facility Identification Number

Field Name: fac_id

Definition: A unique six-digit identifier assigned to each facility by the Office of Statewide Health Planning and Development. The first two digits indicate the county in which the facility is located. The last four digits are unique within each county. Appendix F – Counts by Facility (Encounters) (ED) and Appendix F – Counts by Facility (Encounters) (AS) list facility ID number, name, and number of encounters.

Variable Type: Character

Variable Length: 6

Facility Name

Field Name: facility_name

Definition: The facility name documented on the official license issued by the California Department of Public Health (CDPH) Licensing and Certification Division and submitted to OSHPD's Licensed Facility Information System (LFIS). Displayed names use a standardized "doing business as" naming format. Note that names associated with facility ID potentially change across years and year-specific code-label crosswalks must be used.

Variable Type: Character

Variable Length: 60

License Type

Field Name: lic_type

Definition: The license type of the reporting facility. For Ambulatory Surgery data, this variable can be used to distinguish between freestanding ambulatory surgery centers and hospital-based ambulatory surgery.

Variable Type: Character

Variable Length: Code version: 1 Label version: 8

C = Clinic

H = Hospital

Patient ZIP Code

Field Name: patzip3

Definition: The patient's 3-digit ZIP Code of residence. If the reported ZIP Code is invalid or if the ZIP Code is unknown, it is assigned a value of "999". If only the city of residence is known, the city's 3-digit ZIP is assigned to the record.

Variable Type: Character

Variable Length: 3

Service Year

Field Name: serv_y

Definition: The year service was provided to the patient.

Variable Type: Character

Variable Length: 4

Patient Type

Field Name: pat_type

Definition: The type of facility where a particular patient encounter occurred. The AS and ED files are distributed separately and this variable is "A" in every record in the AS file and "E" in every record in the ED file.

Variable Type: Character

Variable Length: 1

A = Ambulatory Surgery

E = Emergency Department

Disposition

Field Name: dispn

Definition: The consequent arrangement or event ending a patient's encounter in the reporting facility. Reported invalid and missing values for disposition were defaulted to "99". For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/EDASManual/Disposition.pdf

Variable History: Prior to January 1, 2011, the description for "04" was "Discharged/Transferred to an intermediate care facility (ICF)." Into the future, the National Uniform Billing Committee (NUBC) approved sixteen (16) patient disposition codes effective with encounters on and after October 1, 2013. The new disposition codes require regulatory approval for OSHPD reporting. The new codes are accepted by OSHPD, but will not be required until California Regulations are amended to reflect the changes. Facilities may report the new plan codes to OSHPD while regulations are pending approval.

Variable Type: Character

Variable Length: Code version: 2 Label version: 51

- 01 = Discharged to home or self care (routine discharge)
- 02 = Discharged/Transferred to a short-term general hospital for inpatient care
- 03 = Discharged/Transferred to a skilled nursing facility (SNF) with Medicare certification in anticipation of covered skilled care
- 04 = Discharged/Transferred to a facility that provides custodial or supportive care
- 05 = Discharged/Transferred to a designated cancer center or children's hospital
- 06 = Discharged/Transferred home under the care of organized home health service organization in anticipation of covered skilled care
- 07 = Left against medical advice or discontinued care
- 20 = Expired
- 21 = Discharged/Transferred to court/law enforcement (New 10/01/09)
- 43 = Discharged/Transferred to a federal health care facility
- 50 = Discharged home with hospice care
- 51 = Discharged to a medical facility with hospice care
- 61 = Discharged/Transferred to a hospital-based Medicare approved swing bed
- 62 = Discharged/Transferred to an inpatient rehabilitation facility (IRF) including rehabilitation distinct part unit of a hospital

63 = Discharged/Transferred to a Medicare certified long-term care hospital (LTCH)

64 = Discharged/Transferred to a nursing facility certified under Medicaid (Medi-Cal), but not certified under Medicare

65 = Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital

66 = Discharged/Transferred to a critical access hospital (CAH)

69 = Discharged/Transferred to a designated Disaster Alternative Care Site

70 = Discharged/Transferred to another type of healthcare institution not defined elsewhere on this code list

81 = Discharged/Transferred to Home or Self care with a Planned Acute Care Hospital Inpatient Readmission

82 = Discharged/Transferred to a Short Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission

83 = Discharged/Transferred to Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission

84 = Discharged/Transferred to a facility that provides custodial or supportive care (includes intermediate care facility) with a Planned Acute Care Hospital Inpatient Readmission

85 = Discharged/Transferred to a designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission

86 = Discharged/Transferred to home under care of organized home health service organization with a Planned Acute Care Hospital Inpatient Readmission

87 = Discharged/Transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission

88 = Discharged/Transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission

89 = Discharged/Transferred to a hospital-based Medicare approved swing bed with a Planned Acute Care Hospital Inpatient Readmission

90 = Discharged/Transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission

91 = Discharged/Transferred to a Medicare certified Long Term Care Hospital (LTCH) a Planned Acute Care Hospital Inpatient Readmission

92 = Discharged/Transferred to a Nursing Facility certified under Medicaid (Medi-Cal), but not certified under Medicare with a Planned Acute Care Hospital Inpatient Readmission

93 = Discharged/Transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission

94 = Discharged/Transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission

95 = Discharged/Transferred to another type of health care institution not defined elsewhere in this code list with a Planned Acute Care Hospital Inpatient Readmission

00 = Other

99 = Invalid / Blank

Expected Source of Payment

Field Name: payer

Definition: The type of entity or organization expected to pay the greatest share of the patient's bill. For more information, see the documentation provided by the MIRCal (data submission) system: http://www.oshpd.ca.gov/HID/MIRCal/Text_pdfs/ManualsGuides/EDASManual/ExpectedSourcePayment.pdf.

Variable Type: Character

Variable Length: 2

09 = Self Pay
11 = Other Non-federal Programs
12 = Preferred Provider Organization (PPO)
13 = Point of Service (POS)
14 = Exclusive Provider Organization (EPO)
16 = Health Maintenance Organization (HMO) Medicare Risk
AM = Automobile Medical
BL = Blue Cross/Blue Shield
CH = CHAMPUS (TRICARE)
CI = Commercial Insurance Company
DS = Disability
HM = Health Maintenance Organization
MA = Medicare Part A
MB = Medicare Part B
MC = Medicaid (Medi-Cal)
OF = Other Federal Program
TV = Title V
VA = Veterans Affairs Plan
WC = Workers' Compensation Health Claim
00 = Other
99 = Invalid/Unknown

External Cause of Injury – Principal E-Code

Field Name: ec_prin

Definition: The external cause of injury or poisoning or adverse effect code (E800-E999) which describes the mechanism that resulted in the most severe injury, poisoning, or adverse effect related to the admission. An E-Code is to be reported on the record for the first episode of care reportable to OSHPD during which the injury, poisoning, and/or adverse effect was diagnosed and/or treated. If a patient was first diagnosed in a doctor's office and then sent to an ED or AS facility, the E-Code was reported on the ED or AS record. If the E-Code has been previously reported on a discharge or encounter, the E-Code will not be reported again on the encounter record. E-Codes are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character (implied decimal after the 4th character from the left)

Variable Length: 7

External Cause of Injury – Other E-Code (up to 4)

Field Name(s): ec1 – ec4

Definition: The additional external cause of injury or poisoning or adverse effect codes (E800-E999) that completely describe the mechanisms that contributed to, or the causal events surrounding, any injury, poisoning, or adverse effect. Up to 4 other E-Codes should be included for the first reportable episode of care during which the injury, poisoning, or adverse effect was diagnosed and/or treated only. If a patient was diagnosed in a doctor's office and then sent to an ED or AS facility, the E-Code was reported on the ED or AS record. If the E-Code has been previously reported on a discharge or encounter, the E-Code will not be reported again on the encounter record. E-Codes are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis, Principal Procedure, or Principal E-Code was reported for a facility.

Variable Type: Character (implied decimal after the 4th character from the left)

Variable Length: 7

Principal Diagnosis

Field Name(s): dx_prin

Definition: The condition, problem, or other reason established to be the chief cause of the encounter for care. Diagnoses are coded according to the ICD-9-CM. If the reporting principal diagnosis code is blank or invalid and is not corrected by the reporting facility after it is identified by OSHPD as an error, the principal diagnosis was defaulted to 799.9, in accordance with Health and Safety Code Section 97248.

Variable Type: Character (implied decimal after the 3rd character from the left)

Variable Length: 7

Other Diagnoses (up to 24)

Field Name(s): odx1 – odx24

Definition: All conditions that coexist at the time of the encounter for emergency or ambulatory surgery care, that develop subsequently during the encounter, or that affect the treatment received. Diagnoses are coded according to the ICD-9-CM. This variable is masked (*) on records where only one instance of a Principal Diagnosis or Principal Procedure code was reported for a facility.

Variable Type: Character (implied decimal after the 3rd character from the left)

Variable Length: 7

Principal Procedure

Field Name(s): pr_prin

Definition: The procedure that is surgical in nature, or carries a procedural risk, or carries an anesthetic risk and is most closely related to the principal diagnosis, as the chief reason for the encounter. Procedures are coded according to the Current Procedural Terminology, Fourth Edition (CPT-4). Category II CPT-4 codes and modifiers are not accepted by OSHPD. The procedure date is assumed to be the same as the service date. For more information on the risks and cancelled surgeries, see the California Emergency Department and Ambulatory Surgery Data Reporting Manual: http://www.oshpd.ca.gov/HID/MIRCal/EDASManual.html.

Variable Type: Character

Variable Length: 5

Other Procedures (up to 20)

Field Name(s): opr1 – opr20

Definition: All other procedures related to the encounter, which are surgical in nature, carry a procedural risk or carry an anesthetic risk. Procedures are coded according to the Current Procedural Terminology, Fourth Edition (CPT-4). Category II CPT-4 codes and modifiers are not accepted by OSHPD. The procedure date is assumed to be the same as the service date. This variable is masked (*) on records where only one instance of a Principal Diagnosis or Principal Procedure code was reported for a facility. For more information on the risks and cancelled surgeries, see the California Emergency Department and Ambulatory Surgery Data Reporting Manual: http://www.oshpd.ca.gov/HID/MIRCal/EDASManual.html.

Variable Type: Character

Variable Length: 5