Inpatient Stays Related to Nonalcoholic Fatty Liver Disease, 2016-2022

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Introduction

Nonalcoholic fatty liver disease (NAFLD), also known as metabolic dysfunction-associated steatotic liver disease (MASLD), is a condition characterized by excess fat buildup in the liver, not caused by heavy alcohol use. It ranges from simple fatty liver, which typically doesn't cause symptoms, to nonalcoholic steatohepatitis (NASH), which can progress to liver fibrosis, cirrhosis, and even liver cancer1. It is estimated that about 1 in 4 Americans have NAFLD and between 1.5 to 6.5 percent of US adults have the more severe form NASH1. Individuals diagnosed with NAFLD face an elevated risk of liver-related health complications and mortality, and NASH has become a leading cause of liver transplantation. NAFLD often coexists with other metabolic conditions, potentially leading to increased burdens on healthcare systems.2 NAFLD is not typically the primary reason for an inpatient stay; rather, it is often an incidental finding or a comorbidity that complicates the inpatient stay.

This Healthcare Cost and Utilization Project (HCUP) Statistical Brief presents weighted estimates on non-neonatal inpatient stays involving NAFLD from the National Inpatient Sample (NIS). First, trends on the number of inpatient stays involving NAFLD from 2016 to 2022 are presented. Second, patient characteristics of NAFLD-related stays are compared with all other stays using the 2022 NIS. For stays with a secondary diagnosis of NAFLD, the most frequent principal diagnoses are presented. Finally, frequencies of 20 comorbidities, defined by the Elixhauser Comorbidity Software Refined for the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM), v2024.1, are presented for stays with and without a NAFLD diagnosis3.

Because of the large sample size of the NIS data, small differences can be statistically significant but not necessarily meaningful. All differences noted in the text are greater than or equal to 10 percent.

Highlights

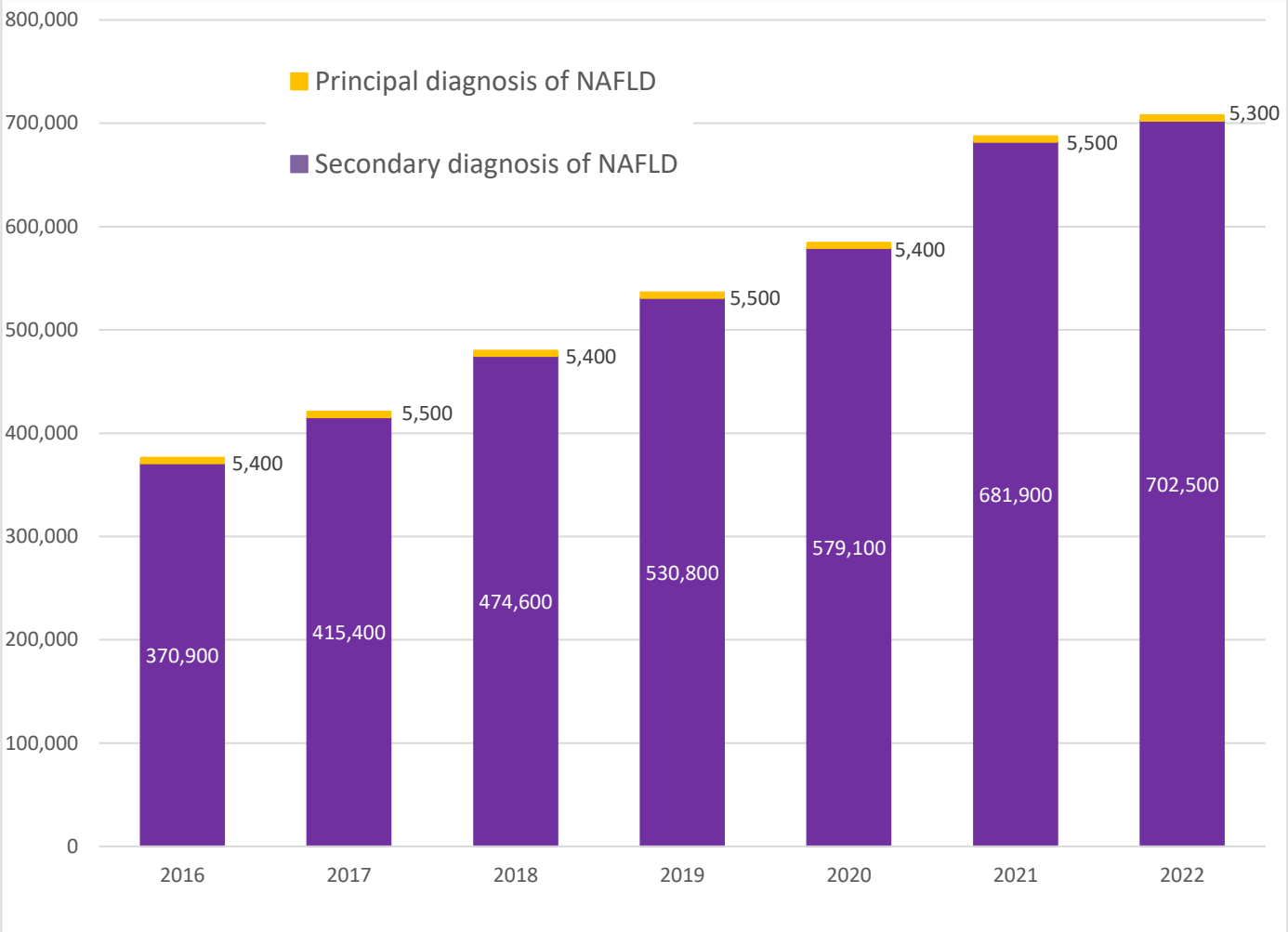
- The number of NAFLD-related inpatient stays increased 88.1 percent from 2016 to 2022.
- NAFLD-related inpatient stays constituted a small fraction of all inpatient stays -- between about 1 percent and 2 percent during 2016-2022.
- NAFLD occurred predominantly as a secondary diagnosis.
- A higher percentage of stays involving NAFLD were for patients 45 to 64 years old, compared to stays that did not involve NAFLD (40.8 vs. 24.3 percent).
- Compared to stays without any NAFLD diagnosis, stays for patients with NAFLD more frequently had a principal diagnosis of hepatitis, hepatic failure, pancreatic disorders, obesity, or other liver disease.
- NAFLD-related stays were associated with a higher prevalence of comorbidities compared to stays without NAFLD, with 93.4 percent of NAFLD-related stays having at least one comorbidity, compared to 78.2 percent for stays without NAFLD.

Findings

Number of NAFLD-related inpatient stays, 2016-2022

Figure 1 presents the number of NAFLD-related inpatient stays per year from 2016 to 2022. NAFLD-related inpatient stays were identified by any diagnosis of NAFLD. The number of inpatient stays related to NAFLD includes hospitalizations in which NAFLD was the reason for the stay (i.e., principal diagnosis) or a co-occurring condition or complication of the stay (i.e., reported as a secondary diagnosis).

Figure 1. Number of NAFLD-related inpatient stays, United States, 2016-2022



Abbreviations: NAFLD=nonalcoholic fatty liver disease.
Note: Number of stays is rounded to the nearest hundred.
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2016-2022

- The number of NAFLD-related inpatient stays increased from 2016 to 2022, with an average annual growth rate of 11.1 percent, amounting to an increase of 88.1 percent during the period.
- The number of inpatient stays with a principal diagnosis of NAFLD remained stable between 2016 to 2022, between 5,300 and 5,500. The overall rise in inpatient stays involving NAFLD was largely driven by cases where it is listed as a secondary diagnosis—typically identified in patients hospitalized for other medical conditions.
- NAFLD-related inpatient stays remained a small fraction of all non-neonatal inpatient stays (1.2 percent of the 31.7 million inpatient stays in 2016 and 2.4 percent of the 29.2 million inpatient stays in 2022, data not shown).

Characteristics of inpatient stays related to NAFLD, 2022

Table 1 presents characteristics of inpatient stays involving NAFLD in 2022. Characteristics of inpatient stays that do not involve NAFLD are provided for comparison.

Table 1. Distribution of inpatient stays by characteristic and presence of any NAFLD diagnosis, United States, 2022

Characteristic	Stays with any NAFLD		Stays without any NAFLD	
	Number	Percent	Number	Percent
Overall	**707,800**	**100.0**	**28,530,300**	**100.0**
Age group (in years)		**100.0**		**100.0**
0 - 17	5,000	0.7	1,376,500	4.8
18 - 44	177,500	25.1	7,695,600	27.0
45 - 64	288,800	40.8	6,942,900	24.3
65+	236,500	33.4	12,515,300	43.9
Sex		**100.0**		**100.0**
Male	331,000	46.8	12,475,100	43.7
Female	376,800	53.2	16,058,200	56.3
Primary expected payer		**100.0**		**100.0**
Medicare	269,800	38.2	12,944,800	45.4
Medicaid	155,000	21.9	5,979,300	21.0
Private	217,900	30.8	7,522,100	26.4
Self-pay / no charge	43,100	6.1	1,125,100	3.9
Other	21,100	3.0	925,400	3.2
Patient location		**100.0**		**100.0**
Large central metro	209,400	29.7	8,278,200	29.2
Large fringe metro	176,100	25.0	7,087,700	25.0
Medium/small	223,200	31.7	8,616,700	30.4
Micro/noncore	95,200	13.5	4,383,700	15.5
Hospital region of the U.S.		**100.0**		**100.0**
Northeast	117,900	16.7	5,139,300	18.0
Midwest	153,600	21.7	6,131,300	21.5
South	282,100	39.9	11,629,100	40.7
West	154,100	21.8	5,638,400	19.8

Abbreviations: NAFLD=nonalcoholic fatty liver disease.
Notes: Neonates are excluded from the analysis. Number of stays is rounded to the nearest hundred. Other payers include other Federal and local government programs (e.g., TRICARE, CHAMPVA, Indian Health Service, Black Lung, Title V) and Workers' Compensation.
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS) 2022

- A higher percentage of stays involving NAFLD were for patients 45 to 64 years old, compared to stays that did not involve NAFLD (40.8 vs. 24.3 percent).
- Among NAFLD-related stays, private insurance was more often the primary expected payer compared to non-NAFLD stays (30.8 percent vs. 26.4 percent); and Medicare, less often (38.2 percent vs. 45.4 percent).

Top 25 most common principal diagnoses and average hospital cost among stays with a secondary NAFLD diagnosis.

Table 2 presents principal diagnoses (i.e., the primary reason for the inpatient stay) for stays with and without a secondary NAFLD diagnosis in 2022. The conditions are sorted by the relative prevalence of stays with a NAFLD diagnosis. The average cost per stay and percentage of all inpatient stays are presented in addition to the number of stays.

Table 2. Number and average hospital cost of inpatient stays by top 25 principal diagnoses and presence of secondary NAFLD diagnosis, United States, 2022

Rank among stays with NAFLD	Principal diagnosis (CCSR)	Stays with secondary NAFLD			Stays without secondary NAFLD			Prevalence ratio of diagnosis among NAFLD vs no NAFLD
		Number	Percent	Average hospital cost, $	Number	Percent	Average hospital cost, $	
1	Septicemia	80,900	11.5	25,600	2,340,000	8.2	24,800	1.4
2	Pancreatic disorders (excl. diabetes)	44,700	6.4	13,000	217,100	0.8	13,000	8.4
3	Obesity	36,800	5.2	15,400	177,200	0.6	14,900	8.4
4	Biliary tract disease	31,700	4.5	16,900	280,200	1.0	16,500	4.6
5	Alcohol-related disorders	29,800	4.2	12,500	296,300	1.0	9,500	4.1
6	Other specified and unspecified liver disease	29,100	4.1	20,400	154,800	0.5	21,500	7.6
7	Heart failure	20,400	2.9	19,600	1,077,800	3.8	16,600	0.8
8	Diabetes mellitus with complication	18,000	2.6	14,400	669,200	2.3	16,000	1.1
9	Coronavirus disease – 2019	16,100	2.3	25,800	804,500	2.8	19,400	0.8
10	Hepatic failure	14,200	2.0	24,800	54,500	0.2	25,000	10.6
11	Acute and unspecified renal failure	13,900	2.0	14,500	483,400	1.7	13,200	1.2
12	Gastrointestinal hemorrhage	11,200	1.6	15,000	251,300	0.9	15,000	1.8
13	Urinary tract infections	11,100	1.6	11,200	451,100	1.6	10,400	1.0
14	Diverticulosis and diverticulitis	10,800	1.5	14,400	249,300	0.9	15,000	1.8
15	Fluid and electrolyte disorders	10,000	1.4	12,500	350,600	1.2	10,500	1.2
16	Acute myocardial infarction	9,300	1.3	32,600	572,700	2.0	28,000	0.7
17	Cardiac dysrhythmias	9,000	1.3	18,700	587,000	2.1	16,600	0.6
18	Pneumonia (except that caused by tuberculosis)	8,700	1.2	17,300	538,400	1.9	13,900	0.7
19	Intestinal obstruction and ileus	7,900	1.1	14,400	298,600	1.0	14,600	1.1
20	Spondylopathies/spondyloarthropathy (including infective)	7,100	1.0	33,000	440,000	1.5	31,500	0.7
21	Hepatitis	7,000	1.0	14,200	21,500	0.1	16,800	13.2
22	Complication of other surgical or medical care, injury, initial encounter	6,800	1.0	24,800	333,800	1.2	23,400	0.8
23	Skin and subcutaneous tissue infections	6,600	0.9	12,600	366,400	1.3	10,500	0.7
24	Esophageal disorders	6,400	0.9	14,000	102,400	0.4	14,100	2.5
25	Respiratory failure; insufficiency; arrest	6,300	0.9	24,000	425,700	1.5	22,100	0.6

Abbreviations: NAFLD=nonalcoholic fatty liver disease; CCSR=Clinical Classifications Software Refined; ICD-10-CM, International Classification of Diseases, Tenth Revision, Clinical Modification
Notes: Diagnoses are grouped using the Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses. Principal diagnosis is assigned to a single default CCSR category (see Definitions section below). Number of stays and mean hospital costs are rounded to the nearest hundred.
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2022

- Among inpatient stays involving NAFLD, septicemia was the most common reason for the stay, followed by pancreatic disorders and obesity.
- Nine of the top 25 principal diagnoses among stays with a NAFLD secondary diagnosis were related to the digestive system.
- Hepatitis, hepatic failure, obesity, pancreatic disorders, and other specified and unspecified liver disease were among the most disproportionally represented principal diagnoses among stays with a secondary NAFLD diagnosis compared to stays without NAFLD (prevalence ratio = 13.2, 10.6, 8.4, 8.4 and 7.6, respectively).

- Although NAFLD is not alcohol-related, a principal diagnosis of alcohol-related disorder was 4.1 times more common among the NAFLD stays (4.2 vs. 1.0 percent).
- Among inpatient stays with a principal diagnosis of alcohol-related disorder, those with a secondary diagnosis of NAFLD have a 32 percent greater average cost than non-NAFLD stays ($12,500 vs. $9,500).

Comorbidities associated with any NAFLD diagnosis

Table 3 lists pre-existing comorbidities for NAFLD-related inpatient stays in 2022. Comorbidities for stays without any NAFLD diagnosis are listed for comparison. The conditions are sorted by the volume of stays involving NAFLD.

Table 3. Number and percent of stays by presence of comorbidity and NAFLD diagnosis, United States, 2022

Rank among stays with NAFLD	Comorbidity	Stays with any NAFLD		Stays without any NAFLD		Prevalence ratio of comorbidity among NAFLD vs no NAFLD
		Number	Percent	Number	Percent	
	No co-morbidities	46,900	6.6	6,229,400	21.8	0.3
	Any co-morbidity	660,900	93.4	22,308,700	78.2	1.2
1	Hypertension, uncomplicated	290,700	41.1	8,302,500	29.1	1.4
2	Obesity	283,400	40.0	5,316,200	18.6	2.1
3	Diabetes with chronic complications	185,200	26.2	5,132,800	18.0	1.5
4	Chronic pulmonary disease	156,500	22.1	5,793,300	20.3	1.1
5	Hypertension, complicated	155,500	22.0	6,576,800	23.0	1.0
6	Depression	126,500	17.9	3,512,400	12.3	1.5
7	Alcohol abuse	121,000	17.1	1,454,800	5.1	3.4
8	Hypothyroidism	106,100	15.0	3,576,600	12.5	1.2
9	Diabetes without chronic complications	101,600	14.3	2,611,900		1.6
10	Peripheral vascular disease	40,300	5.7	1,729,700	6.1	0.9
11	Drug abuse	35,500	5.0	1,529,600	5.4	0.9
12	Autoimmune conditions	30,400	4.3	896,200	3.1	1.4
13	Solid tumor without metastasis, malignant	20,900	2.9	842,400	3.0	1.0
14	Dementia	20,400	2.9	1,800,000	6.3	0.5
15	Metastatic cancer	16,200	2.3	922,400	3.2	0.7
16	Other thyroid disorders	12,700	1.8	399,900	1.4	1.3
17	Lymphoma	6,000	0.8	279,200	1.0	0.9
18	Leukemia	5,500	0.8	225,900	0.8	1.0
19	Acquired immune deficiency syndrome	4,100	0.6	182,200	0.6	0.9
20	Solid tumor without metastasis, in situ	300	0.0	8,800	0.0	1.2

Abbreviations: NAFLD=nonalcoholic fatty liver disease.
Notes: Number of stays is rounded to the nearest hundred. The Elixhauser Comorbidity Software Refined for ICD-10-CM, v2024.1, was used to identify comorbidities. Only the 20 comorbidities that were assumed to be present on admission were included in this analysis. A discharge record may indicate more than one comorbidity
Source: Agency for Healthcare Research and Quality (AHRQ), Healthcare Cost and Utilization Project (HCUP), National Inpatient Sample (NIS), 2022

- NAFLD related stays more frequently had at least one comorbidity compared to stays without NAFLD (93.4 vs. 78.2 percent).
- The most common comorbidities for NAFLD-related stays were uncomplicated hypertension (41.1 percent), obesity (40.0 percent), and diabetes with chronic complications (26.2 percent).
- The most disproportionally represented comorbidities among stays involving NAFLD compared to stays without NAFLD were alcohol abuse (17.1 vs. 5.1 percent, prevalence ratio (PR)=3.4), obesity (40.0 vs 18.6 percent, PR=2.2), diabetes with and without chronic complications (PR=1.5 and 1.6, respectively), and depression (17.9 vs. 12.3 percent, PR=1.5).

References

[1] National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK). https://www.niddk.nih.gov/health-information/liver-disease/nafld-nash/definition-facts. Accessed March 20, 2024.

[2] Younossi, Z., Anstee, Q., Marietti, M. et al. Global burden of NAFLD and NASH: trends, predictions, risk factors and prevention. Nat Rev Gastroenterol Hepatol 15, 11–20 (2018). https://doi.org/10.1038/nrgastro.2017.109

[3] Agency for Healthcare Research and Quality. Elixhauser Comorbidity Software Refined for ICD-10-CM, v2024.1. Healthcare Cost and Utilization Project (HCUP). March 2024. https://hcup-us.ahrq.gov/toolssoftware/comorbidityicd10/comorbidity_icd10.jsp. Accessed March 21, 2024.

Data Source

This brief uses data from the 2016 to 2022 Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) National Inpatient Sample (NIS). For additional information about the HCUP NIS, please visit: https://hcup-us.ahrq.gov/db/nation/nis/nisdbdocumentation.jsp

Population Studied

Case Definition of Non-Alcoholic Fatty Liver Disease (NAFLD)

Two ICD-10-CM codes define non-alcoholic fatty liver disease (NAFLD): K75.81 nonalcoholic steatohepatitis (NASH) and K76.0 (fatty (change of) liver, not elsewhere classified). NAFLD-related inpatient stays include stays with NAFLD as the principal diagnosis and/or as a secondary diagnosis.

The unit of analysis is the discharge (i.e., the hospital stay) from a nonfederal acute care hospital, not a person or patient. 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. Neonatal inpatient stays, defined as patients between 0 to 28 days old, are excluded from the analysis.

Definitions

Diagnoses

The *principal diagnosis* is that 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 admission that require or affect patient care treatment received or management, or that develop during the inpatient stay. *All-listed diagnoses* include the principal diagnosis plus the secondary conditions.

ICD-10-CM Coding System

ICD-10-CM/PCS is the *International Classification of Diseases, Tenth Revision, Clinical Modification/Procedure Coding System*. There are over 70,000 ICD-10-CM diagnosis codes. There are over 75,000 ICD-10-PCS procedure codes.

Clinical Classifications Software Refined (CCSR) for ICD-10-CM Diagnoses

The CCSR for ICD-10-CM diagnoses aggregates over 73,000 ICD-10-CM diagnosis codes into 540 clinically meaningful categories. 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. For this brief, the principal diagnosis code is assigned to a single default CCSR based on clinical coding guidelines, etiology and pathology of diseases, and standards set by other Federal agencies. For this brief, v2024.1 of the CCSR was used. For more information on the CCSR, see https://hcup-us.ahrq.gov/toolssoftware/ccsr/ccs_refined.jsp

Elixhauser Comorbidity Software Refined for ICD-10-CM Diagnoses

The AHRQ comorbidity measures identify coexisting medical conditions that are not directly related to the principal diagnosis, or the main reason for admission, and are likely to have originated prior to the hospital stay.[3] These comorbidities can make a hospital stay more expensive and complicated. There are 38 comorbidities, 20 of which do not use present on admission (POA) indicators because the condition is assumed to be pre-existing and not a result of hospital care. The additional 18 measures on based on whether the secondary diagnosis was POA. Since the NIS does not include POA indicators, comorbidities presented in this analysis are limited to the 20 that do not rely on a POA indicator. The AHRQ comorbidity measures were developed originally as one of the HCUP tools. Complete documentation on the comorbidity measures is available on the HCUP User Support Website under Tools & Software (http://www.hcup-us.ahrq.gov/toolssoftware/comorbidity/comorbidity.jsp).

Primary expected payer

To make coding uniform across all HCUP data sources, the primary expected payer 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

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

Location of patient residence

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

Urban:

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

Rural:

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

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).[1] *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 brief, costs are reported to the nearest hundred dollars. Further information on the Cost-to-Charge Ratio can be found at: https://hcup-us.ahrq.gov/db/ccr/costtocharge.jsp.

Calculations

Prevalence ratio (PR)

[1] Agency for Healthcare Research and Quality. Cost-to-Charge Ratio Files. Healthcare Cost and Utilization Project (HCUP). Agency for Healthcare Research and Quality. Updated November 2021. www.hcup-us.ahrq.gov/db/state/costtocharge.jsp. Accessed March 9, 2022.

The prevalence ratio PR is the ratio of the probability of an event in one group to the probability of the event in another group. It was calculated using the following formula:

$$PR(X)A\ vs\ B = \frac{P(X|A)}{P(X|B)}$$

where event X is the principal diagnosis or comorbidity; group A comprises those stays with a NAFLD diagnosis, and group B, those without a NAFLD diagnosis.

About HCUP

The Agency for Healthcare Research and Quality (AHRQ) Healthcare Cost and Utilization Project (HCUP) is a family of databases, software tools, and related products developed through a federal-state-industry partnership with state data organizations, hospital associations, and private data organizations from 48 states and the District of Columbia. HCUP includes the near universe of encounter-level inpatient, emergency department, and ambulatory surgery data, regardless of the patient's age, diagnosis, or expected payer, from all nonfederal acute care hospitals in participating states. Produced annually since 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. For more information about HCUP, see: https://hcup-us.ahrq.gov/

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

Alaska Department of Health
Arizona Department of Health Services
Arkansas Department of Health
California Department of Health Care Access and Information (HCAI)
Colorado Hospital Association
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Delaware Department of Health and Social Services
District of Columbia Hospital Association
Florida Agency for Health Care Administration
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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 Health Authority
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 Authority
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 Office of Shared Administration
Wisconsin Department of Health Services
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For More Information

The HCUP-US website also offers readily available statistics in the form of reports, downloadable tables or interactive data visualizations. Examples include the following:

- AHRQ HCUP Statistical Briefs present simple, descriptive reports on a variety of specific, healthcare related issues
- AHRQ HCUPnet is a free, online query system that provides statistics and data tables based on AHRQ HCUP data.
- AHRQ HCUP Summary Trend Tables provide downloadable tables containing State-specific monthly trends in hospital utilization derived from the AHRQ HCUP State Inpatient Databases (SID) and State Emergency Department Databases (SEDD).
- AHRQ HCUP Fast Stats is an online query tool that uses visual displays to compare national or State statistics on a range of healthcare topics
- AHRQ HCUP Methods Series Reports feature a broad array of methodological information on the HCUP databases and software tools
- AHRQ HCUP Topical Reports provide information on various priority populations
- AHRQ HCUP Infographics provide a visual representation of HCUP Statistical Briefs and other data
- AHRQ HCUP Findings-At-A-Glance provide snapshots covering a broad range of issues related to hospital use and costs.

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 healthcare in the United States. We also invite you to tell us how you are using this HCUP 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 email us at hcup@ahrq.gov or send a letter to the address below:

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