Online Data Supplement

Classification of Patients by Baseline Exacerbation History

For baseline exacerbation history, patients were classified on the presence of any exacerbation (moderate or severe) or no exacerbation. A moderate exacerbation was defined as an ambulatory (outpatient or office visit) or emergency department visit with a diagnosis of COPD (ICD-9-CM, 491.xx [except 491.20]; 492.x or 496; ICD-10-CM, J41-J44), either: 1) as a primary diagnosis or 2) as a secondary diagnosis with a primary diagnosis of respiratory failure (ICD-9-CM, 518.81, 518.82 or 518.84; ICD-10-CM, J96.00, J96.01, J96.02, J80, J96.20, J96.21, J96.22) and at least one dispensing of an antibiotic and/or systemic corticosteroids within 7 days following the encounter (i.e., visit date + 7 days). A severe exacerbation was defined as an inpatient hospital stay with a diagnosis of COPD, either: 1) as a primary diagnosis or 2) as a secondary diagnosis with a primary diagnosis of respiratory failure (E1).

Reference

E1. Stanford RH, Nag A, Mapel DW, Lee TA, Rosiello R, Vekeman F, Gauthier-Loiselle M, Duh MS, Merrigan JF, Schatz M. Validation of a new risk measure for chronic obstructive pulmonary disease exacerbation using health insurance claims data. *Ann Am Thorac Soc* 2016;13:1067–1075.