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DEFINITIONS OF TERMS AND VARIABLES

Activities of daily living (ADLs): Activities of daily living are activities related to personal care. They include bathing or showering, dressing, getting in and out of bed or a chair, using the toilet, and eating. If a sample person had any difficulty performing an activity by himself/herself and without special equipment, or did not perform the activity at all because of health problems, the person was deemed to have a limitation in that activity. The limitation may have been temporary or chronic at the time of the survey. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Arthritis: The category arthritis includes rheumatoid arthritis, osteoarthritis, and other forms of arthritis.

Annual rate of change: The annual rates of change in Tables 6.1 to 6.16 refer to average annual growth rates. The growth rate from one year to the next is the ratio of the figure for the second year to the figure for the first year, minus 1. The growth rate over a 2-year period is the square root of the ratio of the figure for the third year to the figure for the first year, minus 1. The growth rate over a 3-year period is the cube root of the ratio of the figure for the fourth year to the figure for the first year, minus 1, and so on. For example, the figure for annual rate of change from 1992 to 1995 is calculated as follows: the figure for 1995 is divided by the figure for 1992, and then the cube root of the result is calculated. This figure minus 1 is the average annual growth from 1992 to 1995:

$$\sqrt[3]{1995 / 1992} - 1 \quad .$$

Similarly, the formula used to calculate the average annual growth rate from 1992 to 2006 is:

$$\sqrt[14]{2006 / 1992} - 1 \quad .$$

The annual growth rate from 2005 to 2006 is calculated as follows:

$$(2006 / 2005) - 1 \quad .$$

The result is then multiplied by 100 to give the percentage presented in the table. It is not possible to calculate standard errors for the growth rates.

Balance billing: In the Medicare program, the practice of billing a Medicare beneficiary in excess of Medicare's allowed charge is known as balance billing. The balance billing amount is the difference between Medicare's allowed charge and the provider's actual charge to the patient.

Capitation payment: A capitation payment is a predetermined, per-member, per-month payment from the Medicare program to risk health maintenance organizations (HMOs) (see health maintenance organization). Risk HMOs use the capitation payment to finance all necessary Medicare-covered services provided to Medicare beneficiaries enrolled in the HMO. The amount paid for each Medicare enrollee does not depend on the actual cost of services provided to the individual.

Chronic conditions: Chronic conditions consists of heart disease, cancer (other than skin cancer), Alzheimer's disease/other dementias, mental illness/disorder (depression/anxiety disorders), hypertension (high blood pressure), diabetes, arthritis, osteoporosis, broken hip, pulmonary disease, stroke, Parkinson's disease, and urinary incontinence that occurs once a week or more often. In 2003, cancer (other

than skin cancer), Alzheimer's disease/other dementias, and mental illness/disorder (depression/anxiety disorders) were added to the list of chronic conditions.

Claim-only event: A claim-only event is a medical service or event known only through the presence of a Medicare claim. The event did not originate from, and was not matched to, an event or service reported by a sample person during an interview.

Coinsurance: A coinsurance is the percentage of covered hospital or medical expense, after subtraction of any deductible, for which an insured person is responsible. For example, after the annual deductible has been met, Medicare will generally pay 80 percent of approved charges for services and supplies covered under Medicare Part B. The remaining 20 percent of the approved charge is the coinsurance amount, for which the beneficiary is liable.

Copayment: A copayment is a form of cost-sharing whereby the insured pays a specific amount at the point of service or use (e.g., $10 per doctor visit).

Cost-sharing liability: Cost-sharing is the portion of payment to a provider of health care services that is the liability of the patient. Cost-sharing liabilities include deductibles, copayments, coinsurance, and balance billing amounts.

Deductible: A deductible is an initial expense of a specific amount of approved charges for covered services within a given time period (e.g., $100 per year) payable by an insured person before the insurer assumes liability for any additional costs of covered services. For example, from the first day through the 60th day of an inpatient hospital stay in 2006, Medicare Part A paid for all covered services except for the first $952. The $952 constituted the inpatient hospital deductible.

Dental service: The basic unit measuring use of dental services is a single visit to the dentist, at which time a variety of services, including cleaning, x-rays, and an exam, might be rendered.

End-stage renal disease (ESRD): End-stage renal disease is that state of kidney impairment that is irreversible, cannot be controlled by conservative management alone, and requires dialysis or kidney transplantation to maintain life.

Fee-for-service payment: Fee-for-service is a method of paying for medical services in which each service delivered by a provider bears a charge. This charge is paid by the patient receiving the service or by an insurer on behalf of the patient.

Functional limitations: Sample persons who reported no limitations in any of the activities of daily living (ADLs) or instrumental activities of daily living (IADLs) due to health problems were included in the category "none." Sample persons with limitations in at least one IADL, but no ADL, were included in the category "IADL only." Sample persons with ADL limitations were categorized by the number of limitations (1 to 2, 3 to 5) regardless of the presence or number of IADL limitations. Sample persons who were administered a community interview answered questions about their functional limitations themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's functional limitations for long-term care facility interviews.

Health maintenance organization (HMO): An HMO provides, or arranges for the provision of, a comprehensive package of health care services to enrolled persons for a fixed capitation payment (see capitation payment). The term "Medicare HMO" includes all types of HMOs that contract with Medicare, encompassing risk HMOs, cost HMOs, and health care prepayment plans (HCPPs). Risk HMOs are paid on a capitation basis to provide Part A and Part B services to Medicare enrollees. Cost HMOs are paid by Medicare on a reasonable

cost basis to provide Part A and Part B services to Medicare enrollees. HCPPs are paid by Medicare on a reasonable cost basis to provide Part B services to Medicare enrollees.

Health status: A sample person was asked to rate his or her general health compared to other people of the same age. Sample persons who were administered a community interview answered health status questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status for long-term care facility interviews.

Heart disease: The category heart disease includes myocardial infarction (heart attack), angina pectoris or coronary heart disease, congestive heart failure, problems with valves in the heart, or problems with rhythm of the heartbeat.

Income: Income is for calendar year 2006. It is for the sample person, or the sample person and spouse if the sample person was married in 2006. All sources of income from jobs, pensions, Social Security benefits, Railroad Retirement and other retirement income, Supplemental Security Income (SSI), interest, dividends, and other income sources are included. This sourcebook categorizes the continuous income variable into nine income classes.

Inpatient hospital stay: The basic unit measuring use of inpatient hospital services is a single admission. Inpatient hospital expenses include charges for an emergency room visit that resulted in an inpatient admission. Inpatient hospital events are included in the 2006 cost and use files if the discharge date for the stay was in 2006.

Instrumental activities of daily living (IADLs): Instrumental activities of daily living are activities related to independent living. They include preparing meals, managing money, shopping for groceries or personal items, performing light or heavy housework, and using a telephone. If a sample person had any difficulty performing an activity by himself/herself, or did not perform the activity at all, because of health problems, the person was deemed to have a limitation in that activity. The limitation may have been temporary or chronic at the time of the survey. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews. Facility interviewers did not ask about the sample person's ability to prepare meals or perform light or heavy housework, since they are not applicable to the sample person's situation; however, interviewers did question proxies about the sample person's ability to manage money, shop for groceries or personal items, or use a telephone.

Insurance coverage: Insurance categories were derived from annual insurance coverage variables in the 2006 Cost and Use files. The annual variables indicate whether a sample person held that type of insurance at some point during 2006. Insurance categories in this sourcebook were constructed to be mutually exclusive by prioritizing insurance holdings. Medicaid coverage had the highest priority; i.e., if a sample person was eligible for Medicaid benefits at some point during 2006, the person was included in the Medicaid category, regardless of other insurance holdings during the year. Enrollment in a Medicare HMO had the second-highest priority, after Medicaid eligibility. Other public health insurance plans, including Veterans Administration eligibility or a State-sponsored drug plan, are distributed across the insurance categories according to the sample person's highest-priority insurance coverage. For example, a person eligible for Medicaid coverage who was also eligible for a State-sponsored drug plan is categorized under "Medicaid."

The categories defined below apply to community residents. Facility residents have only four insurance categories: Medicare fee-for-service-only, Medicaid, private insurance, and Medicare HMO. No distinction was made during the collection of the facility data as to the source of

a private health insurance plan. The four insurance categories are analogous to those defined below for community residents. For beneficiaries who resided in a long-term care facility for part of the year and in the community for part of the year, community insurance status is shown.

- ***Medicare fee-for-service-only*** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who did not have Medicaid coverage, private insurance, and who were not enrolled in a private or Medicare HMO at any time during 2006. However, sample persons may have had other public insurance coverage, such as a State-sponsored prescription drug plan, or may have been eligible for Veterans Administration health care benefits.

- ***Medicaid*** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who were eligible for State Medicaid benefits at some point during 2006, regardless of the person's other insurance holdings.

- ***Individually-purchased private insurance*** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had self-purchased private insurance plans ("Medigap" insurance), but did not have Medicaid, private or Medicare HMO, or employer-sponsored private insurance coverage at any point during 2006.

- ***Employer-sponsored private insurance*** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had employer-purchased private insurance plans, but did not have Medicaid, Medicare HMO, or self-purchased private insurance coverage at any point during 2006. Sample persons enrolled in private HMOs, who did not have Medicaid or Medicare HMO coverage at any point during 2006, are also included in this category.

- **Both types of private insurance** encompasses sample persons eligible for Part A and/or Part B Medicare benefits, and who had both employer-sponsored private insurance and self-purchased private insurance, but who did not have Medicaid or Medicare HMO coverage at any point during 2006.

- ***Medicare HMO*** encompasses sample persons enrolled in any type of Medicare HMO, who were not eligible for Medicaid benefits at any point during 2006. The category includes beneficiaries enrolled in Medicare risk HMOs, Medicare cost HMOs, and health care prepayment plans (see health maintenance organization).

Living arrangement: For community residents, sample persons were separated into mutually exclusive categories: 1) beneficiary lives alone, 2) beneficiary lives with a spouse only, or lives with a spouse and other relatives or nonrelatives, 3) beneficiary lives with his or her children, or lives with his or her children and other relatives or nonrelatives, but does not live with a spouse, or 4) beneficiary lives with other relatives or nonrelatives, but not with his or her children or a spouse. For beneficiaries who resided in a long-term care facility for part of the year and in the community for part of the year, community residence status is shown.

Long-term care facility: The basic unit measuring use of facility services is a "stay" in a long-term care facility. Stays are measured in terms of days of residence in that facility. If the beneficiary was still in the facility at the end of the year, the stay is not complete, but all data for 2006 are present. To qualify for the survey, a long-term care facility must have three or more long-term care beds, and provide either personal care services to residents, provide continuous supervision of residents, or provide long-term care services throughout the facility or in a separately identifiable unit. Types of long-term care facilities include licensed nursing homes, skilled nursing homes, intermediate care facilities, retirement homes, domiciliary or personal care facili-

ties, distinct long-term care units in a hospital complex, mental health facilities and centers, assisted and foster care homes, and institutions for the mentally retarded and developmentally disabled. If noted in footnotes, long-term care facility use and expenditures in this sourcebook include short-term facility stays (institutional events), primarily in skilled nursing facilities, that were reported either during a community interview or created through Medicare claims data. Institutional events are included in the 2006 cost and use files if the discharge date for the stay was in 2006.

Medicare home health services: Home health care services are narrowly defined in the MCBS public use files. Home health care is limited to skilled nursing services and other therapeutic services provided by a Medicare participating home health agency. In the MCBS, home health use represents events where medical care, as opposed to personal care and support, was furnished to the sample person. Medicare pays 100 percent of the approved cost of covered home health visits, and 80 percent of the approved cost of durable medical equipment.

Medicare hospice services: Hospice services are narrowly defined in the MCBS public use files. Hospice care is limited to Medicare-covered services for terminally ill individuals who have elected to receive hospice care rather than standard Medicare benefits. Hospice services include medical, nursing, counseling, and other supportive services rendered to terminally ill people and their families. Hospice care is intended to be palliative and to improve quality of life rather than to cure disease or extend life. Almost all services provided to the hospice beneficiary are fully covered by Medicare. Two exceptions are prescribed medicines and inpatient respite care. These two types of services require a small amount of copayment.

Mental illnesses/disorders: The category mental illnesses/disorders includes mental retardation, depression, and other mental disorders. This definition was expanded to include mental retardation, schizophrenia, and manic depression for facility residents in 1997; and it was further expanded to include depression for community residents in 2000.

Missing values: When amounts (e.g., beneficiary counts or expenditures per beneficiary) are displayed in a table in this sourcebook, sample persons with missing responses or who belong to a category of a variable not shown in the table (e.g., "other" for the variable "race/ethnicity") are excluded from individual categories displayed, but are included in the total. When column or row percentages are displayed in a table, sample persons with missing responses are assumed to be distributed the same as reported data and are included in the percentages. That is, column or row percentages sum to 100 percent of the column or row total.

Mobility limitation: If the sample person had no difficulty at all walking a quarter of a mile, the response was coded as "no." If the sample person had a little, some, or a lot of difficulty, or could not walk a quarter of a mile, the response was coded as "yes." The response reflects whether the sample person usually had trouble walking, rather than temporary difficulty, such as from a short-term injury. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Outpatient hospital services: For a survey-reported event, the basic unit measuring use of outpatient services is a separate visit to any part of an outpatient department or outpatient clinic at a hospital. For Medicare claim-only events, it may represent 1) a single visit; 2) multiple procedures or services within one visit; or 3) multiple visits billed together. Outpatient hospital events include emergency room visits that did not result in an inpatient hospital admission.

Personal health care expenditures: Personal health care expenditures consist of health care goods and services purchased directly by individuals. They exclude public program administration costs, the net cost of private health insurance, research by nonprofit groups and government entities, and the value of new construction put in place for hospitals and nursing homes.

- ***Total personal health care expenditures*** in this source-book equal the sum of expenditures by Medicare, Medicaid, private insurance, out-of-pocket, and other sources, as defined below.
  - ***Long-term care facility expenditures*** include expenditures for short-term facility stays (institutional events), primarily in skilled nursing facilities, that were reported during a community interview or created through Medicare claims data as noted in footnotes.
  - ***Medicare expenditures*** equal Medicare program payments for fee-for-service beneficiaries, annual capitation payments to Medicare HMOs on behalf of enrollees,[1] and pass-through expenses for inpatient hospital services (see definition below). They exclude reported or imputed charges for individual events reported by Medicare HMO enrollees. Capitation payments were allocated across medical service types in the same proportions as Medicare fee-for-service payments for medical service types.
    - Medicare expenditures for ***inpatient hospital services*** include pass-through expenses. Medicare's Prospective Payment System (PPS) for inpatient hospital services pays a fixed, predetermined amount per case. However, this payment excludes some hospital expenses, particularly for capital costs, that are reimbursed on a cost basis (i.e., capital costs are "passed through" for payment). In order to calculate total Medicare program payments (actual PPS case payment plus the prorated share of pass-through costs), estimated pass-through costs were added to charges for inpatient hospital events.
    - Medicare expenditures for ***long-term care services*** consist of payments made by Medicare to long-term care facilities for skilled nursing or skilled rehabilitation services that are not included in any of the other event records.
  - ***Medicaid expenditures*** consist of payments for services made by State Medicaid programs. Medicaid covers coinsurance amounts, copayments, deductibles, and charges for some non-Medicare covered services not paid for by other public or private insurance plans.
  - ***Private insurance expenditures*** consist of payments made by individually-purchased private insurance plans and employer-sponsored private insurance plans, plus payments reported by or imputed for sample persons enrolled in private health maintenance organizations. The definition applies to community residents and part-year community/part-year facility residents. For facility residents, private insurance expenditures consist of payments made by private health insurance plans, whose sources (i.e., individual purchase or employer-sponsored) are unknown. No distinction was made during the collection of the facility data as to the source of private health insurance plans.

[1] In this sourcebook, the following changes were made in calculating total Medicare HMO expenditures: a) administrative cost (about 10 percent of the total annual Medicare HMO capitated payments) was subtracted from the total annual Medicare HMO capitated payments; and b) annual Medicare HMO premiums were added to the total annual Medicare HMO capitated payments.

- ***Out-of-pocket expenditures*** consist of direct payments to providers made by the sample person, or by another person on behalf of the sample person. These payments are for coinsurance amounts, copayments, deductibles, balance billings, and charges for non-Medicare covered services not paid for by public or private insurance plans.

- ***Other source expenditures*** consist of payments made by other public health plans and private liability insurance plans. For sample persons who resided in the community, examples of other public sources of payment include State pharmaceutical assistance programs and payments for sample persons who received medical services from the Veterans Administration. For sample persons who resided in a long-term care facility, examples of other public sources of payment include payments from State, county, or community departments of mental health, State supplemental assistance and welfare programs, and Black Lung funds.

Physician/supplier services: Physician/supplier services include medi cal doctor, osteopathic doctor, and health practitioner visits; diagnostic laboratory and radiology services; medical and surgical services; durable medical equipment; and nondurable medical supplies. Health practitioners include audiologists, optometrists, chiropractors, podiatrists, mental health professionals, therapists, nurses, paramedics, and physician's assistants. For survey-reported events, the basic unit measuring use of physician/supplier services is a separate visit, procedure, service, or purchase of a medical supply or medical equipment. For Medicare claim-only events, it may represent 1) single or multiple visits; 2) single or multiple procedures; 3) single or multiple services; or 4) single or multiple supplies, depending on the number of items bundled together on a single bill.

Prescription medicines: The basic unit measuring use of prescription medicines is a single purchase of a single drug in a single container. Prescription drug use is collected only for sample persons living in the community, and does not include prescription medicines administered during an inpatient hospital stay.

Pulmonary disease: The category pulmonary disease includes emphysema, asthma, and cardiopulmonary disease.

Race/ethnicity: Race and ethnic categories were recorded as interpreted by the respondent. Sample persons who reported they were white and not of Hispanic ancestry were coded as white non-Hispanic; those who reported they were black/African American and not of Hispanic ancestry were coded as black non-Hispanic; persons who reported they were of Hispanic ancestry, regardless of their race, were coded as Hispanic; persons who reported they were American Indian, an Asian or Pacific Islander, or other race and not of Hispanic ancestry were coded as other race/ethnicity. Hispanic includes persons of Mexican, Puerto Rican, Cuban, Central or South American, or other Spanish culture or origin, regardless of race. Beginning in calendar year 1998, sample persons with more than one racial background were captured in a separate category and collapsed into the "other" category in the sourcebook.

Residence status: Community residents are Medicare beneficiaries who lived solely in household units during 2006, referred to as "community settings" in this sourcebook, and who received community interviews only. Long-term care facility residents are Medicare beneficiaries who lived solely in a long-term care facility during 2006 (see long-term care facility), and who received facility interviews only. Part-year community/part-year facility residents are Medicare beneficiaries who lived part of the year in the community and part of the year in a long-term care facility, and who received both community and facility interviews. When part-year community/part-year facility residents are included in a table, their community status is shown.

Satisfaction with care: In section 5 of the detailed tables, "(Very) Unsatisfied" includes a response of either "unsatisfied" or "very unsatisfied." Sample persons with responses of "satisfied" and "no experience" are not shown in the tables but are included in the total population, which constitutes the denominator for calculating percentages of persons with a given response. The questions about satisfaction with care represent the respondent's general opinion of all medical care received in the year preceding the interview.

- *General care* refers to the sample person's rating of the overall quality of medical care received. Of the 10,936 community-only resident sample persons represented in the tables, 6,853 responded they were "satisfied," and 279 responded they had "no experience."

- *Follow-up care* refers to the sample person's rating of follow-up care received after an initial treatment or operation. Of the 10,936 community-only resident sample persons represented in the tables, 7,213 responded they were "satisfied," and 1,192 responded they had "no experience."

- *Availability* refers to the sample person's rating of the availability of medical care at night and on weekends. Of the 10,936 community-only resident sample persons represented in the tables, 4,663 responded they were "satisfied," and 4,542 responded they had "no experience."

- *Ease of access to doctor* refers to the sample person's rating of the ease and convenience of getting to a doctor from her or his residence. Of the 10,936 community-only resident sample persons represented in the tables, 7,698 responded they were "satisfied," and 231 responded they had "no experience."

- *Can obtain care in same location* refers to the sample person's rating of his or her ability to get all medical care needs taken care of at the same location. Of the 10,936 community-only resident sample persons represented in the tables, 7,019 responded they were "satisfied," and 1,647 responded they had "no experience."

- *Information from doctor* refers to the sample person's rating of the information given to the sample person about what was wrong with him or her. Of the 10,936 community-only resident sample persons represented in the tables, 7,862 responded they were "satisfied," and 356 responded they had "no experience."

- *Doctor's concern for overall health* refers to the sample person's rating of the doctor's concerns for her or his overall health rather than for an isolated symptom or disease. Of the 10,936 community-only resident sample persons represented in the tables, 7,539 responded they were "satisfied," and 395 responded they had "no experience."

- *Cost* refers to the sample person's rating of the out-of-pocket costs he or she paid for medical care. Of the 10,936 community-only resident sample persons represented in the tables, 6,892 responded they were "satisfied," and 290 responded they had "no experience."

Schooling: Schooling categories are based on the highest school grade completed. Before calendar year 1998, education does not specify education or training received in vocational, trade, or business schools outside of the regular school system. Since calendar year 1998, education or training received at these types of institutions are collapsed into "13–15 years" of schooling.

Smoker: Smoker categories in this sourcebook are mutually exclusive. Sample persons who had never smoked were categorized as "never smoked." Sample persons who smoked previously but were not

current smokers were categorized as "former smoker." Sample persons who reported they currently smoked were categorized as "current smoker." Smoking includes a period of regular smoking of cigarettes or pipes, but does not include use of other forms of tobacco, such as chewing tobacco.

Social activity limitation: If the sample person responded that health had not limited her or his social life in the past month, the response was coded as "no." If the sample person responded that health had limited her or his social life in the past month some, most, or all of the time, the response was coded as "yes." Limitations on social life include limitations on visiting with friends or close relatives, and reflect the sample person's experience over the preceding month, even if that experience was atypical. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Source of payment: See personal health care expenditures.

Survey-reported event: A survey-reported event is a medical service or event reported by a sample person during an interview. The event may have been matched to a Medicare claim, or it may be a survey-only event, in which case it was not matched to a Medicare claim and is only known through the survey.

Upper extremity limitation: If the sample person had no difficulty at all reaching or extending his or her arms above shoulder level, and had no difficulty writing or handling and grasping small objects, the response was coded as "no." If the sample person had a little, some, or a lot of difficulty with these tasks, or could not do them at all, the response was coded as "yes." The response reflects whether the sample person usually had trouble reaching over her or his head or writing, rather than temporary difficulty, such as from a short-term injury. Sample persons who were administered a community interview answered health status and functioning questions themselves, unless they were unable to do so. A proxy, such as a nurse, always answered questions about the sample person's health status and functioning for long-term care facility interviews.

Urinary incontinence: If the sample person had lost urine beyond his or her control at least once during the past 12 months, the response was coded as "yes." If the sample person was on dialysis or had a catheter, the response was coded as missing.

User rate: A user rate is defined as the percentage of beneficiaries with the given characteristics who used at least one of the relevant services during calendar year 2006. For example, the dental services user rate for persons age 85 or older who had Medicaid coverage is equal to the number of beneficiaries age 85 or older with Medicaid coverage who had at least one dental visit in 2006, divided by the total number of persons age 85 or older with Medicaid coverage.

Usual source of care: If the sample person responded that he or she did not have a particular medical person or clinic where he or she usually went for care or advice about health, the response was coded as "none." If the sample person responded that he or she did have a usual source of care, the sample person was questioned about the type of place. "Other clinic/health center" includes a neighborhood or family health center, a freestanding surgical center, a rural health clinic, a company clinic, any other kind of clinic, a walk-in urgent center, a home visit from a doctor, care in a Veterans Administration facility, a mental health center, or other place not included in the listed categories.