New York State Department of Health Adult Sepsis Data Dictionary

Digitalized Data Collection, D6.0

Version (Digital) D6.0

February 06, 2025

Effective with
Discharges from 01/01/2025

This dictionary refers to administrative codes available for download as csv files to assist in data extraction.

The most recent version of this document, the *Frequently Asked Questions* document, the *Table of Elements* data template, and the instructions may be found at:
https://ny.sepsis.ipro.org

Questions regarding this document should be submitted at:
https://ny.sepsis.ipro.org/support

==Changes from version D5.0.2 to D6.0 are highlighted in yellow.==

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Change Log

Version D<mark>6.0</mark>

- <mark>Changes from version D5.0.2 to D6.0 are highlighted in yellow in this Data Dictionary.</mark>
- Replaced "NYSDOH" abbreviation with "Department of Health."
- Revised the name of all the CSV files to reflect the new data dictionary version: change from D5.0.2 to D6.0.
- Revised the CSV files for the variables listed below to add, remove, or revise ICD-10-CM codes for the 01/01/2025 discharges. A summary of changes made to the ICD-10-CM codes can be found in the **Summary of ICD-10 Code Changes_VerD6.0** document. This document includes the codes that were added, removed, or revised for this data dictionary version.
  - Modified the list of ICD-10-CM codes of the prior CSV file:
    - *Severity Variables*
      - *Organ Dysfunction Cardiovascular (POA)*
  - Aligned prior CSV files with the ICD-10-CM codes from the Elixhauser Comorbidity Index for the following variables:
    - *Comorbidity/Risk Factor Variables*
      - *AIDS/HIV Disease*
      - *Chronic Liver Disease (POA)*
      - *Chronic Kidney Disease (POA)*
      - *Heart Failure (POA)*
      - *Dementia*
      - *Diabetes*
      - *Lymphoma Leukemia Multiple Myeloma*
      - *Metastatic Cancer*
- Removed the following variables and any associated CSV files from the data dictionary:
  - *Comorbidity/Risk Factor Variables*
    - *Acute Cardiovascular Conditions (POA)*
    - *Asthma*
    - *Dialysis Comorbidity (POA)*
    - *Hypertension*
    - *Mechanical Ventilation Comorbidity (POA)*
    - *Obesity*
    - *Pregnancy Comorbidity*
    - *Smoking Vaping*
    - *Tracheostomy on Arrival (POA)*
  - *Clinical Variables*
    - *COVID-19 Virus*
    - *Drug Resistant Pathogen*
    - *Flu Positive*

- o *Outcome (at discharge) Variables*
  - *Dialysis Outcome*
  - *Mechanical Ventilation Outcome*
  - *Tracheostomy at Discharge*
- o *Outcome (in hospital) Variables*
  - *Cardiovascular Outcomes in Hospital*
  - *ICU During Hospitalization*
  - *Tracheostomy in Hospital*
- o *Severity Variables*
  - *Organ Dysfunction Hematologic*
  - *Organ Dysfunction Hepatic*
  - *Organ Dysfunction Renal*
- Modified the Notes of Abstraction with the removal of the *Severity Variables* for the following variables:
  - o *Bilirubin Arrival Datetime*, *Bilirubin Max Datetime*
    - Substituting "Organ Dysfunction Hepatic" with "Bilirubin"
  - o *Creatinine Arrival Datetime*, *Creatinine Max Datetime*
    - Substituting "Organ Dysfunction Renal" with "Creatinine"
- Renamed the data element and template variable name and added POA requirement for the following *Comorbidity Variable: Congestive Heart Failure* to *Heart Failure (POA)*
- Revised the data element and template variable names and added POA requirement for the following variables:
  - o *Comorbidity/Risk Factor Variables*
    - *Chronic Liver Disease (POA)*
    - *Chronic Kidney Disease (POA)*
  - o *Severity Variables*
    - *Organ Dysfunction Cardiovascular (POA)*
    - *Organ Dysfunction CNS (POA)*
    - *Organ Dysfunction Respiratory (POA)*
- Redefined the POA instructions and added POA table in the Notes of Abstraction for the following variables:
  - o *Comorbidity/Risk Factor Variables*
    - *Coagulopathy (POA)*
    - *Chronic Liver Disease (POA)*
    - *Chronic Kidney Disease (POA)*
    - *Heart Failure (POA)*
  - o *Severity Variables*
    - *Organ Dysfunction Cardiovascular (POA)*
    - *Organ Dysfunction CNS (POA)*
    - *Organ Dysfunction Respiratory (POA)*

Key points to remember during data extraction

The New York State Department of Health (Department of Health) is seeking the collection of data for all severe sepsis and septic shock inpatients, emergency department (ED) patients and Observation patients who meet the case inclusion definition provided in the Inclusion Definition section of this dictionary.

Data for all patients who are 21 years of age or older are to be reported into the Department of Health's adult database. Patient age at admission should be used to determine reporting to the adult or the pediatric database. For patients who are not admitted to the hospital (i.e., ED and Observation only), the patient's age at arrival should be used to determine reporting to the adult or the pediatric database.

Hospitals with no reportable Adult severe sepsis and/or septic shock cases for any given submission period must Attest to Zero (0) Cases in the Data Collection Portal to meet the reporting requirements of 10 NYCRR 405.4 (a)(7).

When using the csv files for the identification of relevant ICD-10-CM codes, be sure to capture any code (ICD-10-CM) in any position at any point during hospitalization unless otherwise indicated in the variable directions.

Hospitals must report all variables outlined in the Data Dictionary for all cases that meet inclusion criteria. There are some exceptions such as *Transfer Facility Identifier Receiving* and *Transfer Facility Identifier Sending,* which are situational. For transfer data elements we recognize that your hospital EHR may not have Transfer Facility Identifier Receiving/Sending but may have Transfer Facility Name Receiving/Sending. Please report all data you have regarding transfers. Within hospital (interdepartmental transfers) are not considered transfers for these data elements.

Hospitals that have within hospital transfer patients (i.e., patient transferred from one unit to another within the same hospital) should report the case as it is collected in the EHR. For example, if your EHR represents a patient transferred from a rehab unit to an acute care unit as a combined record in your EHR, please report this episode of care as one record, even if two separate bills are generated for the rehab and the inpatient admission. If there are two separate records in the EHR, please submit it as two separate cases if inclusion criteria are met for each case. Be sure to use the appropriate discharge disposition to accurately represent the case.

This data dictionary has been designed to eliminate the need for manual chart abstraction and to permit hospitals to utilize their information technology staff and electronic medical record systems to extract the necessary data. This data will be accepted into the current portal in a flat file format following existing procedures which may be found at https://ny.sepsis.ipro.org/.

The csv files of codes are provided separately. Each csv file for ICD-10-CM codes contains seven columns: the codes for the variable, the corresponding code description, a subcategory if applicable, Add, Revise, ICD-10 CM CODE DECIMAL, and Subcategory Code if applicable. The columns titled ICD-10 CM CODE DECIMAL and Subcategory Code are provided for optional use by hospitals.

The 'Add' and 'Revise' columns indicate if a code has been added or if the code description has been revised in the current data dictionary update. 0 = No, 1 = Yes.

For example:

ICD-10-CM CODE	ICD-10-CM CODE DESCRIPTION	Subcategory	Add	Revise	ICD-10-CM CODE DECIMAL	Subcategory Code
U099	Post COVID-19 condition, unspecified		1	0	U09.9	

Please note that variables with multiple selections (more than Yes/No) will have values/contents in the subcategory column in the csv files, for example *History of Other Cardiovascular Disease*. In general, the naming convention for csv files is TemplateVariable_code_Version.
For example:

- aids_hiv_disease_code_VerD6.0.csv

Many of the Demographic Variables in the New York State Department of Health Adult Sepsis Data Dictionary are also collected in SPARCS.

Please visit https://www.health.ny.gov/statistics/sparcs/access/ for more information about the SPARCS Data Dictionary. Please navigate to the Data Use Resources section where you can find a link to the most current SPARCS Data Dictionary as shown on here:

Data Use Resources

Data Release Notes

- SPARCS Data Release Notes (Updated December 2022)

Output Data Dictionaries

- SPARCS Data Dictionary - In use; use for all data extracts received October 1, 2017 and forward.
- Old Format - No longer in use; used for data extracts received July 30, 2012 to September 30, 2017.
- Old Format - No longer in use; used for data extracts received prior to July 30, 2012.

Inclusion Definition

The <mark>Department of Health</mark> is identifying the (denominator) population of cases for inclusion into the database using ICD-10-CM codes. Hospitals may use all sources of data for case inclusion (electronic medical record codes as well as administrative and billing codes); however, cases should only be reported if one of the below inclusion codes is a final diagnosis. This will allow for electronic identification of cases. The ICD-10-CM code-based definition for identifying the severe sepsis and/or septic shock patient population for abstraction includes the following codes which are presented in Table A. Cases with code(s) in Table A are to be reported.

Examples:
- Patient with Code T8112XA and no other code from Table A is reported.
- Patient with R6520 and no other codes from Table A is reported. This case is reported because R6520 alone is a reportable case regardless of additional codes reported on the case.

Table A: Severe sepsis and/or septic shock inclusion ICD-10-CM codes

Severe Sepsis/Septic Shock	
ICD-10-CM	**Description**
R6520	Severe sepsis without septic shock
R6521	Severe sepsis with septic shock
T8112XA	Post procedural septic shock, initial encounter

Demographic Variables

Dataset Segment: Demographic Variables

Data Element Name:	Admission Datetime
Template Variable:	admission_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the date and time that the patient was admitted to inpatient status at the hospital.

Codes and Values:

Enter the Admission Datetime.

Notes for Abstraction:

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm is **NOT** allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00
- Cannot have been after *Discharge Datetime*.
- Observation only cases and ED only cases that do not progress to an inpatient admission may use the *Arrival Datetime* as admission date and time.
- If there is a difference between arrival to inpatient floor and the written admission order, report the time the admission order was written.
- This variable is also collected in SPARCS as Data Element 'Admission Datetime' and SPARCS Definition ADMIT_DT

Dataset Segment:	Demographic Variables

Data Element Name:	Arrival Datetime
Template Variable:	arrival_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the earliest documented date and time the patient arrived at the hospital.

Codes and Values:

Enter the Arrival Datetime.

Notes for Abstraction:

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm is **NOT** allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00
- Report earliest date and time the patient arrived at the ED, at the nursing floor, for observation, or as a direct admit to the cath lab.
- The arrival date and time may differ from the *Admission Datetime*.
- Cannot be after the *Discharge Datetime*.
- Observation Status:
    o If the patient was admitted to observation from an outpatient setting of the hospital, use the date and time the patient arrives at the ED or on the floor of observation care as the arrival date and time.
    o If the patient was admitted to observation from the ED of the hospital, use the date and time the patient arrived at the ED as the *Arrival Datetime*.
- Direct Admits:
    o If the patient is a "Direct Admit" to the cath lab, use the earliest date and time the patient arrived at the cath lab (or cath lab staging/holding area) as the *Arrival Datetime*.

- o If the patient is a "Direct Admit" to acute inpatient or observation, use the earliest date and time the patient arrived at the nursing floor or in observation as the *Arrival Datetime*.
- If the patient was transferred from your hospital's satellite/free-standing ED or from another hospital within your hospital's system (as an inpatient or ED patient) and there is one medical record for the care provided at both facilities, use the *Arrival Datetime* at the first facility.
- The *Arrival Datetime* can be obtained from the time period that the patient was an ED patient.

Dataset Segment:	Demographic Variables

Data Element Name:	Date of Birth
Template Variable:	date_of_birth
Format – Length:	Date — 10
Mandatory:	Yes

Description:

Indicates the date of birth of the patient.

Codes and Values:

Enter the Date of Birth.

Notes for Abstraction:

- Formatting:
    1. Format must be YYYY-MM-DD
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
    3. Example: November 3, 1959 = 1959-11-03
- *Date of Birth* cannot be after *Admission Datetime*.
- Patient age at admission should be used to determine reporting to the adult or the pediatric database. If a patient is observation only or ED only, please use patient age at the time of arrival for determination of the adult or pediatric database inclusion.
- Data for all patients who are 21 years of age or older are to be reported into the Department of Health's adult database.
    o Patients under 21 as of their admission date will be rejected and required for submission to the pediatric sepsis data file.
- This variable is also collected in SPARCS as Data Element 'Date of Birth' and SPARCS Definition BIRTH_DT

Dataset Segment: **Demographic Variables**

Data Element Name: Discharge Datetime
Template Variable: discharge_dt
Format – Length: Datetime — 16
Mandatory: Yes

Description:

Indicates the date and time that the patient was discharged from the hospital, left against medical advice, or expired.

Codes and Values:

   Enter the Discharge Datetime.

Notes for Abstraction:

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm **NOT** allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00
- Cannot precede 2014-04-01 00:00.
- Cannot precede *Admission Datetime* or *Arrival Datetime.*
- If the time of death and administrative discharge date and times are not the same, use the time of death for *Discharge Datetime.*
- For a patient who is discharged from one unit/department to another unit/department within the same facility, the **final discharge from the facility** is what should be reported for *Discharge Datetime.* Do not use discharges from internal transfers, since these are not actually separate hospital admissions – the entire period should be submitted as one record.
- This variable is also collected in SPARCS as Data Element 'Discharge Datetime' and SPARCS Definition DISCH_DT

Dataset Segment: **Demographic Variables**

Data Element Name: Discharge Status
Template Variable: discharge_status
Format – Length: Enumerated – 2
Mandatory: Yes

Description:

Indicates the code that best represents the patient's destination after discharge from the hospital.

Codes and Values:

- 01 = Discharge to Home or Self Care (Routine Discharge). Includes discharge to home; home on oxygen if DME only; any other DME only; group home, foster care, independent living and other residential care arrangements; outpatient programs, such as partial hospitalization or outpatient chemical dependency programs.
- 02 = Discharged/transferred to a Short-Term General Hospital for Inpatient Care.
- 03 = Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification in anticipation of Skilled Care. Medicare indicates that the patient is discharged/transferred to a Medicare certified nursing facility. For hospitals with an approved swing bed arrangement, use Code 61 Swing Bed. For reporting other discharges/transfers to nursing facilities see 04 and 64.
- 04 = Discharged/transferred to a Facility that Provides Custodial or Supportive Care. This is used to designate patients that are discharged/transferred to a nursing facility with neither Medicare nor Medicaid certification and for discharges/transfers to Assisted Living Facilities.
- 05 = Discharged/transferred to a Designated Cancer Center or Children's Hospital.
- 06 = Discharged/transferred to Home under Care of Organized Home Health Service Organization in Anticipation of Covered Skilled Care. Report this code when the patient is discharged/transferred to home with a written plan of care (tailored to the patient's medical needs) for home care services. Not used for home health services provided by a DME supplier or from a Home IV provider for home IV services.
- 07 = Left against medical advice or discontinued care.
- 20 = Expired.
- 21 = Discharged/transferred to Court/Law Enforcement.
- 50 = Hospice – Home.
- 51 = Hospice – Medical Facility (Certified) Providing Hospice Level of Care.
- 61 = Discharged/transferred to 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 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 Health Care Institution not defined Elsewhere in this Code List.

81 = Discharged 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 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 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 Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission.

91 = Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission.

92 = Discharged/transferred to a Nursing Facility Certified under Medicaid 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.

Notes for Abstraction:

- This variable is also collected in SPARCS as Data Element 'Discharge Status' and SPARCS Definition PAT_STATUS_CD
- For patients transferring out of this hospital (Transfer Out = "1"), the reporting hospital should report the discharge status as either "02" or "82."

Dataset Segment:	Demographic Variables
Data Element Name:	Ethnicity
Template Variable:	ethnicity
Format – Length:	Set – maximum 5 codes
Mandatory:	Yes

Description:

Indicates the code that best describes the ethnicity of the patient from the electronic health record (EHR).

Codes and Values:

Examples:
E1 = SPANISH/HISPANIC ORIGIN
E1.04.004 = Colombian
E2 = NOT HISPANIC OR LATINO
E9 = UNKNOWN

Notes for Abstraction:

- If reporting multiple ethnicity codes (up to 5 codes), separate each code using a colon (e.g., "E1.02: E1.04" is Mexican and South American).
- Multiple ethnicity codes within the same heading are expected as there might be many different origins within a heading (e.g., "E1.02.001 Mexican American" and "E1.02.002 Mexicano" are within the same heading "E1.02 Mexican"). However, we would not expect a selection of codes within any two headings of "E1 SPANISH/HISPANIC ORIGIN", "E2 NOT HISPANIC OR LATINO", and "E9 UNKNOWN".
- This variable is also collected in SPARCS as Data Element 'Ethnicity' and SPARCS Definition RACE_ETHNIC_CD
- To obtain the full list of codes, please visit https://www.health.ny.gov/statistics/sparcs/access/ and navigate to the Data Use Resources section where you can find a link to the most current SPARCS Data Dictionary as shown below. Please use Tab 5, '5) Codes and Values Unique', **SPARCS Column Name = RACE_ETHNIC_CD** to find the complete list of applicable codes:

Data Use Resources

Data Release Notes

- SPARCS Data Release Notes (Updated December 2022)

Output Data Dictionaries

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- Old Format - No longer in use; used for data extracts received July 30, 2012 to September 30, 2017.
- Old Format - No longer in use; used for data extracts received prior to July 30, 2012.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Facility Identifier
Template Variable:	facility_identifier
Format – Length:	Varchar – 6
Mandatory:	Yes

Description:

This number is the facility's four to six-digit Permanent Facility Identifier (PFI) assigned by the Department of Health.

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

Enter the Facility Identifier.

Notes for Abstraction:

- Must be a valid number as maintained by the Department of Health.
- Can only contain numbers 0-9.
- This variable is also collected in SPARCS as Data Element 'Facility Identifier' and SPARCS Definition FAC_ID

Dataset Segment:	**Demographic Variables**

Data Element Name:	ICD-10-CM Code (n)
Template Variable:	icd_10_cm_code_n
Format – Length:	Set — 8
Mandatory:	Yes

Description:

All diagnosis codes (primary and secondary) from the final hospital billed codes. There can be up to 25 codes, and each code will have its own variable and POA indicator. The first ICD-10-CM (Code 1) will be the **principal** diagnosis.

Codes and Values:

Enter the ICD-10-CM Codes.

Notes for Abstraction:

- These should be reported as 25 individual variables. The variable fields for these will be as follows:
  - The first Data Element will be ICD-10-CM Code 1 with a template variable of icd_10_cm_code1. ICD-10-CM Code 1 is the PRINCIPAL Diagnosis. All other codes will be secondary diagnosis codes.
  - The twentieth Data Element will be ICD-10-CM Code 20 with a template variable of icd_10_cm_code_20.
- Please provide the final hospital billed codes in this field.
- Hospitals may report up to 25 codes and their indicators, including the principal and secondary codes.
- The ICD-10-CM codes would be submitted WITH the appropriate decimal place (AFTER the 3rd character) for each ICD-10-CM code.
- This variable is also collected in SPARCS as Data Element 'ICD-10-CM Code (n)' and SPARCS Definition DX_CD

Dataset Segment:	Demographic Variables

Data Element Name:	ICD-10-CM POA Indicator (n)
Template Variable:	icd_10_cm_poa_indicator_n
Format – Length:	Enumerated — 1
Mandatory:	Yes

Description:

Present on Admission (POA) indicator for each ICD-10-CM diagnosis code, aligning with the data element *ICD-10-CM Code (n)*. The first ICD-10-CM POA (Indicator 1) will be the **principal** diagnosis POA indicator.

Codes and Values:

Y = Diagnosis was present at time of inpatient admission

N = Diagnosis was not present at time of inpatient admission

U = Documentation insufficient to determine if the condition was present at the time of inpatient admission

W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission

1 = Unreported/Not used. Exempt from POA reporting.

Notes for Abstraction:

- *ICD-10-CM POA Indicator (n)* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- *ICD-10-CM POA Indicator (n)* is not applicable to emergency department (ED)/observation only cases. For ED/observation only cases, report as blank.
- These should be reported as 25 individual variables. The variable fields for these will be as follows:
    - The first Data Element will be ICD-10-CM_POA Indicator 1 with a template variable of icd_10_cm_ poa_indicator_1. ICD-10-CM POA Code 1 is the PRINCIPAL Diagnosis POA indicator. All other codes will be secondary diagnosis POA indicators.
    - The twentieth Data Element will be ICD-10-CM POA Indicator 20 with a template variable of icd_10_cm_ poa_indicator_20.
- Please provide the final hospital billed codes in this field.
- Hospitals may report up to 25 POA indicators.
- Please provide the final hospital billed code's POA indicator in this field. Please ensure it aligns with *ICD-10-CM Code (n)*.
- Hospitals are required to report a POA indicator for each *ICD-10-CM Code* reported.

- o For example, if there are five (5) ICD-10_CM codes reported then five (5) ICD-10-CM POA indicators will be required in the data submission.
- This variable is also collected in SPARCS as Data Element 'ICD-10-CM POA Indicator (n)' and SPARCS Definition POA_IND

Dataset Segment: **Demographic Variables**

Data Element Name: Inclusion Septic Shock
Template Variable: inclusion_septic_shock
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has septic shock.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: inclusion_septic_shock_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment: **Demographic Variables**

Data Element Name: Inclusion Severe Sepsis
Template Variable: inclusion_severe_sepsis
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has severe sepsis.

Codes and Values:

   0 = No
   1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: inclusion_severe_sepsis_code_Ver<mark>D6.0</mark>.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	Demographic Variables

Data Element Name:	Insurance Number
Template Variable:	insurance_number
Format – Length:	Varchar – 19
Mandatory:	Yes

Description:

Indicates the primary insurance policy identification number for the patient.

Codes and Values:

Enter the Insurance Number.

Notes for Abstraction:

- *Insurance Number* is mandatory.
- Blanks are allowed only
  - If Element Payer is not:
    - Medicare ("C")
    - Medicaid ("D")
    - Insurance Company ("F")
    - Blue Cross ("G")
  - Or, in rare instances when values are truly unattainable from the EHR.
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.
- This variable is also collected in SPARCS as Data Element 'Insurance Policy Number' and SPARCS Definition POL_NUMB

Facilities are directed to enter the following values:

Payer	Type of Number
Blue Cross	Enter the information depending on specific Blue Cross Plan needs and contract requirement.
CHAMPUS	Enter the information depending on CHAMPUS regulations.
Medicaid	Enter Medicaid Client Identification Number (CIN) of the insured or case head Medicaid number shown on the Medicaid Identification Card.
Medicare	Enter the patient's Medicare Beneficiary Information (MBI) number as shown on the Health Insurance Card, Certificate of Award, Utilization Notice, Temporary Eligibility Notice, and Hospital Transfer Form or as reported by the Social Security Office.

For all other payer types (commercial insurers, etc.) enter the insured's unique number assigned by the payer.

Dataset Segment:	Demographic Variables

Data Element Name:	Medical Record Number
Template Variable:	medical_record_number
Format – Length:	Varchar – 17
Mandatory:	Yes

Description:

Indicates the number used by the hospital's Medical Records Department to identify the patient's permanent medical record file. This number is not the same as the Patient Control Number.

Codes and Values:

Enter the Medical Record Number.

Notes for Abstraction:

- Must not equal zero or blanks.
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.
- This variable is also collected in SPARCS as Data Element 'Medical Record Number' and SPARCS Definition MED_REC_NUMB

Dataset Segment: **Demographic Variables**

Data Element Name: Other Payer
Template Variable: other_payer
Format – Length: Varchar – 50
Mandatory: Yes

Description:

Indicate the other payers for this hospitalization. This aligns with *Payer* source E and/or I.

Codes and Values:

Enter Other Payer.

Notes for Abstraction:

- If either E or I is reported under *Payer*, then *Other Payer* must be completed. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If multiple other payers are to be reported, each payer will be separated by a colon (:).
- Include a code and a description if a code is captured in your EHR.

Dataset Segment: **Demographic Variables**

Data Element Name: Patient Control Number
Template Variable: patient_control_number
Format – Length: Varchar – 20
Mandatory: Yes

Description:

Indicates the patient's unique number assigned by the provider to facilitate retrieval of individual financial and clinical records and posting of payment.

Codes and Values:

Enter the Patient Control Number.

Notes for Abstraction:

- Must not equal zero or blanks.
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.
- This variable is also collected in SPARCS as Data Element 'Patient Control Number' and SPARCS Definition PAT_CTRL_NUMB

Dataset Segment:	**Demographic Variables**

Data Element Name:	Patient City
Template Variable:	pat_addr_city
Format – Length:	Varchar – 30
Mandatory:	Yes

Description:

Indicates the city name of the patient's address.

Codes and Values:

Enter the Patient City Name.

Notes for Abstraction:

- *Patient City* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- This variable is also collected in SPARCS as Data Element 'Patient City' and SPARCS Definition PAT_ADDR_CITY

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient County Code
Template Variable:	pat_addr_cnty_cd
Format – Length:	Varchar – 5
Mandatory:	Yes

Description:

Indicates the five-digit Federal Information Processing System (FIPS) county code of the patient's address.

Codes and Values:

Enter the Patient County Code.

Notes for Abstraction:

- *Patient County Code* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- Must only consist of numbers (0 – 9).
- FIPS county codes: state-county code list (census.gov)
- This variable is also collected in SPARCS as Data Element 'Patient County Code' and SPARCS Definition PAT_ADDR_CNTY_CD

Dataset Segment:	Demographic Variables
Data Element Name:	Patient Street Address Line 1
Template Variable:	pat_addr_line1
Format – Length:	Varchar – 128
Mandatory:	Yes

Description:

Indicates the first line of patient street address.

Codes and Values:

Enter the Patient Street Address Line 1.

Notes for Abstraction:

- *Patient Street Address Line 1* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- This variable is also collected in SPARCS as Data Element 'Patient Street Address Line 1' and SPARCS Definition PAT_ADDR_LINE1

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient Street Address Line 2
Template Variable:	pat_addr_line2
Format – Length:	Varchar – 128
Mandatory:	Yes

Description:

Indicates the second line of patient street address.

Codes and Values:

Enter the Patient Street Address Line 2.

Notes for Abstraction:

- *Patient Street Address Line 2* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- This variable is also collected in SPARCS as Data Element 'Patient Street Address Line 2' and SPARCS Definition PAT_ADDR_LINE2

Dataset Segment:	Demographic Variables

Data Element Name:	Patient State
Template Variable:	pat_addr_st
Format – Length:	Varchar – 2
Mandatory:	Yes

Description:

Indicates the patient's state or province code.

Codes and Values:

Enter the Patient State.

Notes for Abstraction:

- *Patient State* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- For a complete listing of "State Abbreviations" go to the Official United States Postal Service (USPS) Abbreviations Web site: https://about.usps.com/who-we-are/postal-history/state-abbreviations.htm
- Must only consist of letters (a-z, A-Z).
- This variable is also collected in SPARCS as Data Element 'Patient State' and SPARCS Definition PAT_ADDR_ST

Dataset Segment: **Demographic Variables**

Data Element Name: Patient Zip Code of Residence
Template Variable: patient_zip_code_of_residence
Format – Length: Varchar – 10
Mandatory: Yes

Description:

Indicates the patient's 9-digit zip code of residence.

Codes and Values:

Enter the Patient Zip Code of Residence.

Notes for Abstraction:

- *Zip Code of Residence* is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- Format should be xxxxx-xxxx
- If a hospital does not have the four-digit extension to the zip code, then the five-digit zip code should be reported followed by 0000 in the extension (e.g., 11201-0000).
- Must only consist of numbers (0-9).
- This variable is also collected in SPARCS as Data Element 'Patient Zip Code of Residence' and SPARCS Definition PAT_ADDR_ZIP5

Dataset Segment:	Demographic Variables

Data Element Name:	Payer
Template Variable:	payer
Format – Length:	Set – maximum 3 codes
Mandatory:	Yes

Description:

Indicate the codes that identify the payers for this hospitalization. Provide the primary payer first.

Codes and Values:

A = Self-Pay
B = Workers' Compensation
C = Medicare
D = Medicaid
E = Other Federal Program
F = Insurance Company
G = Blue Cross
H = CHAMPUS
I = Other Non-Federal Program
J = Disability
K = Title V
L = Other/Unknown

Notes for Abstraction:

- Report up to 3 payers.
- If either E or I is reported, then *Other Payer* must be completed.
- Each payer will be separated by a colon (:).
- The PRIMARY payer must be listed first.
  - Example:
    - Workers' Compensation as primary payer and Disability: B:J
    - Blue Cross as primary payer, Insurance Company, Other Federal Program: G:F:E
- If the patient has no insurance prior to admission and is pending Medicaid approval during hospitalization, please report the payer as Medicaid.
- This variable is also collected in SPARCS as Data Element 'Payer' and SPARCS Definition PAYR_ID/PAYR_NAME

Dataset Segment: **Demographics**

Data Element Name: Preferred Language
Template Variable: pref_language
Format – Length: Varchar – 3
Mandatory: Yes

Description:

Indicates the language the patient is comfortable using to communicate health care information, which may differ from the patient's native language.

Codes and Values:

English	eng
Arabic	ara
Bengali	ben
Chinese	zho
French	fra
Haitian-Creole	hat
Italian	ita
Korean	kor
Polish	pol
Russian	rus
Spanish	spa
Urdu	urd
Yiddish	yid
Albanian	sqi
Cantonese	yue
German	deu
Greek	gre
Hindi	hin
Japanese	jpn
Mandarin	cmn
Tagalog	tgl
Other	000
Unknown	und

Notes for Abstraction:

- The patient's *Preferred Language* to communicate health care information may differ from the patient's native language. Please ensure to report the preferred language.

- Some hospitals may collect both the language the patient is most comfortable using to communicate health information verbally and the language the patient is most comfortable using to communicate health information in writing. Hospitals should report the language the patient is comfortable using to communicate health information verbally.
- The codes for this variable are derived from a subset of ISO 639-3 codes. Do not use other ISO 639-3 codes that do not appear on this list when submitting data. For example, if a patient's preferred language is Macedonian which is not on the list, enter 000 ("Other") for this variable.

Dataset Segment:	**Demographic Variables**

Data Element Name:	Race
Template Variable:	race
Format – Length:	Set – maximum 56 codes
Mandatory:	Yes

Description:

Indicates the code that best describes the race of the patient based on the electronic health record.

Codes and Values:

Examples:
R2 = Asian
R2.01 = Asian Indian
R5 = White

Notes for Abstraction:

- If reporting multiple race codes, separate each code using a colon (e.g., "R2.12: R2.01" is Korean and Asian Indian).
- This variable is also collected in SPARCS as Data Element 'Race' and SPARCS Definition RACE_ETHNIC_CD
- To obtain the full list of codes, please visit https://www.health.ny.gov/statistics/sparcs/access/ and navigate to the Data Use Resources section where you can find a link to the most current SPARCS Data Dictionary as shown below. Please use Tab 5, '5) Codes and Values Unique', **SPARCS Column Name = RACE_ETHNIC_CD** to find the complete list of applicable codes:

Dataset Segment:	**Demographic Variables**
Data Element Name:	Sex
Template Variable:	sex
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the sex of the patient.

Codes and Values:

    M = Male
    F = Female
    U = Unknown

Notes for Abstraction:

- This variable is also collected in SPARCS as Data Element 'Gender' and SPARCS Definition GENDER_CD

Dataset Segment: **Demographic Variables**

Data Element Name: Source of Admission
Template Variable: source_of_admission
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates the code that best describes the patient's origin before coming to the hospital.

Codes and Values:

    1 = <u>Non-Health Facility Point of Origin</u>: The patient was admitted to this facility from home or from an assisted living facility.

    2 = <u>Clinic</u>: The patient was referred to this facility as a transfer from a freestanding or non-freestanding clinic.

    4 = <u>Transfer from a Hospital (Different Facility)</u>: The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.

    5 = <u>Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF)</u>: The patient was admitted to this facility as a transfer from a SNF or ICF where he/she was a resident.

    6 = <u>Transfer from Another Health Care Facility</u>: The patient was admitted to this facility as a transfer from another type of health care facility that is not defined elsewhere in this code list.

    8 = <u>Court/Law Enforcement</u>: The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative.

    9 = <u>Information Not Available</u>: The means by which the patient was admitted to this hospital was not known.

    E = <u>Transfer from Ambulatory Surgery Center</u>: The patient was admitted to this facility as a transfer from an ambulatory surgery center.

    F = <u>Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program</u>: The patient was admitted to this facility as a transfer from a hospice.

Notes for Abstraction:

- If a patient is moved from one area of the hospital to another (e.g., from the Emergency Department to the ICU), the patient is not considered a transfer. The patient is considered a transfer when the patient is moved between different hospitals with discharge and admission at each location and separate billing from each location.
- Assisted Living is reported as 1, Non-Health Facility Point of Origin.
- For patients transferring into this hospital (Transferred In = "1"), the reporting hospital should report the source of admission as "4."

Dataset Segment: **Demographic Variables**

Data Element Name: Transferred In
Template Variable: transferred_in
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates if the patient was received as a transfer from another acute care hospital.

Codes and Values:

> 0 = No
> 1 = Yes

Notes for Abstraction:

- Report "1", if a patient was transferred in (i.e., received from another acute care hospital).

- Report "0", if a patient was not transferred in.

- This variable is also collected in SPARCS as Data Element 'Transferred In' and SPARCS Definition ADMIT_SRC_CD

- For patients transferring into this hospital (Transferred In = "1"), the reporting hospital should report the source of admission as "4."

Dataset Segment:	**Demographic Variables**

Data Element Name:	Transferred Out
Template Variable:	transferred_out
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates if the patient was transferred out to another acute care hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report "1", if a patient was transferred out (i.e., transferred/discharged to another acute care hospital).

- Report "0", if a patient was not transferred out.

- This variable is also collected in SPARCS as Data Element 'Transferred Out' and SPARCS Definition ADMIT_STATUS_CD

- For patients transferring out of this hospital (Transferred Out = "1"), the reporting hospital should report the discharge status as either "02" or "82."

Dataset Segment:	Demographic Variables
Data Element Name:	Transfer Facility Identifier Receiving
Template Variable:	transfer_facility_id_receiving
Format – Length:	Varchar – 6
Mandatory:	Yes

Description:

If your hospital received a transfer patient from an acute care hospital, report the hospital PFI from which you received that patient. This is the transferring facility's four to six-digit Permanent Facility Identifier (PFI) assigned by the Department of Health.

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

Enter the Transfer Facility Identifier Receiving.

Notes for Abstraction:

- *Transfer Facility Identifier Receiving* is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- Must be a valid number as maintained by the Department of Health.
- Must only contain numbers (0-9).
- When receiving a patient from an out-of-state facility, please submit the two-digit state identifier https://www2.census.gov/geo/docs/reference/state.txt to represent the transfer facility state. This is **ONLY** to be used when patients are received from an out of state hospital, therefore the code for New York will not be accepted for data submission. For example, a patient received from a Connecticut hospital is submitted with the *transfer_facility_id_receiving* of 09.

To find a hospital PFI, please visit:

https://www.health.ny.gov/statistics/sparcs/reports/compliance/pfi_facilities.htm

Dataset Segment: **Demographic Variables**

Data Element Name: Transfer Facility Identifier Sending
Template Variable: transfer_facility_id_sending
Format – Length: Varchar – 6
Mandatory: Yes

Description:

If your hospital is transferring a patient to another acute care hospital, report the hospital's PFI to which you are sending the patient.   This number is the transfer sending facility's four to six-digit Permanent Facility Identifier (PFI) assigned by the Department of Health.

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

Enter the Transfer Facility Identifier Sending.

Notes for Abstraction:

- *Transfer Facility Identifier Sending* is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- Must be a valid number as maintained by the <mark>Department of Health</mark>.
- Must only contain numbers (0-9).
- When transferring a patient to an out-of-state facility, please submit the two-digit state identifier https://www2.census.gov/geo/docs/reference/state.txt to represent the transfer facility state. This is ONLY to be used when patients are transferred out of state therefore the code for New York will not be accepted for data submission. For example, a patient transferred to a Connecticut hospital is submitted with the *Transfer Facility Identifier Sending* of 09.

To find a hospital PFI, please visit:
https://www.health.ny.gov/statistics/sparcs/reports/compliance/pfi_facilities.htm

Dataset Segment:	Demographic Variables

Data Element Name:	Transfer Facility Name Receiving
Template Variable:	transfer_facility_nm_receiving
Format – Length:	Varchar – 50
Mandatory:	Yes

Description:

<u>If your hospital received a patient as a transfer from another acute care hospital, report the hospital name from which you received that patient</u>.

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

Enter the Transfer Facility Receiving.

Notes for Abstraction:

- *Transfer Facility Name Receiving* is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- Report when *Transfer Facility Identifier Receiving* is not available.

Dataset Segment:	Demographic Variables

Data Element Name:	Transfer Facility Name Sending
Template Variable:	transfer_facility_nm_sending
Format – Length:	Varchar – 50
Mandatory:	Yes

Description:

<u>If your hospital is transferring a patient to an acute care hospital, report the hospital's name to which you are sending the patient.</u>

Department regulations state that services must be reported under the physical location where they are provided. Common ownership of different facilities does not change this requirement.

Codes and Values:

Enter the Transfer Facility Name Sending.

Notes for Abstraction:

- *Transfer Facility Identifier Sending* is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- Report when *Transfer Facility Identifier Sending* is not available.

Dataset Segment: **Demographic Variables**

Data Element Name: Type of Admission
Template Variable: admit_type_cd
Format – Length: Enumerated - 1
Mandatory: Yes

Description:

Code indicating the priority of the admission/visit.

Codes and Values:

1 = Emergency: The patient requires immediate medical intervention as a result of severe, life threatening, or potentially disabling conditions.

2 = Urgent: The patient requires immediate attention for the care and treatment of a physical or mental disorder. Generally the patient is admitted to the first available and suitable accommodation.

3 = Elective: The patient's condition permits adequate time to schedule the admission based on the availability of a suitable accommodation.

5 = Trauma: Visit to a trauma center/hospital as licensed or designated by the state or local government authority authorized to do so, or as verified by the American College of Surgeons and involving a trauma activation.

9 = Information not available: The provider cannot classify the type of admission.

Notes for Abstraction:

- This variable is also collected in SPARCS as Data Element 'Type of Admission' and SPARCS Definition ADMIT_TYPE_CD

Dataset Segment:	Demographic Variables

Data Element Name:	Unique Personal Identifier
Template Variable:	unique_personal_identifier
Format – Length:	Varchar – 10
Mandatory:	Yes

Description:

A composite field comprised of portions of the patient's last name, first name, and social security number.

Codes and Values:

Included below are the individual components of this data element.
1. **"First 2" and "Last 2" characters of the Patient's Last Name**. The birth name of the patient is preferable if it is available on the facility's information system.
2. **"First 2" characters of the Patient's First Name.**
3. **"Last 4" digits of the Patient's Social Security Number.**

NOTE: This data element is not to be confused with *Patient Control Number*, which provides linkage of all record types containing patient-related data for a specific discharge.

Notes for Abstraction:

- **First and Last Name Components**: Must be **UPPERCASE** alpha characters (A-Z). If the last name is less than 4 characters, the first two and last two characters are used even if some characters are repeated.
    - If the first name is only 1-character, repeat the same character to meet the "First 2" character requirement of the Patient's First Name. For instance, first name "A" would be reported as "AA".
- Included below are examples of how to report some unusual scenarios: A three-character last name, a two-character last name, a name with junior, a one character first name, a last name with an apostrophe, and a hyphenated last name.
    - Joe Tan would be reported as TAANJO
    - Bill Su Jr. would be reported as SUSUBI
    - E John Smith would be reported as SMTHEE
    - Bob O'Brien would be reported as OBENBO
    - Sue Jones-Davis would be reported as JOISSU

- **Social Security Number Component**: Must be numeric. If no Social Security Number is available, this sub-field must be zeroes (e.g., TAANJO0000).

  o Joe Tan with Social Security Number 123-456-7890 would be reported as TAANJO7890
- This variable is also collected in SPARCS as Data Element 'Unique Personal Identifier' and SPARCS Definition UPIDE

Comorbidity/Risk Factor Variables

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	AIDS/HIV Disease
Template Variable:	aids_hiv_disease
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has AIDS or an HIV infection.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: aids_hiv_disease_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment: **Comorbidity/Risk Factor Variables**

Data Element Name: Chronic Liver Disease (POA)
Template Variable: chronic_liver_disease_poa
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has chronic liver disease present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_liver_disease_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Chronic Liver Disease (POA)* listed in the referenced csv file, and has a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - Y = Diagnosis was present at time of inpatient admission
        - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
        - 1 = Unreported/Not used. Exempt from POA reporting.
    - Report the Codes and Values as "0 = No", if the POA indicator is:
        - N = Diagnosis was not present at time of inpatient admission
        - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Chronic Liver Disease (POA)* in the referenced csv file that are exempt from POA reporting, then:
    - Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Chronic Liver Disease (POA)* in the referenced csv file and does **not** have a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival , if it is clinically undetermined whether the condition was

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.
- o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.
- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Chronic Liver Disease (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	Y = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Chronic Kidney Disease <mark>(POA)</mark>
Template Variable:	chronic_kidney_disease<mark>_poa</mark>
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic kidney disease <mark>present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.</mark>

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_kidney_disease_code_VerD<mark>6.0</mark>.csv.
- If the patient has one or more of the ICD-10-CM codes for the *<mark>Chronic Kidney Disease (POA)</mark>* listed in the referenced csv file, and has a POA indicator, then:
  - o <mark>Report the Codes and Values as "1 = Yes" if the POA indicator is:</mark>
    - <mark>Y = Diagnosis was present at time of inpatient admission</mark>
    - <mark>W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission</mark>
    - <mark>1 = Unreported/Not used. Exempt from POA reporting.</mark>
  - o <mark>Report the Codes and Values as "0 = No", if the POA indicator is:</mark>
    - <mark>N = Diagnosis was not present at time of inpatient admission</mark>
    - <mark>U = Documentation insufficient to determine if the condition was present at the time of inpatient admission</mark>
- If the patient has one or more of the ICD-10-CM codes for *<mark>Chronic Kidney Disease (POA)</mark>* <mark>in the referenced csv file that are exempt from POA reporting, then:</mark>
  - o <mark>Report the Codes and Values as "1=Yes"</mark>
- If the patient has one or more of the ICD-10-CM codes for *<mark>Chronic Kidney Disease (POA)</mark>* in the referenced csv file and does **not** have a POA indicator, then:
  - o <mark>Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, if it is clinically undetermined whether the condition was</mark>

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.
- o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.
- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Chronic Kidney Disease (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	**Y** = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment:	Comorbidity/Risk Factor Variables

Data Element Name:	Chronic Respiratory Failure
Template Variable:	chronic_respiratory_failure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic respiratory failure.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_respiratory_failure_code_Ver<mark>D6.0</mark>.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment: **Comorbidity/Risk Factor Variables**

Data Element Name: Coagulopathy (POA)
Template Variable: coagulopathy_poa
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has coagulopathy present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: coagulopathy_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Coagulopathy (POA)* listed in the referenced csv file, and has a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the POA indicator is:
    - Y = Diagnosis was present at time of inpatient admission
    - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - 1 = Unreported/Not used. Exempt from POA reporting.
  - Report the Codes and Values as "0 = No", if the POA indicator is:
    - N = Diagnosis was not present at time of inpatient admission
    - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Coagulopathy (POA)* in the referenced csv file that are exempt from POA reporting, then:
  - Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Coagulopathy (POA)* in the referenced csv file and does **not** have a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, or if it is clinically undetermined whether the condition was

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.

- o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival, or if documentation is insufficient to determine if the condition was present on admission/arrival.

- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Coagulopathy (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	Y = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment:	Comorbidity/Risk Factor Variables

Data Element Name:	COPD
Template Variable:	copd
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic obstructive pulmonary disease (COPD).

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: copd_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Dementia
Template Variable:	dementia
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has dementia.

Codes and Values:

> 0 = No
> 1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: dementia_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Diabetes
Template Variable:	diabetes
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has diabetes.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: diabetes_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	Comorbidity/Risk FactorVariables

Data Element Name:	Heart Failure (POA)
Template Variable:	heart_failure_poa
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has heart failure present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: heart_failure_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Heart Failure (POA)* listed in the referenced csv file, and has a POA indicator, then:
    - o Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - ▪ Y = Diagnosis was present at time of inpatient admission
        - ▪ W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
        - ▪ 1 = Unreported/Not used. Exempt from POA reporting.
    - o Report the Codes and Values as "0 = No", if the POA indicator is:
        - ▪ N = Diagnosis was not present at time of inpatient admission
        - ▪ U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Heart Failure (POA)* in the referenced csv file that are exempt from POA reporting, then:
    - o Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Heart Failure (POA)* in the referenced csv file and does **not** have a POA indicator, then:
    - o Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, if it is clinically undetermined whether the condition was

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.

- o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.
- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Heart Failure (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	**Y** = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	History of Other Cardiovascular Disease
Template Variable:	history_of_other_cvd
Format – Length:	Set – maximum 5 codes
Mandatory:	Yes

Description:

Indicates the patient's history of other cardiovascular disease.

Codes and Values:

1 = Coronary heart disease (e.g. angina pectoris, coronary atherosclerosis)
2 = Peripheral artery disease
3 = Valve disorder
4 = Cerebrovascular disease
5 = Cardiomyopathy
0 = No history of coronary heart disease, peripheral artery disease, valve disorder or cerebrovascular disease

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2:3
- History of (not acute presentation)
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: history_of_other_cvd_code_VerD6.0.csv.
- Report "0", if the patient does not have one of the ICD-10-CM code(s) listed in the referenced csv file.

Dataset Segment:	Comorbidity/Risk Factor Variables

Data Element Name:	Immunocompromising
Template Variable:	immunocompromising
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has an immunocompromising disease/illness.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: immunocompromising_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	Comorbidity/Risk Factor Variables
Data Element Name:	Long-COVID Post-COVID Syndrome
Template Variable:	long_covid_post_covid_syndrome
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has long-COVID or post-COVID syndrome.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: long_covid_post_covid_syndrome_code_VerD6.0.csv..
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	Comorbidity/Risk Factor Variables

Data Element Name:	Lymphoma Leukemia Multiple Myeloma
Template Variable:	lymphoma_leukemia_multi_myeloma
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has malignant neoplasm of lymphatic and hematopoietic tissue including those neoplasms which may be in clinical remission.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: lymphoma_leukemia_multi_myeloma_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Metastatic Cancer
Template Variable:	metastatic_cancer
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has metastatic cancer.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: metastatic_cancer_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Patient Care Considerations
Template Variable:	patient_care_considerations
Format – Length:	Set – maximum 2 codes
Mandatory:	Yes

Description:

Indicates whether the patient has a Do Not Resuscitate (DNR), Do Not Intubate (DNI) or both at any time during the hospital encounter.

Codes and Values:

1 = DNR
2 = DNI
0 = None

Notes for Abstraction:

- This may be present on admission/arrival.
- This may be present at any time during the hospital encounter.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2

Dataset Segment:	**Comorbidity/Risk Factor Variables**

Data Element Name:	Patient Care Considerations Date
Template Variable:	patient_care_considerations_date
Format – Length:	Date – 10
Mandatory:	Yes

Description:

Indicate the earliest date associated with *patient_care_considerations*.

Codes and Values:

Enter the Patient Care Considerations Date.

Notes for Abstraction:

- Format must be YYYY-MM-DD
    a. YYYY = four-digit year
    b. MM = two-digit month (01 = January, etc.)
    c. DD = two-digit day of month (01 through 31)
- Example: November 3, 1959 = 1959-11-03
- If multiple values selected for *patient_care_considerations*, report the earliest date/time associated with the value(s).
- *Patient Care Considerations Date* is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.

Dataset Segment:	Comorbidity/Risk Factor Variables

Data Element Name:	Pregnancy Status During Hospitalization
Template Variable:	pregnancy_status
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient is pregnant, in childbirth, or postpartum on arrival to the hospital or during hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, tests/labs, etc.
- This can be a POA or not a POA variable.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file. Please refer to the following csv file: pregnancy_status_code_VerD6.0.csv.
- Report "1" if detection of human chorionic gonadotropic (hCG) in the urine or blood test (lab value).
- Report "1" if information on whether the patient is pregnant, in childbirth, or postpartum is available from other sources, including but not limited to ICD-10-CM codes beyond those listed in the referenced csv file. The postpartum period begins immediately after delivery and continues for six weeks following delivery.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file or does not have detection of human chorionic gonadotropic (hCG) in the urine or blood test (lab value) or does not have information from other sources indicating that the patient is pregnant, in childbirth, or postpartum.

Dataset Segment: **Comorbidity/Risk Factor Variables**

Data Element Name: Skin Disorders/Burns
Template Variable: skin_disorders_burns
Format – Length: Set– maximum 3 codes
Mandatory: Yes

Description:

Indicates that the patient had one or more of the following skin disorders or burns.

Codes and Values:

  0 = None
  1 = Epidermolysis bullosa
  2 = Burn/Corrosion of skin
  3 = Frostbite

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: skin_disorders_burn_disease_code_VerD6.0.csv.
- Report "1", if the patient has one of the ICD-10-CM codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Treatment (in hospital) Variables

Dataset Segment: **Treatment (in hospital) Variables**

Data Element Name: Dialysis Treatment
Template Variable: dialysis_treatment
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has an order for dialysis during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: dialysis_treatment_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report "1", if the patient has an order for dialysis in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for dialysis in the EHR.

Dataset Segment:	Treatment (in hospital) Variables

Data Element Name:	ECMO
Template Variable:	ecmo
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient has an order for extracorporeal membrane oxygenation (ECMO) during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: ecmo_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report "1", if the patient has an order ECMO in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for ECMO in the EHR.

Dataset Segment: **Treatment (in hospital) Variables**

Data Element Name: High Flow Nasal Cannula
Template Variable: high_flow_nasal_cannula
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates the patient has an order for high flow nasal cannula at any time during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report "1" when the patient has an order for high flow nasal cannula at any time during the hospital encounter.
- Report "0", if the patient does not have an order for high flow nasal cannula at any time during the hospital encounter.

Dataset Segment: **Treatment (in hospital) Variables**

Data Element Name: Mechanical Ventilation Treatment
Template Variable: mechanical_vent_treatment
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates the patient has an order for mechanical ventilation at any time during the hospitalization.

Codes and Values:

    0 = No
    1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: mechanical_vent_treatment_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report "1", if the patient has an order for mechanical ventilation in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for mechanical ventilation in the EHR.

Dataset Segment: **Treatment (in hospital) Variables**

Data Element Name: Non-Invasive Positive Pressure Ventilation
Template Variable: non_invasive_pos_pressure_vent
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates the patient has an order for non-invasive-positive pressure ventilation (CPAP, BiPAP) during the hospitalization.

Codes and Values:

   0 = No
   1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: non_invasive_pos_pressure_vent_code_VerD6.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report "1", if the patient has an order for non-invasive positive pressure ventilation in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report "0", if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for non-invasive positive pressure ventilation in the EHR.

Severity Variables

Dataset Segment: **Severity Variables**

Data Element Name:	aPTT 1
Template Variable:	aptt_1
Format – Length:	String – 8
Mandatory:	Yes

Description:

Indicates the first activated partial thromboplastin time (aPTT) level collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name:	aPTT 2
Template Variable:	aptt_2
Format – Length:	String – 8
Mandatory:	Yes

Description:

Indicates the second aPTT value collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name:	aPTT 3
Template Variable:	aptt_3
Format – Length:	String – 8
Mandatory:	Yes

Description:

Indicates the third aPTT level collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name:	aPTT Max
Template Variable:	aptt_max
Format – Length:	String – 8
Mandatory:	Yes

Description:

Indicates the first maximum aPTT value collected after arrival to the hospital.

Codes and Values:

Enter the aPTT levels.

Notes for Abstraction:

- *aPTT 1/2/3/Max* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 19.8). For example, 30.7 or 30.0; place hold with 0.
  - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the aPTT level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding the aPTT level results:
  - 30.48 is rounded to 30.5
  - 45.43 is rounded to 45.4
  - 61.75 is rounded to 61.8
  - 55.97 is rounded to 56.0
  - **NOT CORRECT:** 61.75 is truncated to 61.7 (this should be rounded to 61.8)

Dataset Segment: **Severity Variables**

Data Element Name: aPTT Datetime 1
Template Variable: aptt_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first aPTT level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: aPTT Datetime 2
Template Variable: aptt_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second aPTT level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: aPTT Datetime 3
Template Variable: aptt_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third aPTT level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: aPTT Datetime Max
Template Variable: aptt_dt_max
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum aPTT level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the aPTT Datetimes.

Notes for Abstraction:

- *aPTT 1/2/3/Max Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any aPTT is reported then the datetime for the aPTT should be reported. For example, if *aPTT 1* has a value, then *aPTT Datetime 1* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm NOT allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00

Dataset Segment:	Severity Variables
Data Element Name:	Bilirubin Arrival
Template Variable:	bilirubin_arrival
Format – Length:	String – 6
Mandatory:	Yes

Description:

Indicates the first total bilirubin level collected after the patient's arrival to the hospital.

Dataset Segment:	Severity Variables
Data Element Name:	Bilirubin Max
Template Variable:	bilirubin_max
Format – Length:	String – 6
Mandatory:	Yes

Description:

Indicates the first maximum total bilirubin level collected after arrival to the hospital.

Codes and Values:

Enter the actual total bilirubin levels. Convert the units to mg/dL if needed.

Notes for Abstraction:

- *Bilirubin Arrival/Max* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 2.8).
  - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the total bilirubin level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding total bilirubin level results:

- 2.51 is rounded to 2.5
- .75 is rounded to .8
- 1.97 is rounded to 2.0
- **NOT CORRECT:** .75 is truncated to .7 (this should be rounded to .8)

Dataset Segment: **Severity Variables**

Data Element Name: Bilirubin Arrival Datetime
Template Variable: bilirubin_arrival_dt
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first total bilirubin collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Bilirubin Max Datetime
Template Variable: bilirubin_max_dt
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum total bilirubin level collected after arrival to the hospital.

Codes and Values:

Enter the total Bilirubin Datetimes.

Notes for Abstraction:

- *Bilirubin Arrival/Max Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Bilirubin is reported, then the datetime for Bilirubin value should be reported. For example, if *Bilirubin Arrival* has a value, *Bilirubin Arrival Datetime* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment:	Severity Variables
Data Element Name:	Creatinine Arrival
Template Variable:	creatinine_arrival
Format – Length:	String – 4
Mandatory:	Yes

Description:

Indicates the first creatinine level collected after the patient's arrival to the hospital.

Dataset Segment:	Severity Variables
Data Element Name:	Creatinine Max
Template Variable:	creatinine_max
Format – Length:	String – 4
Mandatory:	Yes

Description:

Indicates the first maximum creatinine level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Creatinine levels. Convert the units to mg/dL if needed.

Notes for Abstraction:

- *Creatinine Arrival/Max* and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 2.8).
  - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the creatinine level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding creatinine level results:

- 2.81 is rounded to 2.8
- 1.75 is rounded to 1.8
- 1.42 is rounded to 1.4
- 2.97 is rounded to 3.0
- **NOT CORRECT:** 1.75 is truncated to 1.7 (this should be rounded to 1.8)

Dataset Segment: **Severity Variables**

Data Element Name: Creatinine Arrival Datetime
Template Variable: creatinine_arrival_dt
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first creatinine level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Creatinine Max Datetime
Template Variable: creatinine_max_dt
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum creatinine level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Creatinine Datetimes.

Notes for Abstraction:

- *Bilirubin Arrival/Creatinine Arrival Datetime* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Creatinine is reported, then the datetime for Creatinine value should be reported. For example, if *Creatinine Arrival* has a value, *Creatinine Arrival Datetime* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
      a. YYYY-MM-DDThh:mm is also valid

2. YYYY = four-digit year
    MM = two-digit month (01 = January, etc.)
    DD = two-digit day of month (01 through 31)
    hh = two digits of hour (00 through 23) (am/pm NOT allowed)
    mm = two digits of minute (00 through 59)
3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
    a. 1959-11-03T23:42 is also valid
4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic First
Template Variable: diastolic_1
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicates the patient's first diastolic blood pressure collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Second
Template Variable: diastolic _2
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicate the patient's second diastolic blood pressure collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Third
Template Variable: diastolic _3
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicate the patient's third diastolic blood pressure collected after arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Min
Template Variable: diastolic _min
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicates the patient's first minimum diastolic blood pressure collected after arrival to the hospital.

Codes and Values:

Enter the actual Diastolic Values.

Notes for Abstraction:

- Diastolic values are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Diastolic is reported, then the datetime for the Diastolic value should be reported. For example, if *Diastolic Second* has a value, then *Diastolic Second Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MIN values, report the first one after the patient's arrival to the hospital.
- If the blood pressure is measured as mean arterial pressure (MAP), report the subsequent blood pressure measured as systolic/diastolic pressures.
- Hospitals may report blood pressure reading obtained by either blood pressure cuff or arterial line.

- Formatting:
- Format must be a number up to 3 digits.
  1. Example:
     a. Diastolic blood pressure 80mm Hg should be reported as 80
     b. Diastolic blood pressure 112 Hg should be reported as 112

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic First Datetime 1
Template Variable: diastolic _dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first diastolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Second Datetime 2
Template Variable: diastolic _dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second diastolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Third Datetime 3
Template Variable: diastolic _dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third diastolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Diastolic Datetime Min
Template Variable: diastolic _dt_min
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first minimum diastolic blood pressure collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Diastolic Datetimes.

Notes for Abstraction:

- Diastolic Datetimes are mandatory. In rare instances when values are truly unattainable from the EHR report missing values as blank.
- If any Diastolic is reported, then the datetime for the Diastolic value should be reported. For example, if *Diastolic Second* has a value, then *Diastolic Second Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MIN values, report the first one after the patient's arrival to the hospital.
- If the blood pressure is measured as mean arterial pressure (MAP), report the subsequent blood pressure measured as systolic/diastolic pressures.
- Hospitals may report blood pressure reading obtained by either blood pressure cuff or arterial line.

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm NOT allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: **Severity Variables**

Data Element Name: INR 1
Template Variable: inr_1
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the first INR value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR 2
Template Variable: inr_2
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the second INR level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR 3
Template Variable: inr_3
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the third INR level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR Max
Template Variable: inr_max
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the first maximum INR level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual INR levels.

Notes for Abstraction:

- *INR 1/2/3/Max* and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 1.2 or 11.5).
    - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the INR level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding INR level results:
    - 2.48 is rounded to 2.5
    - 11.75 is rounded to 11.8
    - 2.97 is rounded to 3.0
    - **NOT CORRECT:** 11.75 is truncated to 11.7 (this should be rounded to 11.8)

Dataset Segment: **Severity Variables**

Data Element Name: INR Datetime 1
Template Variable: inr_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first INR level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR Datetime 2
Template Variable: inr_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second INR level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR Datetime 3

Template Variable: inr_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third INR collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: INR Datetime Max

Template Variable: inr_dt_max
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum INR level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the INR Datetimes.

Notes for Abstraction:

- *INR 1/2/3/Max Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any INR is reported, then the datetime for the INR value should be reported. For example, if *INR 1* has not value, *INR Datetime 1* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: Severity Variables

Data Element Name: Lactate Level 1
Template Variable: lactate_level_1
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the first lactate level collected after the patient's arrival to the hospital.

Dataset Segment: Severity Variables

Data Element Name: Lactate Level 2
Template Variable: lactate_level_2
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the second lactate level collected after the patient's arrival to the hospital.

Dataset Segment: Severity Variables

Data Element Name: Lactate Level 3
Template Variable: lactate_level_3
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the third lactate level collected after the patient's arrival to the hospital.

Dataset Segment: Severity Variables

Data Element Name: Lactate Level Max
Template Variable: lactate_level_max
Format – Length: String – 4
Mandatory: Yes

Description:

Indicates the first maximum lactate level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Lactate levels using the mmol/L value. Convert from mg/dL if needed.

Notes for Abstraction:

- *Lactate Level 1/2/3/Max* and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 5.8).
    - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the lactate level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding lactate level results:
    - 4.81 is rounded to 4.8
    - 4.85 is rounded to 4.9
    - 4.23 is rounded to 4.2
    - 4.97 is rounded to 5.0
    - **NOT CORRECT**: 4.85 is truncated to 4.8 (this should be rounded to 4.9)
- Either the level of Lactic Acid or Lactate can be used for reporting as long as the hospital's lab sanctions them as equivalent – if using a point of care ABG analyzer, etc. For instance, if both orders go through the lab, then a measurement performed at the same time as the arterial sample being analyzed for oxygen (O2) and carbon dioxide (CO_2) should be comparable to an arterial sample sent only for lactate.

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level Datetime 1
Template Variable:	lactate_level_dt_1
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the date and time of the first lactate level collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level Datetime 2
Template Variable:	lactate_level_dt_2
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the date and time of the second lactate level collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level Datetime 3
Template Variable:	lactate_level_dt_3
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the date and time of the third lactate level collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level Datetime Max
Template Variable:	lactate_level_dt_max
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

Indicates the date and time of the first maximum lactate level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Lacate Datetimes.

Notes for Abstraction:

- *Lactate Level 1/2/3/Max Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Lactate Level is reported, then the datetime for the Lactate Level value should be reported. For example, if *Lactate Level 1* has a value, *Lactate Level Datetime 1* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: Severity Variables

Data Element Name: Organ Dysfunction Cardiovascular (POA)
Template Variable: organ_dysfunc_cardiovascular_poa
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has cardiovascular organ dysfunction present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

  0 = No
  1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_cardiovascular_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Organ Dysfunction Cardiovascular (POA)* listed in the referenced csv file, and has a POA indicator, then:
    - o Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - ▪ Y = Diagnosis was present at time of inpatient admission
        - ▪ W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
        - ▪ 1 = Unreported/Not used. Exempt from POA reporting.
    - o Report the Codes and Values as "0 = No", if the POA indicator is:
        - ▪ N = Diagnosis was not present at time of inpatient admission
        - ▪ U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction Cardiovascular (POA)* in the referenced csv file that are exempt from POA reporting, then:
    - o Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction Cardiovascular (POA)* in the referenced csv file and does **not** have a POA indicator, then:
    - o Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, if it is clinically undetermined whether the condition was

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.

- o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.

- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Organ Dysfunction Cardiovascular (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	Y = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment: **Severity Variables**

Data Element Name: Organ Dysfunction CNS (POA)
Template Variable: organ_dysfunc_cns_poa
Format – Length: Enumerated – 1
Mandatory: Yes

Description:

Indicates that the patient has central nervous system (CNS) organ dysfunction present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_cns_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Organ Dysfunction CNS (POA)* listed in the referenced csv file, and has a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the POA indicator is:
    - Y = Diagnosis was present at time of inpatient admission
    - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - 1 = Unreported/Not used. Exempt from POA reporting.
  - Report the Codes and Values as "0 = No", if the POA indicator is:
    - N = Diagnosis was not present at time of inpatient admission
    - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction CNS (POA)* in the referenced csv file that are exempt from POA reporting, then:
  - Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction CNS (POA)* in the referenced csv file and does **not** have a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, if it is clinically undetermined whether the condition was

present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.
  - o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.
- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Organ Dysfunction CNS (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	**Y** = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment:	Severity Variables

Data Element Name:	Organ Dysfunction Respiratory (POA)
Template Variable:	organ_dysfunc_respiratory_poa
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has respiratory organ dysfunction present on or prior to admission/arrival to the hospital. This may or may not be evident as a yes on the present on admission indicator as an ICD-10-CM code at or on arrival. Since the intent is to capture all codes not just final billed ICD-10-CMs, a POA indicator may not be available for all cases.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_respiratory_code_VerD6.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the *Organ Dysfunction Respiratory (POA)* listed in the referenced csv file, and has a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the POA indicator is:
    - Y = Diagnosis was present at time of inpatient admission
    - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - 1 = Unreported/Not used. Exempt from POA reporting.
  - Report the Codes and Values as "0 = No", if the POA indicator is:
    - N = Diagnosis was not present at time of inpatient admission
    - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction Respiratory (POA)* in the referenced csv file that are exempt from POA reporting, then:
  - Report the Codes and Values as "1=Yes"
- If the patient has one or more of the ICD-10-CM codes for *Organ Dysfunction Respiratory (POA)* in the referenced csv file and does **not** have a POA indicator, then:

- o Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, if it is clinically undetermined whether the condition was present on admission/arrival, or if the ICD-10-CM code is exempt from POA reporting.
  - o Report the Codes and Values as "0 = No" if it is determined that the condition was **not** present on admission/arrival or if documentation is insufficient to determine if the condition was present on admission/arrival.
- Report the Codes and Values as "0 = No", if the patient does not have any of the ICD-10-CM codes for *Organ Dysfunction Respiratory (POA)* listed in the referenced csv file.

For example, if patient has one or more ICD-10 codes in referenced CSV file:

POA Indicator	Determination	Report As:
POA Indicator Present	**Y** = Diagnosis was present at the time of inpatient admission	1 = Yes
	W = Clinically undetermined: Provider unable to clinically determine whether the condition was present at the time of inpatient admission	
	1 = Unreported/Not used. Exempt from POA reporting.	
	N = Diagnosis was not present at time of inpatient admission	0 = No
	U = Documentation insufficient to determine if the condition was present at the time of inpatient admission	
No POA Indicator	**Diagnosis was present** on admission/arrival	1 = Yes
	Clinically undetermined whether the condition was present on admission/arrival	
	Code is exempt from POA reporting	
	Condition was not present on admission/arrival	0 = No
	Documentation is insufficient to determine if the condition was present on admission/arrival	

Dataset Segment: **Severity Variables**

Data Element Name: Platelets 1
Template Variable: platelets_1
Format – Length: String — 10
Mandatory: Yes

Description:

Indicates the first platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets 2
Template Variable: platelets_2
Format – Length: String — 10
Mandatory: Yes

Description:

Indicates the second platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets 3
Template Variable: platelets_3
Format – Length: String — 10
Mandatory: Yes

Description:

Indicates the third platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets Min
Template Variable: platelets_min
Format – Length: String — 10
Mandatory: Yes

Description:

Indicates the first minimum platelet level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Platelet levels. Convert the units to cells/uL if needed.

Notes for Abstraction:

- *Platelets 1/2/3/Min* and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MIN values, please report the first one after the patient's arrival to the hospital.
- If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value.

- Formatting:
  1. Format must be a string up to 10-digits long.
  2. Example:
     a. Platelet 320,000/uL should be reported as 320000
     b. Platelet 60,000/uL should be reported as 60000

Dataset Segment: **Severity Variables**

Data Element Name: Platelets Datetime 1
Template Variable: platelets_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets Datetime 2
Template Variable: platelets_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets Datetime 3
Template Variable: platelets_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third platelet level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Platelets Datetime Min
Template Variable: platelets_dt_min
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first minimum platelet level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Platelets Datetimes.

Notes for Abstraction:

- *Platelets 1/2/3/Min Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Platelets are reported, then the datetime for the Platelets value should be reported. For example, if *Platelets 1* has a value, *Platelets Datetime 1* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MIN values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate 1
Template Variable: sirs_heartrate_1
Format – Length: Enumerated— 3
Mandatory: Yes

Description:

Indicates the first heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate 2
Template Variable: sirs_heartrate_2
Format – Length: Enumerated — 3
Mandatory: Yes

Description:

Indicates the second heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate 3
Template Variable: sirs_heartrate_3
Format – Length: Enumerated — 3
Mandatory: Yes

Description:

Indicates the third heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate Max
Template Variable: sirs_heartrate_max
Format – Length: Enumerated — 3
Mandatory: Yes

Description:

Indicates the first maximum heart rate value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Heart Rates.

Notes for Abstraction:

- Heart Rates are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If *SIRS Heart Rate 2, SIRS Heart Rate 3,* and/or *SIRS Heart Rate Max* are collected then these values and their corresponding datetimes must be reported.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be a number up to 3 digits.
  2. Example:
     a. Heart rate/Pulse 100 beats per minutes (bpm) should be reported as 100
     b. Heart rate/Pulse 43 beats per minutes (bpm) should be reported as 43

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate Datetime 1
Template Variable: sirs_heartrate_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate Datetime 2
Template Variable: sirs_heartrate_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate Datetime 3
Template Variable: sirs_heartrate_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third heart rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Heart Rate Datetime Max
Template Variable: sirs_heartrate_dt_max
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum heart rate value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Heart Rate Datetimes.

Notes for Abstraction:

- Heart Rate Datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Heart Rate is reported, then the datetime for the Heart Rate value should be reported. For example, if *SIRS Heart Rate 2* has a value, then *SIRS Heart Rate Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment:	Severity Variables
Data Element Name:	SIRS Leukocyte Arrival
Template Variable:	sirs_leukocyte_arrival
Format – Length:	String — 10
Mandatory:	Yes

Description:

Indicates the first white blood cell (WBC) level collected after the patient's arrival to the hospital.

Dataset Segment:	Severity Variables
Data Element Name:	SIRS Leukocyte Min
Template Variable:	sirs_leukocyte_min
Format – Length:	String — 10
Mandatory:	Yes

Description:

Indicates the first minimum white blood cell (WBC) level collected after the patient's arrival to the hospital.

Dataset Segment:	Severity Variables
Data Element Name:	SIRS Leukocyte Max
Template Variable:	sirs_leukocyte_max
Format – Length:	String — 10
Mandatory:	Yes

Description:

Indicates the first maximum white blood cell (WBC) level collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual White Blood Cell (WBC) counts. Convert the units to cells/uL if needed.

Notes for Abstraction:

- *SIRS Leukocyte Arrival/Min/Max* and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.

- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MIN or MAX values, report the first one after the patient's arrival to the hospital. If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value.

- <u>Formatting:</u>
    1. Format must be a string up to 10-digits.
    2. Example:
        o WBC 100,000/uL should be reported as 100000
        o WBC 11,500/uL should be reported as 11500
        o WBC 4,400/uL should be reported as 4400

Dataset Segment: **Severity Variables**

Data Element Name:	SIRS Leukocyte Arrival Datetime
Template Variable:	sirs_leukocyte_arrival_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description

Indicates the date and time of the first white blood cell (WBC) collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name:	SIRS Leukocyte Min Datetime
Template Variable:	sirs_leukocyte_min_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description

Indicates the date and time of the first minimum white blood cell (WBC) level collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name:	SIRS Leukocyte Max Datetime
Template Variable:	sirs_leukocyte_max_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description

Indicates the date and time of the first maximum white blood cell (WBC) level collected after the patient's arrival to the hospital.

Codes and Values:

    Enter the Leukocyte Datetimes.

Notes for Abstraction:

- *SIRS Leukocyte Arrival/Min/Max Datetimes* are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.

- If any SIRS Leukocyte is reported, then the datetime for the SIRS Leukocyte value should be reported. For example, if *SIRS Leukocyte Arrival* has a value, *SIRS Leukocyte Arrival Datetime* should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MIN or MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
    1. Format must be YYYY-MM-DD hh:mm
        a. YYYY-MM-DDThh:mm is also valid
    2. YYYY = four-digit year
       MM = two-digit month (01 = January, etc.)
       DD = two-digit day of month (01 through 31)
       hh = two digits of hour (00 through 23) (am/pm NOT allowed)
       mm = two digits of minute (00 through 59)
    3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
        a. 1959-11-03T23:42 is also valid
    4. Midnight = 00:00, **NOT** 24:00

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Respiratory Rate 1
Template Variable:	sirs_respiratoryrate_1
Format – Length:	Number — 2
Mandatory:	Yes

Description:

Indicates the first respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Respiratory Rate 2
Template Variable:	sirs_respiratoryrate_2
Format – Length:	Number — 2
Mandatory:	Yes

Description:

Indicates the second respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Respiratory Rate 3
Template Variable:	sirs_respiratoryrate_3
Format – Length:	Number — 2
Mandatory:	Yes

Description:

Indicates the third respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Respiratory Rate Max
Template Variable:	sirs_respiratoryrate_max
Format – Length:	Number — 2
Mandatory:	Yes

Description:

Indicates the first maximum respiratory rate value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Respiratory Rates.

Notes for Abstraction:

- Respiratory Rates are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If *SIRS Respiratory Rate 2*, *SIRS Respiratory Rate 3*, and/or *SIRS Respiratory Rate Max* are collected then these values and their corresponding datetimes must be reported.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be a number up to 2-digits.
  2. Example:
     a. Respiratory rate 12 breaths per minutes (bpm) should be reported as 12
     b. Respiratory rate 9 breaths per minutes (bpm) should be reported as 9

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Respiratory Rate Datetime 1
Template Variable: sirs_respiratoryrate_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Respiratory Rate Datetime 2
Template Variable: sirs_respiratoryrate_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Respiratory Rate Datetime 3
Template Variable: sirs_respiratoryrate_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third respiratory rate value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Respiratory Rate Datetime Max
Template Variable: sirs_respiratoryrate_dt_max
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum respiratory rate value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Respiratory Datetimes.

Notes for Abstraction:

- Respiratory Datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any SIRS Respiratory Rate is reported, then the corresponding datetime should be reported. For example, if *SIRS Respiratory Rate 2* has a value, then *SIRS Respiratory Rate Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature 1
Template Variable: sirs_temperature_1
Format – Length: Enumerated — 5
Mandatory: Yes

Description:

Indicates the first temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature 2
Template Variable: sirs_temperature_2
Format – Length: Enumerated — 5
Mandatory: Yes

Description:

Indicates the second temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature 3
Template Variable: sirs_temperature_3
Format – Length: Enumerated — 5
Mandatory: Yes

Description:

Indicates the third temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature Max
Template Variable: sirs_temperature_max
Format – Length: Enumerated — 5
Mandatory: Yes

Description:

Indicates the first maximum temperature value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Temperature levels using Fahrenheit. Convert from Celsius if needed.

Notes for Abstraction:

- Temperatures are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If *SIRS Temperature 2*, *SIRS Temperature 3,* and/or *SIRS Temperature Max* are collected then these values and their corresponding datetimes should be reported.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Must be numeric to one decimal place (example 98.8)
  2. Example:
     a. 100.4°F should be reported as 100.4
     b. 96°F should be reported as 96.0
     c. 97.6°F should be reported as 97.6

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature Datetime 1
Template Variable: sirs_temperature_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature Datetime 2
Template Variable: sirs_temperature_dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature Datetime 3
Template Variable: sirs_temperature_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third temperature value collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: SIRS Temperature Datetime Max
Template Variable: sirs_temperature_dt_max
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first maximum temperature value collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Temperature Datetimes.

Notes for Abstraction:

- Temperature Datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Temperature is reported then the datetime for the Temperature value should be reported. For example, if *SIRS Temperature 2* has a value, then *SIRS Temperature Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

Dataset Segment: **Severity Variables**

Data Element Name: Systolic First
Template Variable: systolic_1
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicates the patient's first systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Second
Template Variable: systolic_2
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicate the patient's second systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Third
Template Variable: systolic_3
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicate the patient's third systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Min
Template Variable: systolic_min
Format – Length: Number – 3
Mandatory: Yes

Description:

Indicates the patient's first minimum systolic blood pressure collected after the patient's arrival to the hospital.

Codes and Values:

Enter the actual Systolic Values.

Notes for Abstraction:

- Systolic values are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Systolic is reported, then the datetime for the Systolic value should be reported. For example, if *Systolic Second* has a value, then *Systolic Second Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MIN values, report the first one after the patient's arrival to the hospital.
- If the blood pressure is measured as mean arterial pressure (MAP), report the subsequent blood pressure measured as systolic/diastolic pressures.
- Hospitals may report blood pressure reading obtained by either blood pressure cuff or arterial line.

- Formatting:
- Format must be a number up to 3 digits.
    1. Example:
        a. Systolic blood pressure 80mm Hg should be reported as 80
        b. Systolic blood pressure 112 Hg should be reported as 112

Dataset Segment: **Severity Variables**

Data Element Name: Systolic First Datetime 1
Template Variable: systolic_dt_1
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Second Datetime 2
Template Variable: systolic _dt_2
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the second systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Third Datetime 3
Template Variable: systolic_dt_3
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the third systolic blood pressure collected after the patient's arrival to the hospital.

Dataset Segment: **Severity Variables**

Data Element Name: Systolic Datetime Min
Template Variable: systolic_dt_min
Format – Length: Datetime – 16
Mandatory: Yes

Description:

Indicates the date and time of the first minimum systolic blood pressure collected after the patient's arrival to the hospital.

Codes and Values:

Enter the Systolic Datetimes.

Notes for Abstraction:

- Systolic Datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Systolic is reported, then the datetime for the Systolic value should be reported. For example, if *Systolic Second* has a value, then *Systolic Second Datetime 2* should not be blank.
- For all vital signs (i.e., diastolic pressure, systolic pressure, heart rate, respiratory rate, temperature), if the initial vital sign collected was invalid or determined questionable (e.g., instrumentation error), report the value and the date and time of the subsequent vital sign collected.
- When there are multiple identical MIN values, report the first one after the patient's arrival to the hospital.
- If the blood pressure is measured as mean arterial pressure (MAP), report the subsequent blood pressure measured as systolic/diastolic pressures.
- Hospitals may report blood pressure reading obtained by either blood pressure cuff or arterial line.

- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00