NYSDOH Pediatric Sepsis and COVID-19 Data Dictionary

Digitalized Data Collection, D1.0

Version (Digital) D1.0

July 15, 2021

This dictionary includes the administrative codes found in the Appendices in a CSV format available for download 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

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Key points to remember during data extraction

The New York State Department of Health (NYSDOH) is seeking the collection of data for inpatient admissions with severe sepsis, septic shock, and/or COVID-19 as defined by the case ***inclusion definition*** provided on the following page of this dictionary.

Data for all patients under 21 years of age at the time of admission and meet the case ***inclusion definition***, are to be reported into the pediatric NYSDOH database. This excludes non-discharged newborn patients, and patients evaluated only in the ED or Observation but never admitted. Patient age at admission should be used to determine reporting to the adult or the pediatric database.

When using the appendices 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.

Most variables are required but 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 Transer Facility Name Receiving/Sending. Please report all data you have regarding transfers.

Hospitals that have within hospital transfers 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 one single admission with one combined medical record, please report this as one admission, even when separate bills are generated for the acute care and rehab admission. If there are two separate medical records for this transfer, please report this as separate admissions; in this case, both separate medical records/admissions must meet the inclusion criteria separately. 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/.

A CSV file for the codes found in the appendices is provided separately. Each CSV file contains three columns: the codes of one variable/data element in appendices, the corresponding code description, and the subcategory if applicable.

ICD-10-CM CODE	ICD-10-CM CODE DESCRIPTION	Subcategory

I2101	ST elevation (STEMI) myocardial infarction involving left main coronary artery	MI
I2102	ST elevation (STEMI) myocardial infarction involving left anterior descending coronary artery	MI

Please note that data elements with multiple selections (more than Yes/No) will have values/contents in the subcategory column in the CSV files, for example ***Acute Cardiovascular Conditions***. In general, the naming convention for CSV files is TemplateVariable_code_Version. For example:

- asthma_code_VerD1.0.csv

When the CSV files are for NDC codes of medications, ndc is added in the naming convention. For example:

- medication_anticoagulation_ndc_code_VerD1.0.csv

Inclusion Definition

Unlike the adult database, the pediatric database only includes inpatient admissions with severe sepsis, septic shock, and/or COVID-19. This excludes non-discharged newborn patients, and patients evaluated only in the ED or Observation but never admitted. Hospitals should include admissions as defined by the ICD-10-CM codes delineated below.

The NYSDOH 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). This will allow for electronic identification of cases. The ICD-10-CM code-based definition for identifying the severe sepsis/septic shock and COVID-19 patient population for abstraction includes the following codes which are presented in Tables A and B. Cases with codes in either table are to be reported.

Hospitals will report cases where criteria are met by:

- At least one code in Table A; OR
- At least one code in Table B

Examples:

- Patient with Code T8112XA and no other code from Table A or Table B is reported.
- Patient with Code U072 and no other code from Table A or Table B is reported.

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

OR

Table B: COVID-19 inclusion ICD-10-CM codes

COVID-19 ICD-10-CM	Description	Type
U071	COVID-19, virus identified	COVID-19
U072	COVID-19, virus not identified (Clinically-epidemiologically diagnosed COVID-19)	COVID-19
J1282	Pneumonia due to coronavirus disease 2019 *The code J1282 is effective as of January 1, 2021	COVID-19

COVID-19 ICD-10-CM	Description	Type
M358	Other specified systemic involvement of connective tissue	MIS-C
M3581	Multisystem Inflammatory syndrome (MIS) *The code M3581 is effective as of January 1, 2021	MIS-C
M3589	Other specified systemic involvement of connective tissue *The code M3589 is effective as of January 1, 2021	MIS-C

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***.
- If there is a difference between arrival to inpatient floor and the written admission order, report the time the admission order was written.

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: Only include these observation cases if admitted to inpatient status.
  - 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.
  - 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:
  - 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***.

    - 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.
- Data for all patients who are under 21 years of age are to be reported into the pediatric NYSDOH database.
  - Patients 21 years of age or older as of their admission date will be rejected and required for submission to the adult sepsis data file.

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.

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.
09 = Admitted as an Inpatient to this Hospital. Patient admitted to the same short-term medical or specialty hospital where the hospital-based ambulatory surgery service was performed (excluding chronic disease hospitals).
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.

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".
- To obtain the full list of codes, please refer to the following link to the SPARCS code set:
- SPARCS (RR-Race and Ethnicity Codes, Source: Race and Ethnicity Code Set -Version 1.0): https://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

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 NYSDOH.
- Can only contain numbers 0-9.

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

Description:

Indicates the gender of the patient.

Codes and Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

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.

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 = Present on admission
N = Not present on admission
U = No information in the record
W = Clinically undetermined
E = Exempt from POA reporting

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_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.
    - 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.

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:

- Allows blanks only if Element Payer is not:
  - Medicare ("C")
  - Medicaid ("D")
  - Insurance Company ("F")
  - Blue Cross ("G")
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.

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 HIC 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.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Other Payer
Template Variable:	other_payer
Format – Length:	Varchar – 50
Mandatory:	No

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.
- 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.

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:

- 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).
- If the hospital does not have the patient's zip code of residence (e.g., foreign resident, homeless), then the five-digit zip code should be reported as 00000-0000.
- Should only consist of numbers 0-9.

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

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).
- To obtain the full list of codes, please refer to the following link to the SPARCS code set:
- SPARCS(RR-Race and Ethnicity Codes, Source: Race and Ethnicity Code Set -Version 1.0): https://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

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 = Non-Health Facility Point of Origin: The patient was admitted to this facility from home or from an assisted living facility.
2 = Clinic: The patient was referred to this facility as a transfer from a freestanding or non-freestanding clinic.
4 = Transfer from a Hospital (Different Facility): 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 = Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he/she was a resident.
6 = Transfer from Another Health Care Facility: 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 = Court/Law Enforcement: 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 = Information Not Available: The means by which the patient was admitted to this hospital was not known.
E = Transfer from Ambulatory Surgery Center: The patient was admitted to this facility as a transfer from an ambulatory surgery center.
F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program: 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.

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.

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.

Dataset Segment:	Demographic Variables
Data Element Name:	Transfer Facility Identifier Receiving
Template Variable:	transfer_facility_id_receiving
Format – Length:	Varchar – 6
Mandatory:	No

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:

- Must be a valid number as maintained by the NYSDOH.
- 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:	No

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:

- Must be a valid number as maintained by the NYSDOH.
- 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_id_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:	No

Description:

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

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:

- 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:	No

Description:

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

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:

- Report when ***Transfer Facility Identifier Sending*** is not available.

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.

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).

Joe Tan with Social Security Number 123-456-7890 would be reported as TAANJO7890

Comorbidity/Risk Factor (POA) Variables

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Acute Cardiovascular Conditions
Template Variable:	acute_cardiovascular_conditions
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient had an acute cardiovascular event present at admission/arrival. 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:

1= Myocardial Infarction
2= Ischemic Stroke/Hemorrhagic Stroke/Transient Ischemic Attack (TIA)
3= Myocarditis secondary to COVID-19
4= Other
0= No Acute Cardiovascular Condition

Notes for Abstraction:

- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2
- Please see Appendix 1A for a list of applicable ICD-10-CM codes.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Acquired Absent Spleen
Template Variable:	acquired_absent_spleen
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has an acquired absent spleen.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1B for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Adrenal Gland Disorder
Template Variable:	adrenal_gland_disorder
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has adrenal gland disorder.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1C for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1D for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Altered Mental Status
Template Variable:	altered_mental_status
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has an altered mental status.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1E for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Asthma
Template Variable:	asthma
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has asthma.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1F for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Bronchopulmonary Dysplasia
Template Variable:	bronchopulmonary_dysplasia
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has bronchopulmonary dysplasia (BPD).

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1G for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Chronic Liver Disease
Template Variable:	chronic_liver_disease
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic liver disease.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1H for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Chronic Renal Failure
Template Variable:	chronic_renal_failure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic renal failure.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1I for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1J for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Coagulopathy
Template Variable:	coagulopathy
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has coagulopathy.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1K for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Congestive Heart Failure
Template Variable:	congestive_heart_failure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has congestive heart failure.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1L for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Cystic Fibrosis
Template Variable:	cystic_fibrosis
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has cystic fibrosis.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1M for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1N for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Dialysis Comorbidity
Template Variable:	dialysis_comorbidity
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient arrived at the hospital already receiving dialysis. 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:

- Please see Appendix 1O for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	History of COVID -19
Template Variable:	history_of_covid
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has a history of a positive COVID-19 test.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report "1" when the patient has a history of a positive COVID-19 test prior to arrival at the hospital. There is not a time limit on reporting the test as positive. If there is a positive test, even if later followed by a negative test, then report the positive test date.
- SARS-Cov-2 LOINC codes can be downloaded to a csv. This file can be found here: https://loinc.org/sars-cov-2-and-covid-19/
- These codes are not static and are updated regularly; therefore, hospitals should take care to use the most current list of codes to capture COVID-19 testing.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	History of COVID-19 Datetime
Template Variable:	history_of_covid_dt
Format – Length:	Datetime – 16
Mandatory:	No

Description:

Indicates the date and time of the positive ***History of COVID-19*** test.

Codes and Values:

Enter the History of COVID-19 Datetime.

Notes for Abstraction:

- If there is more than one positive COVID-19 test, report the earliest positive test.
- 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:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	History of Other Cardiovascular Disease
Template Variable:	history_of_other_cvd
Format – Length:	Set – maximum 4 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 = Congenital Heart Defects
6 = Cardiomyopathy
0 = No history of coronary heart disease, peripheral artery disease, valve disorder, cerebrovascular disease, congenital heart defects, or cardiomyopathy.

Notes for Abstraction:

- 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)
- Please see Appendix 1P for a list of applicable ICD-10-CM codes.
- Report "0", if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Hypertension
Template Variable:	hypertension
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has hypertension.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1Q for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1R for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Kawasaki/Mucocutaneous Lymph Node Syndrome
Template Variable:	kawasaki_mucocutaneous
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has a diagnosis of Kawasaki/Mucocutaneous lymph node syndrome.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- POA and/or during hospitalization
- Please see Appendix 1S for a list of applicable codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1T for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Mechanical Ventilation Comorbidity
Template Variable:	mechanical_vent_comorbidity
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient arrived at the hospital on mechanical ventilation. 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:

- Please see Appendix 1U for applicable ICD-10-CM code.
- Report "1", if the patient has the ICD-10-CM code listed in the referenced appendix.
- Report “0”, if the patient does not have the ICD-10-CM code listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Medication Anticoagulation
Template Variable:	medication_anticoagulation
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient takes anticoagulation medications at home/prior to admission.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1V for a list of applicable medications and NDC codes.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Medication Immune Modifying
Template Variable:	medication_immune_modifying
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient is taking disease modifying medications and therapies (drugs and biologics) for collagen diseases, corticosteroids, chemotherapeutic agents through any modality (oral, IV, IM, etc.) known to specifically adversely impact the function of the immune system as the primary therapeutic goal or as an unintended side effect, including steroids (excluding inhaled or topical steroids), and chemotherapy at time of admission.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1W for a list of applicable medications and NDC codes.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1X for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Neutropenic Patients
Template Variable:	neutropenic_patients
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has neutropenia.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1Y for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Obesity
Template Variable:	obesity
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient is obese.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-CM and/or BMI values from the electronic health record (EHR). Please use the first value upon admission/arrival or the earliest value.
- Please see Appendix 1Z for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “1”, if the patient ≥18-year-old has a BMI value of 30 or higher in the EHR even if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or for patients ≥18-year-old, who does not have a BMI value of 30 or higher in the EHR.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Patient Care Considerations
Template Variable:	patient_care_considerations
Format – Length:	Set – maximum 3 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:

- 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 (POA) Variables**
Data Element Name:	Patient Care Considerations Date
Template Variable:	patient_care_considerations_date
Format – Length:	Date – 10
Mandatory:	No

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

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Pregnancy Comorbidity
Template Variable:	pregnancy_comorbidity
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has a pregnancy-related comorbidity.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Must be “0” if ***Pregnancy Status During Hospitalization*** is “0”
- Please see Appendix 1AA for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Comorbidity/Risk Factor (POA) 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:

- Please see Appendix 1AB for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “Yes” if detection of human chorionic gonadotropic (hCG) in the urine or blood test (lab value).
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have detection of human chorionic gonadotropic (hCG) in the urine or blood test (lab value).

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Prematurity
Template Variable:	prematurity
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient was born before 37 weeks of pregnancy (preterm birth).

Codes and Values:

0 = No
1 = Yes
2= NA, Patient > 1-year-old

Notes for Abstraction:

- Please see Appendix 1AC for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.
- If the patient is greater than 1-year-old, do not specify whether the patient has a history of prematurity. Report these cases as Value “2.”

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Sickle Cell Disease
Template Variable:	sickle_cell_disease
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has Sickle Cell Disease.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1AD for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Skin Disorders/Burns
Template Variable:	skin_disorders_burns
Format – Length:	Set– maximum 2 codes
Mandatory:	Yes

Description:

Indicates that the patient had one of the following skin disorder(s) or burns prior to arrival to the hospital.

Codes and Values:

0 = None
1 = Epidermolysis bullosa
2 = Burn

Notes for Abstraction:

- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2
- Please see Appendix 1AE for a list of applicable ICD-10-CM codes.

Dataset Segment:	Comorbidity/Risk Factor (POA) Variables
Data Element Name:	Smoking Vaping
Template Variable:	smoking_vaping
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient is a current smoker and/or a current vaper.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1AF for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Comorbidity/Risk Factor (POA) Variables**
Data Element Name:	Stem Cell Transplant Recipients
Template Variable:	stem_cell_transplant_recipients
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient is a stem cell transplant recipient.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1AG for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Clinical Variables

Dataset Segment:	**Clinical Variables**
Data Element Name:	COVID-19 Exposure
Template Variable:	covid_exposure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient has exposure to COVID-19.

Codes and Values:

0 = No Positive COVID-19 exposure
1 = Positive COVID-19 exposure

Notes for Abstraction:

- Please see Appendix 2A for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Clinical Variables**
Data Element Name:	COVID-19 Virus
Template Variable:	covid_virus
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates COVID-19 virus is identified or not identified.

Codes and Values:

0 = COVID-19, virus not identified
1 = COVID-19, virus identified

Notes for Abstraction:

- This applies to both present on admission/arrival (POA) or acquired during hospitalization.
- Please see Appendix 2B for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Clinical Variables**
Data Element Name:	Drug Resistant Pathogen
Template Variable:	drug_resistant_pathogen
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has resistance to an antimicrobial drug.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 2C for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Clinical Variables**
Data Element Name:	Flu Positive
Template Variable:	flu_positive
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has a positive flu test present on admission/arrival or during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- POA and/or during hospitalization
- Please see Appendix 2D for a list of applicable codes.
- Report "1", if the patient has one or more of the codes listed in the referenced appendix.
- Report “1”, if the patient has a positive influenza virus test (lab value).
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have a positive influenza virus test (lab value).

Dataset Segment:	**Clinical Variables**
Data Element Name:	Suspected Source of Infection
Template Variable:	suspected_source_of_infection
Format – Length:	Set – maximum 12 codes
Mandatory:	Yes

Description:

The suspected source of infection.

Codes and Values:

1 = septicemia
2 = bacteremia
3 = fungal infection
4 = peritoneal infection
5 = heart infection
6 = upper respiratory infection
7 = lung infection
8 = central nervous system infection
9 = gastrointestinal infection
10 = genitourinary infection
11 =soft tissue infection
12 = other infection source
13 = unknown

Notes for Abstraction:

- Please see Appendix 2E for a list of applicable ICD-10-CM codes.
- If there is not an identified source of infection as specified in Appendix 2E, then report "unknown".
    - Note that "other infection source" is defined in the ICD-10-CM codes provided in the appendix.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 2:9:12

Treatment (during hospitalization) Variables

Dataset Segment:	**Treatment (during hospitalization) 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).
- Please see Appendix 3A for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- 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 appendix.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes listed in the referenced appendix or does not have an order for dialysis in the EHR.

Dataset Segment:	**Treatment (during hospitalization) Variables**
Data Element Name:	During Hospital Anticoagulation
Template Variable:	during_hospital_anticoagulation
Format – Length:	Number – 1
Mandatory:	Yes

Description:

Indicates that the patient has an order for anticoagulation medication during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1V for a list of applicable medications and NDC codes.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced appendix.

Dataset Segment:	**Treatment (during hospitalization) Variables**
Data Element Name:	During Hospital Immune Modifying Medication
Template Variable:	during_hospital_immune_mod_med
Format – Length:	Number – 1
Mandatory:	Yes

Description:

Indicates that the patient has an order for immune-modifying medication during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 1W for a list of applicable medications and NDC codes.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced appendix.

Dataset Segment:	**Treatment (during hospitalization) Variables**
Data Element Name:	During Hospital Remdesivir
Template Variable:	during_hospital_remdesivir
Format – Length:	Number – 1
Mandatory:	Yes

Description:

Indicates the patient has an order for remdesivir during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Generic: Remdesivir
- Brand name: Veklury and GS-5734
- Please see Appendix 3B for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- Report “1”, if the patient has an order for the medication listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes or the medication listed in the referenced appendix.

Dataset Segment:	**Treatment (during hospitalization) 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).
- Please see Appendix 3C for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- 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 appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have an order for ECMO in the EHR.

Dataset Segment:	**Treatment (during hospitalization) 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 (during hospitalization) Variables**
Data Element Name:	IVIG
Template Variable:	ivig
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient has an order for intravenous immunoglobulin (IVIG) 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).
- Please see Appendix 3D for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- 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 appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have an order for ECMO in the EHR.

Dataset Segment:	Treatment (during hospitalization) 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).
- Please see Appendix 3E for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- 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 appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have an order for mechanical ventilation in the EHR.

Dataset Segment:	Treatment (during hospitalization) 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).
- Please see Appendix 3F for a list of applicable ICD-10-PCS codes.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced appendix.
- 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 appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix or does not have an order for non-invasive positive pressure ventilation in the EHR.

Dataset Segment:	Treatment (during hospitalization) Variables
Data Element Name:	Vasopressor Administration
Template Variable:	vasopressor_administration
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient has an order for vasopressors during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 3G for a list of applicable medications and NDC codes.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced appendix.

Outcome (at discharge) Variables

Dataset Segment:	**Outcome (at discharge) Variables**
Data Element Name:	Cardiovascular Outcomes at Discharge
Template Variable:	cv_outcomes_at_discharge
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient had one of the following cardiac outcome(s) at the date of discharge.

Codes and Values:

0 = None
1 = Acute Coronary Syndrome
2 = Ischemic Stroke
3 = Myocarditis secondary to COVID-19
4= Cardiomyopathy

Notes for Abstraction:

- Report all that apply at the date of discharge.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2:3
- Please see Appendix 4A for a list of applicable ICD-10-CM codes.

Dataset Segment:	**Outcome (at discharge) Variables**
Data Element Name:	Dialysis Outcome
Template Variable:	dialysis_outcome
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient is discharged on dialysis.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- If there was a patient order to have dialysis at discharge as evidenced by dialysis on the discharge date, report “1.”
- Please see Appendix 4B for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has the ICD-10-CM code listed in the referenced appendix on the date of discharge.
- Report "0", if the patient does not have the ICD-10-CM code listed in the referenced appendix on the date of discharge.

Dataset Segment:	**Outcome (at discharge) Variables**
Data Element Name:	Mechanical Ventilation Outcome
Template Variable:	mechanical_vent_outcome
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient is discharged on mechanical ventilation.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- If there was a patient order to have mechanical ventilation at discharge as evidenced by mechanical ventilation on the discharge date, report “1”.
- Please see Appendix 4C for a list of applicable ICD-10-CM codes. Report "1", if the patient has the ICD-10-CM code listed in the referenced appendix on the date of discharge.
- Report "0", if the patient does not have the ICD-10-CM code listed in the referenced appendix on the date of discharge.

Dataset Segment:	**Outcome (at discharge) Variables**
Data Element Name:	Neurological Outcome
Template Variable:	neurological_outcome
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient is discharged with neurological outcome.

Codes and Values:

0 = No Neurological Outcome
1 = Neuropathy
2 = Myopathy

Notes for Abstraction:

- Report all that apply at the date of discharge.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2
- Please see Appendix 4D for a list of applicable ICD-10-CM codes.

Outcome (during hospitalization) Variables

Dataset Segment:	**Outcome (in hospital) Variables**
Data Element Name:	Cardiovascular Outcomes in Hospital
Template Variable:	cv_outcomes_in_hospital
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient had one of the following cardiac outcome(s) during the hospitalization.

Codes and Values:

0 = None
1 = Acute Coronary Syndrome
2 = Ischemic Stroke
3 = Myocarditis secondary to COVID-19
4= Cardiomyopathy

Notes for Abstraction:

- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 1:2:3
- Please see Appendix 5A for a list of applicable ICD-10-CM codes.

Dataset Segment:	**Outcome (in hospital) Variables**
Data Element Name:	ICU During Hospitalization
Template Variable:	icu_during_hospitalization
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicate if the patient was admitted to the Intensive Care Unit (NICU; PICU; ICU; MICU; SICU; CCU; Neuro-ICU) during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report “1”, if the patient was admitted at any time to the ICU during the hospital admission.
- Report “0”, if the patient was not admitted to the ICU during the hospital admission.

Dataset Segment:	**Outcome (in hospital) Variables**
Data Element Name:	PE/DVT
Template Variable:	pe_dvt
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates the patient had a pulmonary embolism (PE) and/or deep venous thrombosis (DVT) during the hospitalization.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 5B for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Severity Variables

Dataset Segment:	Severity Variables
Data Element Name:	aPTT 1
Template Variable:	aptt_1
Format – Length:	String – 8
Mandatory:	No

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:	No

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:	No

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:	No

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*** and corresponding datetimes are situational because hospitals may not always have values to report.
- 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:	No

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:	No

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:	No

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:	No

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 situational because hospitals may not always have values to report*.
    - 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.
- This element belongs to Organ Dysfunction Hematologic.
- 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:	No

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:	No

Description:

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

Codes and Values:

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

Notes for Abstraction:

- ***Bilirubin Arrival/Max*** and corresponding datetimes are situational because hospitals may not always have values to report.
- 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:	No

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:	No

Description:

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

Codes and Values:

Enter the total Bilirubin Datetimes.

Notes for Abstraction:

- ***Bilirubin Arrival/Max Datetimes*** are situational because hospitals may not always have values to report.
    - If any Organ Dysfunction Hepatic is reported then the datetime for Organ Dysfunction Hepatic 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:	No

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:	No

Description:

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

Codes and Values:

Enter the actual creatinine level. Convert the units to mg/dL if needed.

Notes for Abstraction:

- ***CreatinineArrival/Max*** and corresponding datetimes are situational because hospitals may not always have values to report.
- 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:	No

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:	No

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:

- ***Creatinine Arrival/Max Datetimes*** are situational because hospitals may not always have values to report
    - If any Organ Dysfunction Renal is reported then the datetime for Organ Dysfunction Renal value should be reported. For example, if ***Creatininel Arrival*** has a value, ***Creatinine Renal 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:	No

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:	No

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:	No

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 First*** and corresponding ***Diastolic First Datetime 1*** are mandatory. However, ***Diastolic Second***, ***Diastolic Third***, ***Diastolic Min*** and corresponding datetimes are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - If ***Diastolic Second***, ***Diastolic Third***, and/or ***Diastolic Min*** are collected, these values and their corresponding datetimes 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.
- Formatting:
    1. Format must be a number up to 3 digits.
    2. 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:	No

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:	No

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:	No

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 First Datetime 1*** is mandatory. However, ***Diastolic Second Datetime 2*****,** ***Diastolic Third Datetime 3*****,** and/or ***Diastolic Datetime Min*** are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - If any Diastolic is reported then the Datetime for the Diastolic value must 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.
- 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:	No

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:	No

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:	No

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:	No

Description:

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

Codes and Values:

Enter the INR level

Notes for Abstraction:

- ***INR 1/2/3/Max*** and corresponding datetimes are situational because hospitals may not always have values to report.
- 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:	No

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:	No

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:	No

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:	No

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 situational because hospitals may not always have values to report.
    - 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.
- This element belongs to Organ Dysfunction Hematologic.
- 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:	No

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:	No

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:	No

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:	No

Description:

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

Codes and Values:

Enter the actual lactate level using the mmol/L value. Convert from mg/dL if needed.

Notes for Abstraction:

- ***Lactate Level 1/2/3/Max*** and corresponding datetimes are situational because hospitals may not always have values to report.
- 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).
    - 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:
    - 7.81 is rounded to 7.8
    - 7.85 is rounded to 7.9
    - 7.23 is rounded to 7.2
    - 7.97 is rounded to 8.0
    - **NOT CORRECT**: 7.85 is truncated to 7.8 (this should be rounded to 7.9)

Dataset Segment:	Severity Variables
Data Element Name:	Lactate Level Datetime 1
Template Variable:	lactate_level_dt_1
Format – Length:	Datetime – 16
Mandatory:	No

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:	No

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:	No

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:	No

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 Lactate Datetimes.

Notes for Abstraction:

- ***Lactate Level 1/2/3/Max Datetimes*** are situational because hospitals may not always have values to report.
    - 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
Template Variable:	organ_dysfunc_cardiovascular
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has cardiovascular organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6A for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Severity Variables**
Data Element Name:	Organ Dysfunction CNS
Template Variable:	organ_dysfunc_cns
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has central nervous system (CNS) organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6B for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Severity Variables
Data Element Name:	Organ Dysfunction Hematologic
Template Variable:	organ_dysfunc_hematologic
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has hematologic organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6C for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Severity Variables**
Data Element Name:	Organ Dysfunction Hepatic
Template Variable:	organ_dysfunc_hepatic
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has hepatic organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6D for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Severity Variables**
Data Element Name:	Organ Dysfunction Renal
Template Variable:	organ_dysfunc_renal
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has renal organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6E for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	**Severity Variables**
Data Element Name:	Organ Dysfunction Respiratory
Template Variable:	organ_dysfunc_respiratory
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has respiratory organ dysfunction after arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Please see Appendix 6F for a list of applicable ICD-10-CM codes.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced appendix.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced appendix.

Dataset Segment:	Severity Variables
Data Element Name:	Platelets 1
Template Variable:	platelets_1
Format – Length:	String — 10
Mandatory:	No

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:	No

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:	No

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:	No

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 situational because hospitals may not always have values to report.
- 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.
- 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.
- This element belongs to Organ Dysfunction Hematologic.
- 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:	No

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:	No

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:	No

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:	No

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 Platelet Datetimes.

Notes for Abstraction:

- ***Platelets 1/2/3/Min Datetimes*** are situational because hospitals may not always have values to report.
    - 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.
- This element belongs to Organ Dysfunction Hematologic.
- 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:	No

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 2
Template Variable:	sirs_heartrate_2
Format – Length:	Enumerated— 3
Mandatory:	No

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:	No

Description:

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

Codes and Values:

Enter the actual heart rate.

Notes for Abstraction:

- ***SIRS Heart Rate 1*** and corresponding ***SIRS Heart Rate Datetime 1*** are mandatory. However, ***SIRS Heart Rate 2***, ***SIRS Heart Rate 3***, and ***SIRS Heart Rate Max*** and corresponding datetimes are situational because hospitals may not always have values to report (i.e., additional values not collected).
    a. If ***SIRS Heart Rate 2***, ***SIRS Heart Rate 3***, and/or ***SIRS Heart Rate 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. 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:	No

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:	No

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:	No

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:

- ***SIRS Heart Rate Datetime 1*** is mandatory. However, ***SIRS Heart Rate Datetime 2***, ***SIRS Heart Rate Datetime 3***, ***SIRS Heart Rate Datetime Max*** are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - 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:	No

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:	No

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:	No

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 situational because hospitals may not always have values to report.
- 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.
- 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.
- <u>Formatting:</u>
    1. Format must be a string up to 10-digits.
    2. Example:
        - WBC 100,000/uL should be reported as 100000
        - WBC 11,500/uL should be reported as 11500
        - 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:	No

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:	No

Description

Indicates the date and time of 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:	No

Description

Indicates the date and time of 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 situational because hospitals may not always have values to report.

- 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.
- <u>Formatting:</u>
  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:	No

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:	No

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:	No

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:

- ***SIRS Respiratory Rate 1*** and corresponding ***SIRS Respiratory Rate Datetime 1*** are mandatory. However, ***SIRS Respiratory Rate 2***, ***SIRS Respiratory Rate 3***, and ***SIRS Respiratory Rate Max*** and corresponding datetimes are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - If ***SIRS Respiratory Rate 2***, ***SIRS Respiratory Rate 3***, and/or ***SIRS Respiratory Rate 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. 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:	No

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:	No

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:	No

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:

- ***SIRS Respiratory Rate Datetime 1*** is mandatory. However, ***SIRS Respiratory Rate Datetime 2***, ***SIRS Respiratory Rate Datetime 3***, and/or ***SIRS Respiratory Rate Datetime Max*** are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - If any Respiratory 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 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:	No

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:	No

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:	No

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:

- ***SIRS Temperature 1*** and corresponding ***SIRS Temperature Datetime 1*** are mandatory. However, ***SIRS Temperature 2***, ***SIRS Temperature 3***, and ***SIRS Temperature Max*** and corresponding datetimes are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - 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:	No

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:	No

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:	No

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:

- ***SIRS Temperature Datetime 1*** is mandatory. However, ***SIRS Temperature Datetime 2***, ***SIRS Temperature Datetime 3***, ***SIRS Temperature Datetime Max*** are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - 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:	No

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:	No

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:	No

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 First*** and corresponding ***Systolic First Datetime 1*** are mandatory. However, ***Systolic Second***, ***Systolic Third***, and ***Systolic Min*** and corresponding datetimes are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - 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.
- 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:	No

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:	No

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:	No

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 First Datetime 1*** is mandatory. However, ***Systolic Second Datetime 2***, ***Systolic Third Datetime 3***, ***Systolic Datetime Min*** are situational because hospitals may not always have values to report (i.e., additional values not collected).
    - 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*** cannot be left 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.
- 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