

NYSDOH Adult Sepsis and COVID-19 Data Dictionary

Digitalized Data Collection, D2.0

Version (Digital) D2.0

January 8, 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 all inpatient, Emergency Department (ED), and observation patients for severe sepsis, septic shock, and severe COVID-19 patients evaluated in the hospital (including ED, Observation, and inpatient patients) as defined by the case [inclusion definition](#) provided on the following page of this dictionary.

Data for all patients who are 21 years of age or older are to be reported into the adult NYSDOH database. Patient age at admission should be used to determine reporting to the adult or the pediatric database. If a patient is observation only or ED only, please use patient age at the time of arrival for determination of the adult or pediatric database inclusion.

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.

All variables except for [Transfer Facility Identifier Receiving](#) and [Transfer Facility Identifier Sending](#) are **required**. These transfer data elements are only required when the patient is transferred between facilities. Within hospital (interdepartment transfers) are not considered transfers for these data elements. Hospitals should report the full care for a patient using the entire hospitalization (admission through discharge record) regardless of within hospital transfers.

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 in to the current portal in a flat file format following existing procedures which may be found at <https://ny.sepsis.ipro.org/>.

CSV files of codes in appendices are provided separately. Each CSV file contains three columns: the codes of the variable/data element in appendices, the corresponding code description, and the subcategory if applicable. For example:

| 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_VerD2.0.csv

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

- medication_anticoagulation_ndc_code_VerD2.0.csv

Inclusion Definition

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 severe 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 alone; OR
- At least two codes in Table B, one of which must be either U071 OR U072 as well as one or more of the codes beginning with J80 through T8112XA

Examples:

- Patient with Code T8112XA and no other code from Table A or Table B is reported.
- Patient with U072 and R602 and no other code from Table A or Table B is reported.
- Patient with U071 and no other code from Table A or Table B is not reported.
- Patient with R6520 and no other codes from Table A or Table B is reported. This case is reported because R6520 alone is a reportable case regardless of additional codes reported on the case.

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

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

OR

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

| Severe 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 |
| AND (one or more of the following) | | |
| J80 | Acute respiratory distress syndrome | Respiratory |
| J9600 | Acute respiratory failure, unsp w hypoxia or hypercapnia | Respiratory |

| Severe COVID-19 | | |
|------------------------|---|-----------------|
| ICD-10-CM | Description | Type |
| J9601 | Acute respiratory failure with hypoxia | Respiratory |
| J9602 | Acute respiratory failure with hypercapnia | Respiratory |
| J9690 | Respiratory failure, unsp, unsp w hypoxia or hypercapnia | Respiratory |
| J9691 | Respiratory failure, unspecified with hypoxia | Respiratory |
| J9692 | Respiratory failure, unspecified with hypercapnia | Respiratory |
| R0600 | Dyspnea, unspecified | Respiratory |
| R0609 | Other forms of dyspnea | Respiratory |
| R092 | Respiratory arrest | Respiratory |
| J1289 | Other viral pneumonia | Respiratory |
| R0902 | Hypoxemia | Respiratory |
| J9620 | Acute and chr resp failure, unsp w hypoxia or hypercapnia | Respiratory |
| J9621 | Acute and chronic respiratory failure with hypoxia | Respiratory |
| J9622 | Acute and chronic respiratory failure with hypercapnia | Respiratory |
| R0603 | Acute respiratory distress | Respiratory |
| R602 | Shortness of breath | Respiratory |
| N170 | Acute kidney failure with tubular necrosis | renal_failure |
| N171 | Acute kidney failure with acute cortical necrosis | renal_failure |
| N172 | Acute kidney failure with medullary necrosis | renal_failure |
| N178 | Other acute kidney failure | renal_failure |
| N179 | Acute kidney failure, unspecified | renal_failure |
| K7111 | Toxic liver disease with hepatic necrosis, with coma | hepatic_failure |
| K7200 | Acute and subacute hepatic failure without coma | hepatic_failure |
| K7201 | Acute and subacute hepatic failure with coma | hepatic_failure |
| K7290 | Hepatic failure, unspecified without coma | hepatic_failure |
| K7291 | Hepatic failure, unspecified with coma | hepatic_failure |

| Severe COVID-19 | | |
|------------------------|--|------------------------|
| ICD-10-CM | Description | Type |
| K762 | Central hemorrhagic necrosis of liver | hepatic_failure |
| K763 | Infarction of liver | hepatic_failure |
| D65 | Disseminated intravascular coagulation | coagulation |
| D688 | Other specified coagulation defects | coagulation |
| D689 | Coagulation defect, unspecified | coagulation |
| D6951 | Posttransfusion purpura | coagulation |
| D6959 | Other secondary thrombocytopenia | coagulation |
| D696 | Thrombocytopenia, unspecified | coagulation |
| F05 | Delirium due to known physiological condition | cns_failure |
| G931 | Anoxic brain damage, not elsewhere classified | cns_failure |
| G9340 | Encephalopathy, unspecified | cns_failure |
| G9341 | Metabolic encephalopathy | cns_failure |
| G9349 | Other encephalopathy | cns_failure |
| R4020 | Unspecified coma | cns_failure |
| I462 | Cardiac arrest due to underlying cardiac condition | cardiovascular_failure |
| I468 | Cardiac arrest due to other underlying condition | cardiovascular_failure |
| I469 | Cardiac arrest, cause unspecified | cardiovascular_failure |
| I951 | Orthostatic hypotension | cardiovascular_failure |
| I9589 | Other hypotension | cardiovascular_failure |
| I959 | Hypotension, unspecified | cardiovascular_failure |
| R031 | Nonspecific low blood-pressure reading | cardiovascular_failure |
| R570 | Cardiogenic shock | cardiovascular_failure |
| R571 | Hypovolemic shock | cardiovascular_failure |
| R578 | Other shock | cardiovascular_failure |
| R579 | Shock, unspecified | cardiovascular_failure |
| R6520 | Severe sepsis without septic shock | severe_sepsis |
| R6521 | Severe sepsis with septic shock | septic_shock |
| T8112XA | Postprocedural septic shock, initial encounter | septic_shock |

Demographic Variables

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Admission Datetime |
| Template Variable: | admission_datetime |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

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

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Arrival Datetime |
| Template Variable: | arrival_datetime |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

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:
 - 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 |

Description:

Indicates the date of birth of the patient.

Codes and Values:

Notes for Abstraction:

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

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Discharge Datetime |
| Template Variable: | discharge_datetime |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

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

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Discharge Status |
| Template Variable: | discharge_status |
| Format – Length: | Enumerated – 2 |

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.

Notes for Abstraction:

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Ethnicity |
| Template Variable: | ethnicity |
| Format – Length: | Enumerated – 1 |

Description:

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

Codes and Values:

- 1 = Spanish/Hispanic Origin
- 2 = Not of Spanish/Hispanic Origin
- 9 = Unknown

Notes for Abstraction:

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Facility Identifier |
| Template Variable: | facility_identifier |
| Format – Length: | Varchar – 6 |

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:

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

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 |

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:

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.

| 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 |

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 |

Description:

Indicates the primary insurance policy identification number for the patient.

Codes and Values:

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:
Template Variable:
Format – Length:

Medical Record Number
medical_record_number
Varchar – 17

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:**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:
Template Variable:
Format – Length:

Patient Control Number
patient_control_number
Varchar – 20

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:**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 |

Description:

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

Codes and Values:

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).
- Should only consist of numbers 0-9.

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Payer |
| Template Variable: | payer |
| Format – Length: | Set – 5 |

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 = Unknown

Notes for Abstraction:

- Report up to 3 payers.
- 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 – 47 |

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

R5.01 = European

Notes for Abstraction:

- If reporting multiple race codes, separate each code using a colon (e.g. “R5.01: R2.01” is European and Asian Indian).
- To get 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/aprr.htm>

| Dataset Segment: | Demographic Variables |
|-------------------------|------------------------------|
| Data Element Name: | Source of Admission |
| Template Variable: | source_of_admission |
| Format – Length: | Enumerated – 1 |

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: | Transfer Facility Identifier Receiving |
| Template Variable: | transfer_facility_id_receiving |
| Format – Length: | Varchar – 6 |

Description:

If you received the patient in severe sepsis, septic shock, or with severe COVID-19 (as defined by the inclusion criteria in this dictionary) report the hospital PFI from whom 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:

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 |

Description:

If you are transferring a patient in severe sepsis, septic shock, or with severe COVID-19 (as defined by the inclusion criteria in this dictionary), report the hospital’s PFI to whom 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:

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: | Unique Personal Identifier |
| Template Variable: | unique_personal_identifier |
| Format – Length: | Varchar – 10 |

Description:

A composite field comprised of portions of the patient 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 |

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)
- 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: | AIDS/HIV Disease |
| Template Variable: | aids_hiv_disease |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has AIDS or an HIV infection.

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: | Altered Mental Status |
| Template Variable: | altered_mental_status |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has an altered mental status.

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: | Asthma |
| Template Variable: | asthma |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has asthma.

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: | Chronic Liver Disease |
| Template Variable: | chronic_liver_disease |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has chronic liver disease.

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: | Chronic Renal Failure |
| Template Variable: | chronic_renal_failure |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has chronic renal failure.

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: | Chronic Respiratory Failure |
| Template Variable: | chronic_respiratory_failure |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has chronic respiratory failure.

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: | Coagulopathy |
| Template Variable: | coagulopathy |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has coagulopathy.

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: | Congestive Heart Failure |
| Template Variable: | congestive_heart_failure |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has congestive heart 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: | COPD |
| Template Variable: | copd |
| Format – Length: | Enumerated – 1 |

Description:

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

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: | Dementia |
| Template Variable: | dementia |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has dementia.

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: | Diabetes |
| Template Variable: | diabetes |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient has diabetes.

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: | Dialysis Comorbidity |
| Template Variable: | dialysis_comorbidity |
| Format – Length: | Enumerated – 1 |

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 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: | History of COVID -19 |
| Template Variable: | history_of_covid |
| Format – Length: | Enumerated – 1 |

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 Date |
| Template Variable: | history_of_covid_date |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

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 – 7 |

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
- 0 = No history of coronary heart disease, peripheral artery disease, valve disorder or cerebrovascular disease

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 1N 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 |

Description:

Indicates that the patient has hypertension.

Codes and Values:

- 0 = No
- 1 = Yes

Notes for Abstraction:

- Please see Appendix 10 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 |

Description:

Indicates that the patient has an immunocompromising disease/illness.

Codes and Values:

- 0 = No
- 1 = Yes

Notes for Abstraction:

- Please see Appendix 1P 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: | Lymphoma Leukemia Multiple Myeloma |
| Template Variable: | lymphoma_leukemia_multi_myeloma |
| Format – Length: | Enumerated – 1 |

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 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: | Mechanical Ventilation Comorbidity |
| Template Variable: | mechanical_vent_comorbidity |
| Format – Length: | Enumerated – 1 |

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 1R 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

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 1S 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 |

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 1T 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 |

Description:

Indicates that the patient has metastatic cancer.

Codes and Values:

- 0 = No
- 1 = Yes

Notes for Abstraction:

- Please see Appendix 1U 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 |

Description:

Indicates that the patient is obese (measured as a body mass index (BMI) of 30 or higher).

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 1V 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 has a BMI value of 30 or higher in the EHR even if they do 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 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 – 7 |

Description:

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

Codes and Values:

- 1 = DNR
- 2 = DNI
- 3 = Comfort Care
- 0 = None

Notes for Abstraction:

- Report all that apply.
- Each payer will be separated by a colon (:).
- For example:
 - To report multiple elements: 1:2:3

| Dataset Segment: | Comorbidity/Risk Factor (POA) Variables |
|-------------------------|--|
| Data Element Name: | Patient Care Considerations Date |
| Template Variable: | patient_care_considerations_date |
| Format – Length: | Date – 10 |

Description:

Indicate the earliest date associated with *patient_care_considerations* (i.e., DNR, DNI, and/or Comfort Care).

Codes and Values:

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 |

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 1W 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 |

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 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 "1" 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: | Smoking Vaping |
| Template Variable: | smoking_vaping |
| Format – Length: | Enumerated – 1 |

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 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) |
|-------------------------|--------------------------------------|
| Data Element Name: | Tracheostomy on Arrival |
| Template Variable: | tracheostomy_on_arrival |
| Format – Length: | Enumerated – 1 |

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- 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 "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 |

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 |

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

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 |

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 – 26

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 |

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 |

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 1S 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 |

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 1T 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 |

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 |

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 |

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: | Mechanical Ventilation Treatment |
| Template Variable: | mechanical_vent_treatment |
| Format – Length: | Enumerated – 1 |

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 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 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 |

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 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 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 |

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 3F 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: | Dialysis Outcome |
| Template Variable: | dialysis_outcome |
| Format – Length: | Enumerated – 1 |

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 4A 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 |

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 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: | Tracheostomy at Discharge |
| Template Variable: | tracheostomy_at_discharge |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient was discharged with a tracheostomy.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- 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 codes listed in the referenced appendix on the date of discharge.

Outcome (during hospitalization) Variables

| Dataset Segment: | Outcome (in hospital) Variables |
|-------------------------|--|
| Data Element Name: | Cardiovascular Outcomes |
| Template Variable: | cardiovascular_outcomes |
| Format – Length: | Enumerated – 1 |

Description:

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

Codes and Values:

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

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 4D 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 |

Description:

Indicate if the patient was admitted to the Intensive Care Unit (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 |

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 4E 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: | Outcome (in hospital) Variables |
|-------------------------|--|
| Data Element Name: | Tracheostomy in Hospital |
| Template Variable: | tracheostomy_in_hospital |
| Format – Length: | Enumerated – 1 |

Description:

Indicates that the patient had a tracheostomy during the hospitalization prior to the discharge date.

Codes and Values:

- 0 = No
- 1 = Yes

Notes for Abstraction:

- If the patient received a tracheotomy at arrival or during the hospitalization, report "1."
- Please see Appendix 4F 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 "0", if the patient does not have one or more of the ICD-10-PCS codes listed in the referenced appendix.

Severity Variables

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | aPTT 1 |
| Template Variable: | aptt_1 |
| Format – Length: | Decimal – 4 |

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: | Decimal – 4 |

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: | Decimal – 4 |

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: | Decimal – 4 |

Description:

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

Codes and Values:

Enter the aPTT level.

Notes for Abstraction:

- 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.
- Must be numeric to one decimal place (example 19.8). For example, 30.7 or 30.0; place hold with 0.
 - If the numeric value is preceded by "<" (less than) or ">" (greater than) signs, this sign should be reported. 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_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_max |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

- 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.
- 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: | Diastolic First |
| Template Variable: | diastolic_1 |
| Format – Length: | Number – 3 |

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 |

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 |

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 |

Description:

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

Codes and Values:

Notes for Abstraction:

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

| Dataset Segment: | Severity Variables |
|-------------------------|----------------------------|
| Data Element Name: | Diastolic First Datetime 1 |
| Template Variable: | diastolic_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_min |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

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

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | INR 1 |
| Template Variable: | inr_1 |
| Format – Length: | Decimal – 4 |

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: | Decimal – 4 |

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: | Decimal – 4 |

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: | Decimal – 4 |

Description:

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

Codes and Values:

Enter the INR level

Notes for Abstraction:

- 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.
- Must be numeric to one decimal place (example 1.2 or 11.5).
 - If the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this sign should be reported. 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_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_max |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

- 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.
- 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: | Decimal – 4 |

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: | Decimal – 4 |

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: | Decimal – -4 |

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: | Decimal – 4 |

Description:

Indicates the 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.

- Values might range from 0 to 9; numbers higher than nine may indicate the value has not been converted to mmol/L.

Notes for Abstraction:

- 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.
- Must be numeric to one decimal place (example 19.8).
 - If the numeric value is preceded by "<" (less than) or ">" (greater than) signs, this sign should be reported. 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_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_max |
| Format – Length: | Datetime – 16 |

Description:

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

Notes for Abstraction:

- 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.
- 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 CNS |
| Template Variable: | organ_dysfunc_cns |
| Format – Length: | Enumerated – 1 |

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 5A 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 Arrival |
| Template Variable: | organ_dysfunc_hepatic_arrival |
| Format – Length: | Decimal – 4 |

Description:

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

| Dataset Segment: | Severity Variables |
|-------------------------|-------------------------------|
| Data Element Name: | Organ Dysfunction Hepatic Max |
| Template Variable: | organ_dysfunc_hepatic_max |
| Format – Length: | Decimal – 4 |

Description:

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

Codes and Values:

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

Notes for Abstraction:

- 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.
- Must be numeric to one decimal place (example 2.8).
 - If the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this sign should be reported. For example <0.1, should be reported as <0.1.
- If the 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 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: | Organ Dysfunction Hepatic Arrival Datetime |
| Template Variable: | organ_dysfunc_hepatic_arrival_dt |
| Format – Length: | Datetime – 16 |

Description:

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

| Dataset Segment: | Severity Variables |
|-------------------------|--|
| Data Element Name: | Organ Dysfunction Hepatic Max Datetime |
| Template Variable: | organ_dysfunc_hepatic_max_dt |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

- 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.
- 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 Renal Arrival |
| Template Variable: | organ_dysfunc_renal_arrival |
| Format – Length: | Decimal – 4 |

Description:

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

| Dataset Segment: | Severity Variables |
|--------------------|-----------------------------|
| Data Element Name: | Organ Dysfunction Renal Max |
| Template Variable: | organ_dysfunc_renal_max |
| Format – Length: | Decimal – 4 |

Description:

Indicates the 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:

- 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.
- Must be numeric to one decimal place (example 2.8).
 - If the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this sign should be reported. 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: | Organ Dysfunction Renal Arrival Datetime |
| Template Variable: | organ_dysfunc_renal_arrival_dt |
| Format – Length: | Datetime – 16 |

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: | Organ Dysfunction Renal Max Datetime |
| Template Variable: | organ_dysfunc_renal_max_dt |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

- 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.
- 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 Respiratory |
| Template Variable: | organ_dysfunc_respiratory |
| Format – Length: | Enumerated – 1 |

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 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.

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | Platelets 1 |
| Template Variable: | platelets_1 |
| Format – Length: | Enumerated – 6 |

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: | Enumerated – 6 |

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: | Enumerated – 6 |

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: | Enumerated – 6 |

Description:

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

Codes and Values:

Enter the actual platelet level. Convert the units to cells/uL if needed.

Notes for Abstraction:

- 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.
 - If the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this should be reported. For example <0.1, should be reported as <0.1.
- This element belongs to Organ Dysfunction Hematologic.
- Formatting:
 1. Format must be a whole number up to 6-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_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_min |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

Notes for Abstraction:

- 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.
- 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_hearttrate_1 |
| Format – Length: | Enumerated— 3 |

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_hearttrate_2 |
| Format – Length: | Enumerated — 3 |

Description:

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

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | SIRS Heart Rate 3 |
| Template Variable: | sirs_hearttrate_3 |
| Format – Length: | Enumerated — 3 |

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_hearttrate_max |
| Format – Length: | Enumerated — 3 |

Description:

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

Codes and Values:

Enter the actual heart rate.

Notes for Abstraction:

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_hearttrate_dt_1 |
| Format – Length: | Datetime – 16 |

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_hearttrate_dt_2 |
| Format – Length: | Datetime – 16 |

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_hearttrate_dt_3 |
| Format – Length: | Datetime – 16 |

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_hearttrate_dt_max |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

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

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | SIRS Leukocyte Arrival |
| Template Variable: | sirs_leuckocyte_arrival |
| Format – Length: | Enumerated – 6 |

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_leuckocyte_min |
| Format – Length: | Enumerated – 6 |

Description:

Indicates the 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_leuckocyte_max |
| Format – Length: | Enumerated – 6 |

Description:

Indicates the 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) count. Convert the units to cells/uL if needed.

Notes for Abstraction:

- 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.
- If the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this may be reported. For example >100,000, should be reported as >100,000.
- Formatting:
 1. Format must be a whole number up to 6-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_leuckocyte_arrival_dt |
| Format – Length: | Datetime – 16 |

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_leuckocyte_min_dt |
| Format – Length: | Datetime – 16 |

Description

Indicates the date and time of 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_leuckocyte_max_dt |
| Format – Length: | Datetime – 16 |

Description

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

Codes and Values:

Notes for Abstraction:

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

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

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

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 |

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 |

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 |

Description:

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

Codes and Values:

Enter the actual respiratory rate.

Notes for Abstraction:

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 |

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 |

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 |

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 |

Description:

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

Codes and Values:

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

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | SIRS Temperature 1 |
| Template Variable: | sirs_temperature_1 |
| Format – Length: | Enumerated – 5 |

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 |

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 |

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 |

Description:

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

Codes and Values:

Enter the actual temperature level using Fahrenheit. Convert from Celsius if needed.

Notes for Abstraction:

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 |

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 |

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 |

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 |

Description:

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

Codes and Values:

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

| Dataset Segment: | Severity Variables |
|-------------------------|---------------------------|
| Data Element Name: | Systolic First |
| Template Variable: | systolic_1 |
| Format – Length: | Number – 3 |

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 |

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 |

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 |

Description:

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

Codes and Values:

Notes for Abstraction:

- Formatting:
- Format must be a number up to 3 digits.
 2. 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_datetime_1 |
| Format – Length: | Datetime – 16 |

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_datetime_2 |
| Format – Length: | Datetime – 16 |

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_datetime_3 |
| Format – Length: | Datetime – 16 |

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_datetime_min |
| Format – Length: | Datetime – 16 |

Description:

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

Codes and Values:

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

Change Log

Version D2.0

- Suspected *Source of Infection* value was changed for option 11 to read “soft tissue infection”.
- The order of the appendices was changed to align with the order of the data elements in the data dictionary.
- Several appendices were updated to include additional codes. Be sure to review Appendices D2.0 for the specific codes that were added. The following appendices were modified:
 - Appendix 1E: Chronic Liver Disease Comorbidity / Risk Factor
 - Appendix 1G: Chronic Respiratory Failure Comorbidity / Risk Factor
 - Appendix 1H: Coagulopathy Comorbidity / Risk Factor
 - Appendix 1P: Immunocompromising Comorbidity / Risk Factor
 - Appendix 1S: Medication Anticoagulant
 - Appendix 1T: Medication Immune Modifying
 - Appendix 1V: Obesity Comorbidity
 - Appendix 2D: Flu Positive Clinical
 - Appendix 2E: Suspected Source of Infection
 - Appendix 3F: Vasopressor Administration Treatment Medication and NDC Codes
- Descriptions of CSV files of codes were added to ***Key points to remember during data extraction.***
- “Collected” was added to the severity variables to specify that collected datetime should be reported for the labs and vital signs.
- *Cardiac outcome* was renamed to *cardiovascular outcome*.
- The notes for abstraction of *Race* were modified to provide a single link to SPARCS codes and values.
- The notes for abstraction of *Pregnancy Status During Hospitalization* were modified.
- The notes for abstraction of *Flu Positive* were modified.
- The notes for abstraction of *Tracheostomy in Hospital* were modified.
- The description of *Medication Immune Modifying* was modified.
- The description and codes and values of *Lactate Level Max* were modified.
- The notes for abstraction of all labs reported as Severity Variables have been modified. The following notes have been added for the labs and their respective collected date and time:
 - 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.
 - For all labs, if the numeric value is preceded by “<” (less than) or “>” (greater than) signs, this sign should be reported. For example <0.1 should be reported as <0.1. For example >100,000 should be reported as >100,000.