NYSDOH Adult Sepsis and COVID-19 Data Dictionary

Digitalized Data Collection, D3.0.2

Version (Digital) D3.0.2

November 10, 2022

Effective with
Discharges from 10/01/2022

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

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

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

Changes from version D3.0.1 to D3.0.2 are highlighted in yellow.

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Office of Quality and Patient Safety
New York State Department of Health
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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 severe sepsis, septic shock, and severe COVID-19 inpatients, emergency department (ED) patients and Observation patients who meet 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. For patients who are not admitted to the hospital (i.e., ED and Observation only), the patient's age at arrival should be used to determine reporting to the adult or the pediatric database.

Because the information in the appendices and csv file is duplicative, appendices will no longer be made available beginning with Data Dictionary Version D3.0. Any references to the appendices have been replaced with references to corresponding csv files. When using the csv files for the identification of relevant ICD-10-CM codes, be sure to capture any code (ICD-10-CM) in any position at any point during hospitalization unless otherwise indicated in the variable directions.

Most variables are required but there are some exceptions such as ***Transfer Facility Identifier Receiving*** and ***Transfer Facility Identifier Sending*** which are situational. For transfer data elements we recognize that your hospital EHR may not have Transfer Facility Identifier Receiving/Sending but may have Transfer Facility Name Receiving/Sending. Please report all data you have regarding transfers. Within hospital (interdepartmental transfers) are not considered transfers for these data elements.

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

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

The csv files of codes are provided separately. Each csv file contains three columns: the codes for the variable, the corresponding code description, and a 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 variables 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_VerD3.0.csv

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

- medication_immune_modifying_ndc_code_VerD3.0.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); however, cases should only be reported if one of the below inclusion codes is a final diagnosis. This will allow for electronic identification of cases. The ICD-10-CM code-based definition for identifying the severe sepsis/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 OR J1282 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
J1282	Pneumonia due to coronavirus disease 2019 (This code is effective as of January 1, 2021).	COVID-19
AND (one or more of the following)		

Severe COVID-19 ICD-10-CM	Description	Type
J80	Acute respiratory distress syndrome	Respiratory
J9600	Acute respiratory failure, unsp w hypoxia or hypercapnia	Respiratory
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
R0602	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

Severe COVID-19 ICD-10-CM	Description	Type
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
K762	Central hemorrhagic necrosis of liver	Hepatic Failure
K763	Infarction of liver	Hepatic Failure
D65	Disseminated intravascular coagulation	Hepatic Failure
D688	Other specified coagulation defects	Hepatic Failure
D689	Coagulation defect, unspecified	Hepatic Failure
D6951	Posttransfusion purpura	Hepatic Failure
D6959	Other secondary thrombocytopenia	Coagulation
D696	Thrombocytopenia, unspecified	Coagulation
F05	Delirium due to known physiological condition	CNS Failure
G92	Toxic encephalopathy	CNS Failure
G928	Other toxic encephalopathy	CNS Failure
G929	Unspecified toxic encephalopathy	CNS Failure
G920	Immune effector cell-associated neurotoxicity syndrome	CNS Failure
G9200	Immune effector cell-associated neurotoxicity syndrome, grade unspecified	CNS Failure
G9201	Immune effector cell-associated neurotoxicity syndrome, grade 1	CNS Failure
G9202	Immune effector cell-associated neurotoxicity syndrome, grade 2	CNS Failure
G9203	Immune effector cell-associated neurotoxicity syndrome, grade 3	CNS Failure
G9204	Immune effector cell-associated neurotoxicity syndrome, grade 4	CNS Failure
G931	Anoxic brain damage, not elsewhere classified	CNS Failure

Severe COVID-19 ICD-10-CM	Description	Type
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_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Admission Datetime.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Arrival Datetime
Template Variable:	arrival_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Arrival Datetime.

Notes for Abstraction:

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

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Date of Birth
Template Variable:	date_of_birth
Format – Length:	Date — 10
Mandatory:	Yes

Description:

Indicates the date of birth of the patient.

Codes and Values:

Enter the Date of Birth.

Notes for Abstraction:

- Formatting:
  1. Format must be YYYY-MM-DD
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
  3. Example: November 3, 1959 = 1959-11-03
- ***Date of Birth*** cannot be after ***Admission Datetime***.
- Patient age at admission should be used to determine reporting to the adult or the pediatric database. 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 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_dt
Format – Length:	Datetime — 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Discharge Datetime.

Notes for Abstraction:

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

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

Description:

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

Codes and Values:

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

63 = Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH).
64 = Discharged/transferred to a Nursing Facility Certified under Medicaid but not certified under Medicare.
65 = Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital.
66 = Discharged/transferred to a Critical Access Hospital (CAH).
69 = Discharged/transferred to a Designated Disaster Alternative Care Site.
70 = Discharged/transferred to another Type of Health Care Institution not defined Elsewhere in this Code List.
81 = Discharged to Home or Self Care with a Planned Acute Care Hospital Inpatient Readmission.
82 = Discharged/transferred to a Short-Term General Hospital for Inpatient Care with a Planned Acute Care Hospital Inpatient Readmission.
83 = Discharged/transferred to Skilled Nursing Facility (SNF) with Medicare Certification with a Planned Acute Care Hospital Inpatient Readmission.
84 = Discharged/transferred to a Facility that Provides Custodial or Supportive Care with a Planned Acute Care Hospital Inpatient Readmission.
85 = Discharged/transferred to a Designated Cancer Center or Children's Hospital with a Planned Acute Care Hospital Inpatient Readmission.
86 = Discharged/transferred to Home under Care of Organized Home Health Service Organization with a Planned Acute Care Hospital Inpatient Readmission.
87 = Discharged/transferred to Court/Law Enforcement with a Planned Acute Care Hospital Inpatient Readmission.
88 = Discharged/transferred to a Federal Health Care Facility with a Planned Acute Care Hospital Inpatient Readmission.
89 = Discharged/transferred to Hospital-Based Medicare Approved Swing Bed with a Planned Acute Care Hospital Inpatient Readmission.
90 = Discharged/transferred to an Inpatient Rehabilitation Facility (IRF) including Rehabilitation Distinct Part Units of a Hospital with a Planned Acute Care Hospital Inpatient Readmission.
91 = Discharged/transferred to a Medicare Certified Long Term Care Hospital (LTCH) with a Planned Acute Care Hospital Inpatient Readmission.
92 = Discharged/transferred to a Nursing Facility Certified under Medicaid but not Certified under Medicare with a Planned Acute Care Hospital Inpatient Readmission.
93 = Discharged/transferred to a Psychiatric Hospital or Psychiatric Distinct Part Unit of a Hospital with a Planned Acute Care Hospital Inpatient Readmission.
94 = Discharged/transferred to a Critical Access Hospital (CAH) with a Planned Acute Care Hospital Inpatient Readmission.
95 = Discharged/transferred to another Type of Health Care Institution not Defined Elsewhere in this Code List with a Planned Acute Care Hospital Inpatient Readmission.

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

- If reporting multiple ethnicity codes (up to 5 codes), separate each code using a colon (e.g., "E1.02: E1.04" is Mexican and South American).
- Multiple ethnicity codes within the same heading are expected as there might be many different origins within a heading (e.g., "E1.02.001 Mexican American" and "E1.02.002 Mexicano" are within the same heading "E1.02 Mexican"). However, we would not expect a selection of codes within any two headings of "E1 SPANISH/HISPANIC ORIGIN", "E2 NOT HISPANIC OR LATINO", and "E9 UNKNOWN".
- To obtain the full list of codes, please refer to the following link to the SPARCS code set:
- SPARCS (RR-Race and Ethnicity Codes, Source: Race and Ethnicity Code Set -Version 1.0): https://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

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

Description:

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

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

Codes and Values:

Enter the Facility Identifier.

Notes for Abstraction:

- Must be a valid number as maintained by the NYSDOH.
- Can only contain numbers 0-9.

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

Description:

Indicates the gender of the patient.

Codes and Values:

M = Male
F = Female
U = Unknown

Notes for Abstraction:

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

Description:

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

Codes and Values:

Enter the ICD-10-CM Codes.

Notes for Abstraction:

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

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

Description:

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

Codes and Values:

Y = Diagnosis was present at time of inpatient admission
N = Diagnosis was not present at time of inpatient admission
U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
W = Clinically undetermined. Provider unable to clinically determine whether the condition was present at the time of inpatient admission
1 = Unreported/Not used. Exempt from POA reporting.

Notes for Abstraction:

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

- 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:	Inclusion Septic Shock
Template Variable:	inclusion_septic_shock
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has septic shock.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: inclusion_septic_shock_code_VerD3.0.1.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Inclusion Severe COVID
Template Variable:	inclusion_severe_covid
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has severe COVID-19.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: inclusion_definition_table_b_1_code_VerD3.0.csv; inclusion_definition_table_b_2_code__VerD3.0.1.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the inclusion_table_b_1_code_VerD3.0.csv file **AND** one or more of the ICD-10-CM codes listed in the inclusion_table_b_2_code_VerD3.0.1.csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in both referenced csv files.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Inclusion Severe Sepsis
Template Variable:	inclusion_severe_sepsis
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has severe sepsis.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: inclusion_severe_sepsis_code_VerD3.0.1.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Insurance Number
Template Variable:	insurance_number
Format – Length:	Varchar – 19
Mandatory:	Yes

Description:

Indicates the primary insurance policy identification number for the patient.

Codes and Values:

Enter the Insurance Number.

Notes for Abstraction:

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

Facilities are directed to enter the following values:

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

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Medical Record Number
Template Variable:	medical_record_number
Format – Length:	Varchar – 17
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Medical Record Number.

Notes for Abstraction:

- Must not equal zero or blanks.
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Other Payer
Template Variable:	other_payer
Format – Length:	Varchar – 50
Mandatory:	Yes

Description:

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

Codes and Values:

Enter Other Payer.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient Control Number
Template Variable:	patient_control_number
Format – Length:	Varchar – 20
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Patient Control Number.

Notes for Abstraction:

- Must not equal zero or blanks.
- Must be alphanumeric (0-9) (a-z, A-Z).
- Special characters are invalid entries.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient City
Template Variable:	pat_addr_city
Format – Length:	Varchar – 30
Mandatory:	Yes

Description:

Indicates the city name of the patient's address.

Codes and Values:

Enter the Patient City Name.

Notes for Abstraction:

- ***Patient City*** is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.

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

Description:

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

Codes and Values:

Enter the Patient County Code.

Notes for Abstraction:

- ***Patient County Code*** is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.
- Must only consist of numbers (0 – 9).
- FIPS county codes: state-county code list (census.gov)

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

Description:

Indicates the first line of patient street address.

Codes and Values:

Enter the Patient Street Address Line 1.

Notes for Abstraction:

- ***Patient Street Address Line 1*** is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.

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

Description:

Indicates the second line of patient street address.

Codes and Values:

Enter the Patient Street Address Line 2.

Notes for Abstraction:

- ***Patient Street Address Line 2*** is mandatory. In rare instances, when the values are truly unattainable from the EHR, report missing values as blank.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient State
Template Variable:	pat_addr_st
Format – Length:	Varchar – 2
Mandatory:	Yes

Description:

Indicates the patient's state or province code.

Codes and Values:

Enter the Patient State.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Patient Zip Code of Residence
Template Variable:	patient_zip_code_of_residence
Format – Length:	Varchar – 10
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Patient Zip Code of Residence.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Payer
Template Variable:	payer
Format – Length:	Set – maximum 3 codes
Mandatory:	Yes

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Race
Template Variable:	race
Format – Length:	Set – maximum 56 codes
Mandatory:	Yes

Description:

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

Codes and Values:

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

Notes for Abstraction:

- If reporting multiple race codes, separate each code using a colon (e.g., "R2.12: R2.01" is Korean and Asian Indian).
- To obtain the full list of codes, please refer to the following link to the SPARCS code set:
- SPARCS (RR-Race and Ethnicity Codes, Source: Race and Ethnicity Code Set -Version 1.0): https://www.health.ny.gov/statistics/sparcs/sysdoc/apprr.htm

Dataset Segment:	**Demographic Variables**
Data Element Name:	Source of Admission
Template Variable:	source_of_admission
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

1 = Non-Health Facility Point of Origin: The patient was admitted to this facility from home or from an assisted living facility.
2 = Clinic: The patient was referred to this facility as a transfer from a freestanding or non-freestanding clinic.
4 = Transfer from a Hospital (Different Facility): The patient was admitted to this facility as a hospital transfer from an acute care facility where he or she was an inpatient or outpatient.
5 = Transfer from a Skilled Nursing Facility (SNF) or Intermediate Care Facility (ICF): The patient was admitted to this facility as a transfer from a SNF or ICF where he/she was a resident.
6 = Transfer from Another Health Care Facility: The patient was admitted to this facility as a transfer from another type of health care facility that is not defined elsewhere in this code list.
8 = Court/Law Enforcement: The patient was admitted to this facility upon the direction of a court of law or upon the request of a law enforcement agency representative.
9 = Information Not Available: The means by which the patient was admitted to this hospital was not known.
E = Transfer from Ambulatory Surgery Center: The patient was admitted to this facility as a transfer from an ambulatory surgery center.
F = Transfer from Hospice and is Under a Hospice Plan of Care or Enrolled in a Hospice Program: The patient was admitted to this facility as a transfer from a hospice.

Notes for Abstraction:

- If a patient is moved from one area of the hospital to another (e.g., from the Emergency Department to the ICU), the patient is not considered a transfer. The patient is considered a transfer when the patient is moved between different hospitals with discharge and admission at each location and separate billing from each location.
- Assisted Living is reported as 1, Non-Health Facility Point of Origin.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Transferred In
Template Variable:	transferred_in
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report “1”, if a patient was transferred in (i.e., received from another acute care hospital).
- Report “0”, if a patient was not transferred in.

Dataset Segment:	**Demographic Variables**
Data Element Name:	Transferred Out
Template Variable:	transferred_out
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Report “1”, if a patient was transferred out (i.e., transferred/discharged to another acute care hospital).
- Report “0”, if a patient was not transferred out.

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

Description:

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

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

Codes and Values:

Enter the Transfer Facility Identifier Receiving.

Notes for Abstraction:

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

To find a hospital PFI, please visit:

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

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

Description:

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

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

Codes and Values:

Enter the Transfer Facility Identifier Sending.

Notes for Abstraction:

- ***Transfer Facility Identifier Sending*** is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- Must be a valid number as maintained by the 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 Identifier Sending*** of 09.

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Transfer Facility Name Receiving
Template Variable:	transfer_facility_nm_receiving
Format – Length:	Varchar – 50
Mandatory:	Yes

Description:

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

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

Codes and Values:

Enter the Transfer Facility Receiving.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Transfer Facility Name Sending
Template Variable:	transfer_facility_nm_sending
Format – Length:	Varchar – 50
Mandatory:	Yes

Description:

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

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

Codes and Values:

Enter the Transfer Facility Name Sending.

Notes for Abstraction:

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

Dataset Segment:	**Demographic Variables**
Data Element Name:	Unique Personal Identifier
Template Variable:	unique_personal_identifier
Format – Length:	Varchar – 10
Mandatory:	Yes

Description:

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

Codes and Values:

Included below are the individual components of this data element.

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

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

Notes for Abstraction:

First and Last Name Components: Must be **UPPERCASE** alpha characters (A-Z). If the last name is less than 4 characters, the first two and last two characters are used even if some characters are repeated.

- If the first name is only 1-character, repeat the same character to meet the "First 2" character requirement of the Patient's First Name. For instance, first name "A" would be reported as "AA".

Included below are examples of how to report some unusual scenarios: A three-character last name, a two-character last name, a name with junior, a one character first name, a last name with an apostrophe, and a hyphenated last name.

- Joe Tan would be reported as TAANJO
- Bill Su Jr. would be reported as SUSUBI
- E John Smith would be reported as SMTHEE
- Bob O'Brien would be reported as OBENBO
- Sue Jones-Davis would be reported as JOISSU

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

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

Comorbidity/Risk Factor Variables

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Acute Cardiovascular Conditions (POA)
Template Variable:	acute_cardiovascular_conditions_poa
Format – Length:	Set – maximum of 3 codes
Mandatory:	Yes

Description:

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

Codes and Values:

1 = Myocardial infarction
2 = Ischemic stroke/Hemorrhagic stroke/Transient ischemic attack (TIA)
3 = Myocarditis secondary to COVID-19
0 = No acute cardiovascular condition

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: acute_cardiovascular_conditions_code_VerD3.0.csv.
- If the patient has one or more of the ICD-10-CM codes associated with the Codes and Values (1 = Myocardial infarction; 2 = Ischemic stroke/Hemorrhagic stroke/Transient ischemic attack (TIA); 3 = Myocarditis secondary to COVID-19) for ***Acute Cardiovascular Conditions (POA)*** in the referenced csv file and has a POA indicator, then:
  - Report the respective Codes and Values if the POA indicator is:
    - Y = Diagnosis was present at time of inpatient admission
    - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
    - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - 1 = Unreported/Not used. Exempt from POA reporting

    - Report the Codes and Values as “0 = No acute cardiovascular condition” if the POA indicator is:
        - N = Diagnosis was not present at time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes associated with the Codes and Values (1 = Myocardial infarction; 2 = Ischemic stroke/Hemorrhagic stroke/Transient ischemic attack (TIA); 3 = Myocarditis secondary to COVID-19) for ***Acute Cardiovascular Conditions (POA)*** in the referenced csv file and does **not** have a POA indicator, then:
    - Report the respective Codes and Values if the diagnosis was present on admission/arrival, or if documentation is insufficient to determine if the condition was present on admission/arrival, or if it is clinically undetermined whether the condition was present on admission/arrival
    - Report the Codes and Values as “0 = No acute cardiovascular condition” if it is determined that the condition(s) was **not** present on admission/arrival.
- Report the Codes and Values as “0 = No acute cardiovascular condition”, if the patient does not have any of the ICD-10-CM codes associated with the Codes and Values for ***Acute Cardiovascular Conditions (POA)*** listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	AIDS/HIV Disease
Template Variable:	aids_hiv_disease
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has AIDS or an HIV infection.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: aids_hiv_disease_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

Indicates that the patient has asthma.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: asthma_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

Indicates that the patient has chronic liver disease.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_liver_disease_code_VerD3.0.2.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Chronic Kidney Disease
Template Variable:	chronic_kidney_disease
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic kidney disease.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_kidney_disease_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Chronic Respiratory Failure
Template Variable:	chronic_respiratory_failure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has chronic respiratory failure.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: chronic_respiratory_failure_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: coagulopathy_code_VerD3.0.2.csv.
- If the patient has one or more of the ICD-10-CM codes for the ***Coagulopathy (POA)*** listed in the referenced csv file, and has a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - Y = Diagnosis was present at time of inpatient admission
        - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
        - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - Report the Codes and Values as "0 = No", if the POA indicator is:
        - N = Diagnosis was not present at time of inpatient admission
- If the the patient has one or more of the ICD-10-CM codes for ***Coagulopathy (POA)*** in the referenced csv file and does **not** have a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, or if documentation is insufficient to determine if the condition was present on admission/arrival, or if it is clinically undetermined whether the condition was present on admission/arrival.
    - Report the Codes and Valus as "0 = No" if it is determined that the condition was **not** present on admission/arrival

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

Dataset Segment:	**Comorbidity/Risk FactorVariables**
Data Element Name:	Congestive Heart Failure
Template Variable:	congestive_heart_failure
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has congestive heart failure.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: congestive_heart_failure_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	COPD
Template Variable:	copd
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: copd_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Dementia
Template Variable:	dementia
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has dementia.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: dementia_code_VerD3.0.2.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Diabetes
Template Variable:	diabetes
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has diabetes.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: diabetes_code_VerD3.0.csv.
- Report “1”, if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: dialysis_comorbidity_code_VerD3.0.csv.
- If the patient has one or more of the ICD-10-CM codes for the ***Dialysis Comorbidity (POA)*** listed in the referenced csv file, and has a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - Y = Diagnosis was present at time of inpatient admission
        - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
        - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
        - 1 = Unreported/Not used. Exempt from POA reporting
    - Report the Codes and Values as "0 = No" if the POA indicator is:
        - N = Diagnosis was not present at time of inpatient admission
- If the the patient has one or more of the ICD-10-CM codes for ***Dialysis Comorbidity (POA)*** in the referenced csv file and does **not** have a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, or if documentation is insufficient to determine if the condition was present on admission/arrival, or if it is clinically undetermined whether the condition was present on admission/arrival.

    - Report the Codes and Values as “0 = No” if it is determined that the condition was **not** present on admission/arrival.
- Report the Codes and Values as “0 = No”, if the patient does not have any of the ICD-10-CM codes for ***Dialysis Comorbidity (POA)*** listed in the referenced csv file.

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

Description:

Indicates that the patient has a history of a positive COVID-19 test within 12 weeks prior to admission/arrival to the hospital.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report "1" when the patient has a history of a positive COVID-19 test within 12 weeks prior to arrival at the hospital. If there is a positive test, even if later followed by a negative test, then report the positive test date.
- Report "1" if there is a patient-reported history of COVID-19 within 12 weeks prior to arrival at the hospital, without a supporting LOINC code.
- 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 Variables**
Data Element Name:	History of COVID-19 Datetime
Template Variable:	history_of_covid _dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the History of COVID-19 Datetime.

Notes for Abstraction:

- If there is more than one positive COVID-19 test, report the earliest positive test.
- If there is a patient-reported history of COVID-19 without a supporting LOINC code, report "1" to ***History of COVID-19*** and leave this variable, ***History of COVID-19 Datetime*** blank.
- If the ***History of COVID-19*** is reported as "0 = No", then ***History of COVID-19 Datetime*** should be reported as blank.
- ***History of COVID-19 Datetime*** is mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- 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 Variables**
Data Element Name:	History of Other Cardiovascular Disease
Template Variable:	history_of_other_cvd
Format – Length:	Set – maximum 5 codes
Mandatory:	Yes

Description:

Indicates the patient's history of other cardiovascular disease.

Codes and Values:

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

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2:3
- History of (not acute presentation)
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: history_of_other_cvd_code_VerD3.0.2.csv.
- Report "0", if the patient does not have one of the ICD-10-CM code(s) listed in the referenced csv file.

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

Description:

Indicates that the patient has hypertension.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: hypertension_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Immunocompromising
Template Variable:	immunocompromising
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has an immunocompromising disease/illness.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: immunocompromising_code_VerD3.0.2.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Lymphoma Leukemia Multiple Myeloma
Template Variable:	lymphoma_leukemia_multi_myeloma
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: lymphoma_leukemia_multi_myeloma_code_ VerD3.0.2.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: mechanical_vent_comorbidity_code_VerD3.0.csv.
- If the patient has one or more of the ICD-10-CM codes for ***Mechanical Ventilation Comorbidity (POA)*** listed in the referened csv file, and has a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the POA indicator is:
    - Y = Diagnosis was present at time of inpatient admission
    - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
    - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
    - 1 = Unreported/Not used. Exempt from POA reporting
  - Report the Codes and Values as "0 = No" if the POA indicator is:
    - N = Diagnosis was not present at time of inpatient admission
- If the the patient has one or more of the ICD-10-CM codes for ***Mechanical Ventilation Comorbidity (POA)*** in the referenced csv file and does **not** have a POA indicator, then:
  - Report the Codes and Values as "1 = Yes" if the diagnosis was present on admission/arrival, or if documentation is insufficient to determine if the condition was present on admission/arrival, or if it is clinically undetermined whether the condition was present on admission/arrival.

    - Report the Codes and Values as “0 = No” if it is determined that the condition was **not** present on admission/arrival.
- Report the Codes and Values as “0 = No”, if the patient does not have any of the ICD-10-CM codes for ***Mechanical Ventilation Comorbidity (POA)*** listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk FactorVariables**
Data Element Name:	Medication Immune Modifying Pre-Hospital
Template Variable:	medication_immune_modifying_pre_hospital
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, medication list, etc.
- For a list of applicable NDC codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: medication_immune_modifying_code_VerD3.0.csv.
- Report “1”, if the patient has one or more of the NDC codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the NDC codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Metastatic Cancer
Template Variable:	metastatic_cancer
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

Indicates that the patient has metastatic cancer.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from othherEHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: metastatic_cancer_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

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:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- 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.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: obesity_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- 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 csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file or a BMI value of 30 or higher in the EHR.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Patient Care Considerations
Template Variable:	patient_care_considerations
Format – Length:	Set – maximum 2 codes
Mandatory:	Yes

Description:

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

Codes and Values:

1 = DNR
2 = DNI
0 = None

Notes for Abstraction:

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

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Patient Care Considerations Date
Template Variable:	patient_care_considerations_date
Format – Length:	Date – 10
Mandatory:	Yes

Description:

Indicate the earliest date associated with ***patient_care_considerations***.

Codes and Values:

Enter the Patient Care Considerations Date.

Notes for Abstraction:

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

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

Description:

Indicates that the patient has a pregnancy-related comorbidity.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Must be “0” if ***Pregnancy Status During Hospitalization*** is “0”
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: pregnancy_comorbidity_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Pregnancy Status During Hospitalization
Template Variable:	pregnancy_status
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, tests/labs, etc.
- This can be a POA or not a POA variable.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: pregnancy_status_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- 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 csv file or does not have detection of human chorionic gonadotropic (hCG) in the urine or blood test (lab value).

Dataset Segment:	**Comorbidity/Risk Factor Variables**
Data Element Name:	Skin Disorders/Burns
Template Variable:	skin_disorders_burns
Format – Length:	Set– maximum 3 codes
Mandatory:	Yes

Description:

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

Codes and Values:

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

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: skin_disorders_burn_disease_code_VerD3.0.csv.
- Report “1”, if the patient has one of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: smoking_vaping_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

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:

- Source is not limited to the billing codes. This information can be obtained from other EHR sources, such as the problem list, medical history, etc.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: tracheostomy_on_arrival_code_VerD3.0.csv.
- If the patient has one or more of the ICD-10-CM codes for ***Tracheostomy on Arrival (POA)*** listed in the referenced csv file, and has a POA indicator, then:
    - Report the Codes and Values as "1 = Yes" if the POA indicator is:
        - Y = Diagnosis was present at time of inpatient admission
        - U = Documentation insufficient to determine if the condition was present at the time of inpatient admission
        - W = Clinically undetermined; Provider unable to clinically determine whether the condition was present at the time of inpatient admission
        - 1 = Unreported/Not used. Exempt from POA reporting
- Report the Codes and Values as "0 = No" if the POA indicator is:
        - N = Diagnosis was not present at time of inpatient admission
- If the patient has one or more of the ICD-10-CM codes for ***Tracheostomy on Arrival (POA)*** listed in the referenced csv file, and does **not** have a POA indicator, then:
    - Report the ***Tracheostomy on Arrival (POA)*** as "1 = Yes" if the diagnosis was present on admission/arrival, or if documentation insufficient to determine if the condition was present on admission/arrival, or if it is clinically undetermined whether the condition was present on admission/arrival.

    - Report the ***Tracheostomy on Arrival (POA)*** as “0 = No” if it is determined that the condition was **not** present on admission/arrival.
- Report the Codes and Values as “0 = No”, if the patient does not have any of the ICD-10-CM codes for ***Tracheostomy on Arrival (POA)*** listed in the referenced csv file.

Clinical Variables

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

Description:

Indicates the patient has exposure to COVID-19.

Codes and Values:

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

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: clinical: covid_exposure_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

Indicates COVID-19 virus is identified or not identified.

Codes and Values:

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

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: clinical: covid_virus_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

Indicates that the patient has resistance to an antimicrobial drug.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: clinical: drug_resistant_pathogen_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- POA and/or during hospitalization
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: clinical: flu_positive_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- 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 csv file or does not have a positive influenza virus test (lab value).

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

Description:

The suspected source of infection.

Codes and Values:

1 = Septicemia
2 = Bacteremia
3 = Fungal infection
4 = Peritoneal infection
5 = Heart infection
6 = Upper respiratory infection
7 = Lung infection
8 = Central nervous system infection
9 = Gastrointestinal infection
10 = Genitourinary infection
11 = Soft tissue infection
12 = Other infection source
13 = Unknown

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: clinical: suspected_source_of_infection_code_VerD3.0.2.csv.
- If there is not an identified source of infection as specified in the referenced csv file, then report "unknown".
    - Note that "other infection source" is defined in the ICD-10-CM codes provided in the referenced csv file.
- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
    - To report multiple elements: 2:9:12

Treatment (in hospital) Variables

Dataset Segment:	**Treatment (in hospital) Variables**
Data Element Name:	Dialysis Treatment
Template Variable:	dialysis_treatment
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: dialysis_treatment_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “1”, if the patient has an order for dialysis in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for dialysis in the EHR.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable NDC codes, please refer to the corresponding csv file for this version of the data dictionary: comorbidity: medication_immune_modifying_ndc_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the NDC codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the NDC codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Generic: Remdesivir
- Brand name: Veklury and GS-5734
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: during_hospital_remdesivir_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “1”, if the patient has an order for the medication listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes or the medication listed in the referenced csv file.

Dataset Segment:	**Treatment (in hospital) Variables**
Data Element Name:	ECMO
Template Variable:	ecmo
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: ecmo_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “1”, if the patient has an order ECMO in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for ECMO in the EHR.

Dataset Segment:	**Treatment (in hospital) Variables**
Data Element Name:	High Flow Nasal Cannula
Template Variable:	high_flow_nasal_cannula
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

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

Dataset Segment:	**Treatment (in hospital) Variables**
Data Element Name:	Mechanical Ventilation Treatment
Template Variable:	mechanical_vent_treatment
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: mechanical_vent_treatment_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “1”, if the patient has an order for mechanical ventilation in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for mechanical ventilation in the EHR.

Dataset Segment:	**Treatment (in hospital) Variables**
Data Element Name:	Non-Invasive Positive Pressure Ventilation
Template Variable:	non_invasive_pos_pressure_vent
Format – Length:	Enumerated – 1
Mandatory:	Yes

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- Combination of ICD-10-PCS or an order from the electronic health record (EHR).
- For a list of applicable ICD-10-PCS codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: non_invasive_pos_pressure_vent_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “1”, if the patient has an order for non-invasive positive pressure ventilation in the EHR even if they do not have one of the ICD-10-PCS codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-PCS codes listed in the referenced csv file or does not have an order for non-invasive positive pressure ventilation in the EHR.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable NDC codes, please refer to the corresponding csv file for this version of the data dictionary: treatment: vasopressor_administration_ndc _code_VerD3.0.csv.
- Report "1", if the patient has one or more of the medications or NDC codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the medications or NDC codes listed in the referenced csv file.

Outcome (at discharge) Variables

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

Description:

Indicates that the patient is discharged on dialysis.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- If there was a patient order to have dialysis at discharge as evidenced by dialysis on the discharge date, report “1.”
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: outcome (at discharge): dialysis_outcome_code_VerD3.0.csv.
- Report "1", if the patient has the ICD-10-CM code listed in the referenced csv file on the date of discharge.
- Report “0”, if the patient does not have the ICD-10-CM code listed in the referenced referenced csv file on the date of discharge.

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

Description:

Indicates the patient is discharged on mechanical ventilation.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- If there was a patient order to have mechanical ventilation at discharge as evidenced by mechanical ventilation on the discharge date, report “1”.
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: outcome (at discharge): mechanical_vent_outcome_code_VerD3.0.csv.
- Report “1”, if the patient has the ICD-10-CM code listed in the referenced csv file on the date of discharge.
- Report “0”, if the patient does not have the ICD-10-CM code listed in the referenced referenced csv file 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
Mandatory:	Yes

Description:

Indicates that the patient was discharged with a tracheostomy.

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: outcome (at discharge): tracheostomy_at_discharge_code_VerD3.0.csv.
- Report "1", if the patient has the ICD-10-CM code listed in the referenced csv file on the date of discharge.
- Report “0”, if the patient does not have the ICD-10-CM code listed in the referenced referenced csv file on the date of discharge.

Outcome (in hospital) Variables

Dataset Segment:	**Outcome (in hospital) Variables**
Data Element Name:	Cardiovascular Outcomes in Hospital
Template Variable:	cv_outcomes_in_hospital
Format – Length:	Set – maximum of 4 codes
Mandatory:	Yes

Description:

Indicates the patient had one or more of the following cardiovascular outcomes during the hospitalization.

Codes and Values:

0 = None
1 = Acute coronary syndrome
2 = Ischemic stroke
3 = Myocarditis secondary to COVID-19
4 = Cardiomyopathy

Notes for Abstraction:

- Report all that apply.
- Each value will be separated by a colon (:).
- For example:
  - To report multiple elements: 1:2:3
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: outcome (in hospital): cv_outcomes_in_hospital_code_VerD3.0.csv.

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

Description:

Indicate if the patient was admitted to the Intensive Care Unit (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:	Tracheostomy in Hospital
Template Variable:	tracheostomy_in_hospital
Format – Length:	Enumerated – 1
Mandatory:	Yes

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.”
- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: outcome (in hospital): tracheostomy _in_hospital_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-PCS codes listed in the referenced csv file.
- Report “0”, if the patient does not have one or more of the ICD-10-PCS codes listed in the referenced csv file.

Severity Variables

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the aPTT levels.

Notes for Abstraction:

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the aPTT Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Bilirubin Arrival Datetime
Template Variable:	bilirubin_arrival_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Bilirubin Max Datetime
Template Variable:	bilirubin_max_dt
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the total Bilirubin Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Creatinine Datetimes.

Notes for Abstraction:

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

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

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Diastolic First
Template Variable:	diastolic_1
Format – Length:	Number – 3
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Diastolic Second
Template Variable:	diastolic _2
Format – Length:	Number – 3
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Diastolic Third
Template Variable:	diastolic _3
Format – Length:	Number – 3
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Diastolic Min
Template Variable:	diastolic _min
Format – Length:	Number – 3
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the actual Diastolic Values.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Diastolic Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the actual INR levels.

Notes for Abstraction:

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

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

Description:

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

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

Description:

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

Dataset Segment:	Severity Variables
Data Element Name:	INR Datetime 3
Template Variable:	inr_dt_3
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Dataset Segment:	Severity Variables
Data Element Name:	INR Datetime Max
Template Variable:	inr_dt_max
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the INR Datetimes.

Notes for Abstraction:

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

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level 1
Template Variable:	lactate_level_1
Format – Length:	String – 4
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level 2
Template Variable:	lactate_level_2
Format – Length:	String – 4
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level 3
Template Variable:	lactate_level_3
Format – Length:	String – 4
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	Lactate Level Max
Template Variable:	lactate_level_max
Format – Length:	String – 4
Mandatory:	Yes

Description:

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

Codes and Values:

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

Notes for Abstraction:

- ***Lactate Level 1/2/3/Max*** and corresponding datetimes are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Must be reported to one decimal place (example 5.8).
    - If your EHR allows the capture and the extraction of "<" (less than) or ">" (greater than) sign for this lab, please report "<" (less than) or ">" (greater than) sign with the value as well. If your EHR does not capture this, you may simply report the numeric value. For example, <0.1, should be reported as <0.1.
- If the lactate level was reported by the lab with more than one decimal place, use the rules of rounding to convert the number to one decimal place.
- Do not just truncate the number in order to convert it to one decimal place.
- Examples of rounding lactate level results:
    - 4.81 is rounded to 4.8
    - 4.85 is rounded to 4.9
    - 4.23 is rounded to 4.2
    - 4.97 is rounded to 5.0
    - **NOT CORRECT**: 4.85 is truncated to 4.8 (this should be rounded to 4.9)

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Lacate Datetimes.

Notes for Abstraction:

- ***Lactate Level 1/2/3/Max Datetimes*** are mandatory. In rare instances, when values are truly unattainable from the EHR, report missing values as blank.
- If any Lactate Level is reported then the datetime for the Lactate Level value should be reported. For example, if ***Lactate Level 1*** has a value, ***Lactate Level Datetime 1*** should not be blank.
- For all labs, if the initial lab collected was contaminated or determined questionable (e.g., did not result), report the result and the date and time of the subsequent lab collected.
- When there are multiple identical MAX values, report the first one after the patient's arrival to the hospital.
- Formatting:
  1. Format must be YYYY-MM-DD hh:mm
     a. YYYY-MM-DDThh:mm is also valid
  2. YYYY = four-digit year
     MM = two-digit month (01 = January, etc.)
     DD = two-digit day of month (01 through 31)
     hh = two digits of hour (00 through 23) (am/pm NOT allowed)
     mm = two digits of minute (00 through 59)
  3. Example: 11:42 pm November 3, 1959 = 1959-11-03 23:42
     a. 1959-11-03T23:42 is also valid
  4. Midnight = 00:00, **NOT** 24:00

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:6

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_cardiovascular_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_cns_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_hematologic_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_hepatic_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_renal_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

Codes and Values:

0 = No
1 = Yes

Notes for Abstraction:

- For a list of applicable ICD-10-CM codes, please refer to the corresponding csv file for this version of the data dictionary: severity: organ_dysfunc_respiratory_code_VerD3.0.csv.
- Report "1", if the patient has one or more of the ICD-10-CM codes listed in the referenced csv file.
- Report “0”, if the patient does not have one of the ICD-10-CM codes listed in the referenced csv file.

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Platelets Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the actual Heart Rates.

Notes for Abstraction:

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

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

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Heart Rate Datetime 1
Template Variable:	sirs_heartrate_dt_1
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Heart Rate Datetime 2
Template Variable:	sirs_heartrate_dt_2
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Heart Rate Datetime 3
Template Variable:	sirs_heartrate_dt_3
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Dataset Segment:	**Severity Variables**
Data Element Name:	SIRS Heart Rate Datetime Max
Template Variable:	sirs_heartrate_dt_max
Format – Length:	Datetime – 16
Mandatory:	Yes

Description:

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

Codes and Values:

Enter the Heart Rate Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

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

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

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

Description

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

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

Description

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

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

Description

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

Codes and Values:

Enter the Leukocyte Datetimes.

Notes for Abstraction:

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

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the actual Respiratory Rates.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Respiratory Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

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

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Temperature Datetimes.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the actual Systolic Values.

Notes for Abstraction:

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

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

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

Description:

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

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

Description:

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

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

Description:

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

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

Description:

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

Codes and Values:

Enter the Systolic Datetimes.

Notes for Abstraction:

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

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

Change Log

Version D3.0.2

- Changes from version D3.0.1 to D3.0.2 are highlighted in yellow.
- Revised the CSV files and the name of the referenced CSV files for the variables listed below. Specifically, added ICD-10-CM codes or revised ICD-10-CM code descriptions to align with the ICD-10-CM FY 2023 October 1 release (effective 10/01/2022). Please refer to the Adult D3.0.2 Summary Change CSV file document to see the complete list of ICD-10-CM code changes and their respective variables.
    - *Comorbidity Variables*
        - Added ***Chronic Liver Disease*** ICD-10-CM codes on the csv file: chronic_liver_disease_code_VerD3.0.2csv
        - Added ***Coagulopathy*** ICD-10-CM codes on the csv file: coagulopathy_code_VerD3.0.2
        - Added and Revised ***Dementia ICD-10-CM Codes*** ICD-10-CM codes on the CSV File: dementia_code_verD3.0.2
        - Added ***History of Other Cardiovascular Disease*** ICD-10-CM codes on the CSV File: history_of_other_cvd_code_verD3.0.2
        - Added ***Immunocompromising*** ICD-10-CM codes on the CSV File: immunocompromising_code_verD3.0.2
        - Revised ***Lymphoma Leukemia Multiple Myeloma*** ICD-10-CM codes on the CSV File: lymphoma_leukemia_multi_myeloma_code_verD3.0.2
    - *Clinical Variables*
        - Revised ***Suspected Source of Infection*** ICD-10-CM codes on the CSV File: suspected_source_of_infection_code_verD3.0.2
- Modified all CSV files to indicate whether a code has been added or whether the code description has been revised.
    - All CSV files now contain two columns: ‘Add’ and ‘Revise’
        - These two columns are marked off as either: ‘0’ or ‘1’
            - ‘0’ means ‘No’ change (either ‘Add’ or ‘Revise’) was made
            - ‘1’ means ‘Yes’ change (either ‘Add’ or ‘Revise’) was made