Data Element Availability

● **For Abstracted Cases Only** ● **For All ED Visits**

Data Element	*Notes*	*Available for download from Registry*	*Available through MEDIC data request process*
Patient Characteristics			
Name	*First and last names*		●
Date of birth		●	●
Age		●	●
MRN		●	●
Visit/Case Number		●	●
Gender		●	●
Primary Insurance Payer	*Plan Payer (eg. BCBSM, Medicare, Medicaid, etc.)*		●
Zip Code			●
Race		●	●
Ethnicity		●	●
Visit Characteristics			
Site Name		●	●
Arrival Department	*For sites w/ separate adult and pediatric EDs*	●	●
Arrival Mode		●	●
Transferred in from another facility			●
Triage Acuity		●	●
Trauma activations			●
NPI of Attending Physician		●	●
Disposition from the ED		●	●
Admission Status	*Observation or inpatient, If admitted*		●
Time stamp variables			
Date and time of visit	*Can calculate day of week*	●	●
Date and time of triage			●
Date and time of first ED provider evaluation/treatment			●
Date and time of ED departure			●
ED Length of Stay	*Calculable – in days and hours*	●	●
Date and time of admission	*If admitted*		●
Date and time of discharge	*If admitted*		●
Inpatient Length of Stay	*Calculable – in days and hours*		●

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Data Element	*Notes*	*Available for download from Registry*	*Available through MEDIC data request process*
Vital Signs	*Includes unit, value, and date and time taken for each measurement obtained during an ED visit*		
Temperature			●
Heart rate (pulse)			●
Systolic blood pressure			●
Diastolic blood pressure			●
Respiratory rate			●
Pulse oximetry			●
Oxygen flow rate			●
Pain score			●
Glasgow Coma Scale (GCS)		●	●
Pediatric Coma Scale (PCS)		●	●
Height			●
Weight			●
Urine voided			●
Diagnosis Information			
Chief Complaint			●
ICD-10 Diagnosis Codes	*For ED visit and associated inpatient stay. Primary dx and secondary diagnosis codes up to 15. If inpatient stay occurs cannot sort out diagnoses that were present in ED from those that occur during admission.*		●
Procedures	*Includes date and time procedure was ordered and performed*		
CPT Code	*Includes the following CPT codes:* *Radiology: 70000 – 79999* *(70000-76499) diagnostic radiology* *(76500–76999) diagnostic ultrasound* *(77001–77032) radiologic guidance* *(77051–77059) breast mammography* *(77071–77084) bone/joint studies* *(77261–77999) radiation oncology* *(78000-79999) nuclear medicine*		●

ABSTRACTED DATA			
Data Element	***Notes***	***Available for download from Registry***	***Available through MEDIC data request process***
Head Injury Abstracted Data			
Was the inciting injury blunt trauma?	Yes/No	●	●
Was there documentation of the patient currently taking antiplatelet or anticoagulation medications?	Yes/No	●	●
Did this case involve a trauma activation?	Yes/No	●	●
Current active pregnancy?	Yes/No	●	●
Documented history of coagulopathy, thrombocytopenia, or bleeding disorder?	Yes/No	●	●
Suspicion of non-accidental injury?	Yes/No	●	●
Documented history of ventricular shunt device, ventriculoperitoneal or VP shunt ?	Yes/No	●	●
Documented history of brain tumor or intracranial mass?	Yes/No	●	●
Documented history of a cognitive deficit?	Yes/No	●	●
Dangerous/Severe mechanism of injury?	Yes/No	●	●
GCS Score recorded?	*Yes/No. If Yes, we collect the lowest value.*	●	●
Documentation of a headache?	*Yes/No*	●	●
Documentation of loss of consciousness?	*Yes/No*	●	●
Documentation of vomiting?	*Yes/No*	●	●
Documentation of >1 episode of vomiting?	*Yes/No*	●	●
Documentation of short-term memory loss or amnesia?	*Yes/No*	●	●
Documentation of altered mental status?	*Yes/No*	●	●
Documentation of patient not acting normally?	*Yes/No*	●	●
Documentation of CT done for patient or family preference?	*Yes/No*	●	●
Signs of basilar skull fracture?	*Yes/No*	●	●
Physical findings of open/depressed skull fracture or tense fontanels?	*Yes/No*	●	●
Physical findings of occipital, parietal, or temporal scalp hematoma?	*Yes/No*	●	●
Documentation of a seizure since the injury occurred?	*Yes/No*	●	●
Focal neurological injury?	*Yes/No*	●	●
Worsening neurologic symptoms?	*Yes/No*	●	●
Documentation of intoxication due to alcohol or other substances?	*Yes/No*	●	●
Was the CT scan appropriate?	*Yes/No*	●	●
Was the CT scan considered overuse?	*Yes/No*	●	●
Was the patient intermediate risk?	*Yes/No. Only for pediatric patients*	●	●
Was a CT scan ordered by the ED?	*Yes/No*	●	●

Data Element	*Notes*	*Available for download from Registry*	*Available through MEDIC data request process*
PE Abstracted Data			
Chest CT ordered to rule out PE?	*Yes/No*	●	●
Current active pregnancy?	*Yes/No*		●
CT scan resulted in dx of acute PE?	*Yes/No*	●	●
CT scan discovered an alternative dx?	*Yes/No. If yes, we collect the alternative dx*	●	●
Was a d-dimer performed?	*Yes/No. If yes, we collect if it was +/-*	●	●
Respiratory Disease Abstracted Data			
Documented history of comorbid conditions?	*Yes/No. If yes, we collect conditions:* • *Bronchopulmonary dysplasia (BPD)* • *Cancer (active treatment)* • *Ciliary Dyskinesia* • *Congenital heart disease (excluding isolated valve disease and/or patent ductus arteriosus)* • *Cystic fibrosis* • *HIV/AIDS* • *Patient was premature (<37 weeks'gestation)* • *Sickle Cell Disease* • *Spinal muscular atrophy (or similar degenerative neuromuscular condition such as muscular dystrophy)* • *Tracheostomy* • *Transplantation (solid organ or bone marrow)* • *Ventilator dependence (invasive or non-invasive)* • *Home supplemental oxygen*	●	●
Documentation of prior high-risk past medical history for the same condition.	• *Hospitalization* • *Intensive care admission* • *Intubation* • *Chronic (ongoing) oral daily steroid use*	●	●
Fever prior to ED arrival?	*Yes/No. If yes, we collect duration*	●	●
Wheezing during ED visit?	*Yes/No*	●	●
First-ever wheezing episode?	*Yes/No*	●	●
Patient complained of chest pain?	*Yes/No*	●	●
Patient was toxic, somnolent, lethargic, listless, or ill-appearing?	*Yes/No*	●	●

First physical exam findings	• *Grunting* • *Nasal flaring* • *Stridor* • *Retractions*	●	●
	• *Wheeze* • *Crackles* • *Decreased air entry*		
Focal breath sounds or crepitus?	*Yes/No*	●	●
Worsening respiratory status?	*Yes/No. If yes, we collect all documented options:* • *Continuous beta agonist use in ED* • *Accessory muscle usage, Retractions* • *Nasal flaring* • *Grunting* • *Head bobbing* • *Hypoxia <92% on room air after 3 treatments with beta agonist* • *Documentation of lethargy despite treatment* • *Documentation of >1 racemic epinephrine treatment in the ED* • *Magnesium Sulfate* • *Use of High Flow Oxygen* • *Intubation, CPAP/BiPAP* • *Child is unable to feed/self-hydrate*	●	●
Documentation of oral steroid medication administered to the patient in the last 24 hours prior to arrival in the ED?	*Yes/No. Only for sampled cases.*	●	●
Documentation of albuterol medication administered to the patient in the last 4 hours prior to arrival in the ED?	*Yes/No. Only for sampled cases.*	●	●
Up to 6 respiratory medications administered in the ED.	*Only for sampled cases. Includes medication, route, dose, dose units, and time administered.*	●	●
Up to 2 respiratory medications prescribed at discharge from the ED.	*Only for sampled cases. Includes medication, route, dose, dose units, and concentration if applicable.*	●	●
Was there documentation of an antibiotic administered in the ED?	*Yes/No. Only for sampled cases.*	●	●
Was there documentation of an antibiotic prescribed upon ED discharge?	*Yes/No. Only for sampled cases.*	●	●
Possible foreign body ingestion within the last 2 weeks?	*Yes/No*	●	●
Was a chest x-ray ordered by the ED?	*Yes/No*	●	●
Asthma, Bronchiolitis, Croup indicators		●	●
Chest Pain Abstracted Data			

Does the patient have documentation of any of the following in their past medical history?	• *Peripheral artery disease (PAD)* • *Stroke/Transient Ischemic Attack (TIA)* • *Hypertension (HTN, including previous treatment)* • *Hypercholesterolemia/Atherosclerosis* • *Diabetes* • *Myocardial Infarction*	●	●
	• *Previous Percutaneous Coronary Intervention (PCI) or Coronary Artery Bypass Grafting (CABG)* • *BMI >30 kg/m2* • *Smoking within the last 90 days* • *First degree relative diagnosed with coronary artery disease before age 55*		
Does the patient have documentation for any of the following characteristics used to describe their symptoms for this ED visit?	• *Middle-or left-sided chest pain* • *Pinpoint/well localized pain* • *Chest pressure, heaviness or tightness* • *Sharp pain* • *Pain worse with exertion* • *Pain relieved by nitroglycerin* • *Pain radiating to arms/jaw/neck* • *Nausea or vomiting* • *Diaphoresis*	●	●
Is there a HEART score recorded?	*Yes/No. If Yes, then we have the value (0-10).*	●	●
Is there documentation for any of the following elements present on the patient's EKG interpretation?	• *EKG interpreted as normal Nonspecific T-wave changes* • *Left ventricular hypertrophy Bundle branch blocks* • *Early repolarization* • *Repolarization abnormalities Pacemaker rhythms* • *Ischemic ST-segment depression* • *New ischemic T-wave inversions* • *Nonspecific ST changes* • *Digoxin effect* • *Abnormal not otherwise specified*	●	●
Was a troponin ordered in the ED?	*Yes/No. If Yes, then we collect the type, the value, and the date and time of the troponin. We collect this information for up to 2 troponins.*	●	●
Was the result of the troponin(s) interpreted by the emergency provider as positive for acute coronary syndrome?	*Yes/No/Indeterminate*	●	●

What was the intended initial disposition from the ED as documented by the ED provider?	• *Discharged from ED without observation* • *Observation in place in the ED* • *Observation in ED Observation Unit* • *Observation in a designated Observation Unit* • *Observation on the floor* • *Admitted inpatient without observation* • *Transferred from ED*	●	●