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*		●
Social Security Numbers	*For select sites only*		●
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*		●

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.*		●
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*		●
Focal breath sounds or crepitus?	*Yes/No*		●
Worsening respiratory status?	*Yes/No. If yes, we collect all documented options*	●	●
Possible foreign body ingestion within the last 2 weeks?	*Yes/No*		●
Documented history of tracheostomy?		●	●
Documentation of prematurity?		●	●
Was a chest x-ray ordered by the ED?	*Yes/No*	●	●
Asthma, Bronchiolitis, Croup indicators		●	●