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An American National Standard

Standard Practice for View of Emergency Medical Care in the Electronic Health Record[1]

This standard is issued under the fixed designation E1744; the number immediately following the designation indicates the year of original adoption or, in the case of revision, the year of last revision. A number in parentheses indicates the year of last reapproval. A superscript epsilon (ε) indicates an editorial change since the last revision or reapproval.

1. Scope

1.1 This practice covers the identification of the information that is necessary to document emergency medical care in an electronic, paperless patient record system that is designed to improve efficiency and cost-effectiveness.

1.2 This practice is a view of the data elements to document the types of emergency medical information that should be included in the electronic health record.

1.2.1 The patient's summary record and derived data sets will be described separately from this practice.

1.2.2 As a view of the electronic health record, the information presented will conform to the structure defined in other ASTM standards for the electronic health record.

1.3 This practice is intended to amplify Guides E1239 and F1629 and the formalisms described in Practices E1384 and E1715.

1.3.1 This practice details the use of data elements already established in these standards and other national guidelines for use during documentation of emergency care in the field or in a treatment facility and places them in the context of the object models for health care in Practice E1384 that will be the vehicle for communication standards for health care data.

1.3.1.1 The data elements and the attributes referred to in this practice are based on national guidelines whenever available.

1.3.1.2 The EMS definitions are based on those generated from the previous EMS consensus conference sponsored by NHTSA and from ASTM task group F 30.03.03 on EMS Management Information Systems.

1.3.1.3 The Emergency Department (ED) definitions are based on the Data Elements for Emergency Department Systems (DEEDS) distributed by the Centers for Disease Control in June 1997.

1.3.1.4 The hospital discharge definitions are based on recommendations from the Centers for Medicare and Medicaid Services (CMS) for Medicare and Medicaid payment and from the Department of Health and Human Services for the Uniform Hospital Discharge Data Set.

1.3.1.5 Because the current trend is to store data as text, the codes for the attribute values have been determined as unnecessary and thus are eliminated from this document.

1.3.1.6 The ASTM process allows for the data elements to be updated as the national consensus changes. When national or professional guides do not exist, or whenever there is a conflict in the existing EMS, ED, hospital or other guides, the committee will recommend a process for resolving the conflict or an explanation of the conflict within each guide.

1.3.2 This practice reinforces the concepts set forth in Guide E1239 and Practice E1384 that documentation of care in all settings shall be seamless and be conducted under a common set of precepts using a common logical record structure and common terminology.

1.4 The electronic health record focuses on the patient.

1.4.1 In particular, the computer–based patient record sets out to ensure that the data document includes:

1.4.1.1 The occurrence of the emergency,

1.4.1.2 The symptoms requiring emergency medical treatment, and potential complications resulting from preexisting conditions,

1.4.1.3 The medical/mental assessment/diagnoses established,

1.4.1.4 The treatment rendered, and

1.4.1.5 The outcome and disposition of the patient after emergency treatment.

1.4.2 The electronic health record consists of subsets of data for the emergency patient that have been captured by different care providers at the time of treatment at the scene and en route, in the emergency department, and in the hospital or other emergency health care settings.

1.4.3 The electronic record focuses on the documentation of information that is necessary to support patient care but does not define appropriate care.

[1] This practice is under the jurisdiction of ASTM Committee E31 on Healthcare Informatics and is the direct responsibility of Subcommittee E31.25 on Healthcare Data Management, Security, Confidentiality, and Privacy.

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2. Referenced Documents

2.1 *ASTM Standards:*[2]

E1239 Practice for Description of Reservation/Registration-Admission, Discharge, Transfer (R-ADT) Systems for Electronic Health Record (EHR) Systems (Withdrawn 2001)[3]

E1384 Practice for Content and Structure of the Electronic Health Record (EHR) (Withdrawn 2001)[3]

E1633 Specification for Coded Values Used in the Electronic Health Record (Withdrawn 2001)[3]

E1715 Practice for An Object-Oriented Model for Registration, Admitting, Discharge, and Transfer (RADT) Functions in Computer-Based Patient Record Systems (Withdrawn 2001)[3]

E1869 Guide for Confidentiality, Privacy, Access, and Data Security Principles for Health Information Including Electronic Health Records (Withdrawn 2001)[3]

E1985 Guide for User Authentication and Authorization (Withdrawn 2001)[3]

E2084 Specification for Authentication of Healthcare Information Using Digital Signatures (Withdrawn 2001)[3]

F1177 Terminology Relating to Emergency Medical Services (Withdrawn 2001)[3]

F1288 Guide for Planning for and Response to a Multiple Casualty Incident (Withdrawn 2001)[3]

F1629 Guide for Establishing Operating Emergency Medical Services and Management Information Systems, or Both (Withdrawn 2001)[3]

2.2 *ANSI Standard:*

X3.172 American National Dictionary for Information Systems 1990[4]

2.3 *Institute of Electrical Electronic Engineers Standards:*

610.12 Standard Glossary of Software Engineering Terminology[5]

3. Terminology

3.1 For definitions of terms used in this specifcation, refer to ANSI X3.172 and IEEE 610.12

3.2 *Definitions of Terms Specific to This Standard:*

3.2.1 *emergency condition*—change(s) in the patient's health status perceived to require immediate medical attention to prevent unnecessary death or disability (See also Guide F1177).

3.2.2 *emergency department (ED) data set*—that set of data elements collected in the emergency outpatient treatment facility prior to admission as an inpatient.

3.2.3 *emergency encounter*—a single event of health care for an emergency, such as care at the scene, or at the emergency outpatient setting. It concludes when the patient proceeds to the next phase of care for the emergency.

3.2.4 *emergency episode*—a series of encounters relating to an emergency condition that may lead either to death, full recovery, or a clinical steady state.

3.2.5 *emergency episode documentation*—those recorded observations that describe the care rendered during the period of an emergency episode, whether brief or extended.

3.2.6 *other emergency outpatient facility*—emergency facility that is not a licensed emergency department connected to an acute care hospital but which provides emergency stabilization and treatment upon demand. Such facilities may include clinic/health centers, freestanding ambulatory surgery center, physician's office, etc.

3.2.7 *pre-hospital EMS data set*—that set of data elements collected at onset and en route prior to arrival at the first treatment facility.

4. Significance and Use

4.1 The Emergency Medical Service System (EMSS) in the United States has largely arisen since 1945 and has drawn to a great degree from the experience gained in military conflicts during and since World War II. The documentation of care, however, has remained largely paper record–based until recently.

4.1.1 Beginning in the 1970s both civilian and military agencies have closely examined electronic means of storing and managing patient data about emergency medical care.

4.1.2 The report of the Institute of Medicine on the Computer-Based Patient Record has emphasized the use of information technology in patient care in general and emergency care data in particular.

4.1.3 During this period ASTM has documented the logical structure of the electronic health record in Guide E1239 and Practice E1384, while Guides F1288 and F1629 has defined the patient care data, to be gathered in the pre-hospital record, and the outcome data, relative to the pre-hospital phase of the emergency, which are collected in the emergency department and after inpatient admission.

4.1.3.1 Specifications for the logical model are also presented in Practice E1715.

4.2 This practice shows how the data gathered for EMS operations and management merge smoothly into the computer-based patient record, consistent with the recognition that these data are part of the primary record of care. Several states[6] have formalized that recognition in state law.

4.2.1 This practice does not instruct physicians how to collect data for patient care.

4.2.2 This practice does not indicate what information needs to be collected at the time of patient care.

4.3 The task now is to document, using standard conventions, the means by which this integration occurs in order to set the stage for the capture and transfer of such emergency care

[2] For referenced ASTM standards, visit the ASTM website, www.astm.org, or contact ASTM Customer Service at service@astm.org. For *Annual Book of ASTM Standards* volume information, refer to the standard's Document Summary page on the ASTM website.

[3] The last approved version of this historical standard is referenced on www.astm.org.

[4] Available from American National Standards Institute (ANSI), 25 W. 43rd St., 4th Floor, New York, NY 10036, http://www.ansi.org.

[5] Available from Institute of Electrical and Electronics Engineers, Inc. (IEEE), 445 Hoes Ln., P.O. Box 1331, Piscataway, NJ 08854-1331, http://www.ieee.org.

[6] State of Washington: Revised Code of Washington 76.168 and Washington Administrative Code 246-976-380.

data using information technology and telecommunications in a standardized way consistent with all other settings of care while protecting the privacy and confidentiality of that data.

4.3.1 The electronic health record has the potential to reduce health care costs by optimizing case management and supporting effective post ED follow-up.

4.3.2 Systematizing the data also enhances its ability to be used consistently, with proper protection, for research into and for management of EMSS operations within the various jurisdictional boundaries.

4.4 The electronic form of the emergency episode documentation utilizes the same logical data model as the electronic health record, but it focuses on data collected during the different phases of the emergency.

4.4.1 These data sets do not limit what may be recorded, or by whom, but they do identify those data considered essential, when they exist. These data sets include all those data recorded to document instances of emergency medical care.

4.4.2 Data organized to enhance flexible and efficient management of information.

4.4.2.1 Identifications of practitioners and facilities will be coded, when necessary, to protect confidentiality and to make provider data comparable. Names will be included when they are necessary to support patient care. Privacy and confidentiality of patient data should be handled according to Guide E1869.

4.4.2.2 Provider identification numbers will be maintained on master data files which also include additional information such as specialty, license level, and the like.

4.4.2.3 Provider identification numbers recorded in the electronic health record will automatically link to the master data files to eliminate the need for duplicate data entry of reference material in the patient record.

4.4.2.4 Coding systems for emergency reporting (ICD-9-CM, CPT,[7] HCPCS,[8] SNOMED[9]) will be referenced in the master data files for Practice E1384 as appropriate.

4.4.2.5 The efficient arrangement of the logical model of Practice E1384 permits output to be generated and identified to mirror the paper record, such as nurse-specific or physician-specific notes.

4.4.2.6 The arrangement of the logical model permits multiple entries of assessment data, using a small group of variables, that can then be used to generate output. For example, sequence of diagnoses by date-time.

[7] *Current Procedure Terminology for Physician Services.*

[8] HCFA (Health Care Financing Administration) Common Procedure Coding System.

[9] *Systematized Nomenclature of Medicine.*

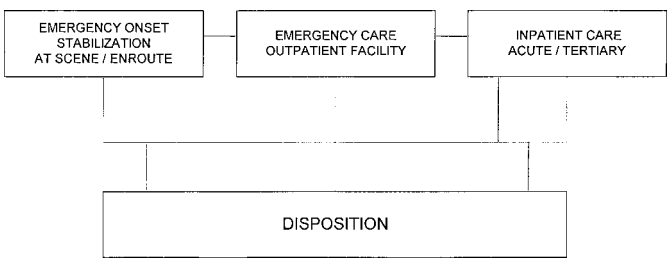

FIG. 1 Data Flow in Emergency Medical Care

5. Phases of Emergency Medical Care

5.1 Patient data are collected during the different phases of the emergency by different care providers, the number and type depend on the severity of the emergency.

5.1.1 Fig. 1 presents the different phases of emergency from onset until final disposition, at which point the patient is no longer the responsibility of emergency care.

5.1.2 In some instances, emergency patients are transported from the location of onset to an emergency department and then later transferred to specialty tertiary care centers to receive treatment for life-threatening medical problems.

5.1.3 Records completed for the emergency patient at different points in time are unique to the type of emergency response and the phase of the emergency.

5.1.4 This practice does not include rehabilitation and outpatient follow-up as part of emergency medical care since this information is recorded elsewhere in the RHR and is not within the scope of this practice.

5.2 Documentation of emergency care is more efficient if the data are captured at the time of collection so that this information can be incorporated simultaneously into the electronic health record at the time of data entry.

5.3 A core of patient identification information (age/date of birth, sex/gender, facility identification, times, etc.) is common to all of the medical records.

5.3.1 Other data elements exist that are unique to the emergency event, and still others exist that are unique to a specific care site.

5.3.2 Although many different records may be completed for a single emergency patient, not all of the data collected are incorporated into the electronic health record.

5.3.2.1 Except for times (see 6.14.4 and 6.14.14), administrative data which are useful for ambulance service management information, such as the use of lights and sirens and mileage, the EMS agency's response number, the type of EMS vehicle, and environmental factors affecting EMS care, have been excluded from the electronic health record, which focuses on the patient.

5.4 The electronic health record has the potential to improve data quality as follows.

5.4.1 Time and date entries will not be subject to the idiosyncrasies of the clock at hand, or the memory of the person entering the data but may be automatically recorded by the computer; however, when data are entered retrospectively, the system should allow a manual override to record actual time.

5.4.2 Direct data entry, by voice, dictation, touch, etc., by the care provider will eliminate the need to interpret the care provider's handwriting.

5.5 Each segment of emergency care is cumulative, though not necessarily sequential, to the prior documentation in the computer–based patient record. Data entered also may update previous documentation.

5.6 The EMS data set is and will continue to be a subset of Practice E1384 and Specification E1633; it will continue to be included in Guide F1629, EMS-MIS global lists of elements.

5.6.1 Each encounter contains contributions to the various record segments noted in Practice E1384.

5.7 Data elements for the emergency patient to be included in the electronic health record are grouped according to the three main phases of a medical emergency.

5.7.1 The first phase refers to the emergency stabilization and treatment provided immediately after onset and en route.

5.7.2 The second phase refers to the emergency diagnostic and treatment care provided at an emergency department/outpatient facility.

5.7.3 The third phase refers to inpatient care.

5.7.4 Potential data sources are listed for each level.

5.8 The data elements within each level are classified as follows according to the segments of the electronic health record presented in Practice E1384;

5.8.1 *Segment 1: Demographics*—Personal data elements sufficient to identify the patient, collected from the patient or patient representative and not related to health status or service provided (see Practice E1384, 6.3.1).

5.8.2 *Segment 2: Legal Agreements* —Data elements indicating legally binding directions or restraints on patient health care, release of information, and disposal of body or body parts, or both, after death.

5.8.3 *Segment 3: Financial Information*—Data elements necessary to document the process and parties involved and responsible for payment of patient health care services.

5.8.4 *Segment 4: Provider/Practitioners* —Data elements identifying the primary organization or establishment responsible for the availability of health care services for this specific episode or encounter and the individuals licensed or certified to deliver care to patients, who had contact with the patient, and provided care based on independent judgment.

5.8.5 *Segment 5: Problem List*—Data elements describing the patient's past medical history and other factors such as social problems, psychiatric problems, risk factors, allergies, reactions to drugs or foods, behavioral problems or other medical alerts.

5.8.6 *Segment 6: Immunizations*—Data elements describing names and dates of immunizations received. (See Table 4 on Patient Record Content Structure Categories, Segments, and Entity Relationships in Practice E1384.)

5.8.7 *Segment 7: Exposure to Hazardous Substances*—Data elements describing exposure to hazardous substances. (See Table 4 on Patient Record Content Structure Categories, Segments, and Entity Relationships in Practice E1384.)

5.8.8 *Segment 8: Family/Prenatal/Cumulative Health/Medical/Dental/Nursing History*—Data elements describing previous signs and symptoms experienced over time.

5.8.9 *Segment 9: Assessments/Exams* —Data elements describing observations of the practitioner during a structured and systematic examination of the patient.

5.8.10 *Segment 10: Care/Treatment Plans and Orders*—Data elements that describe the clinical orders that direct a patient's treatment.

5.8.11 *Segment 11: Diagnostic Tests*—Data elements that document the results from the diagnostic tests performed on the patient.

5.8.12 *Segment 12: Medications*—Data elements that document the patient's current medications and those prescribed during the emergency encounter.

5.8.13 *Segment 13: Scheduled Appointments/Events.*

5.8.14 *Segment 14: Encounters/Episodes* .

5.8.14.1 *Administrative/Diagnostic Summary*—Data elements which clarify the time/date, location, type, and circumstances of the encounter or episode.

5.8.14.2 *Chief Complaint / Present Illness / Injury*—Determination of patient acuity and indication of the chief complaint or reason why the patient came for care, as reported by the patient or others.

5.8.14.3 *Progress Notes/Clinical Course*—Observations of the practitioner(s) during structured and systematic examination of the patient during encounters/episodes. It contains objective observations and measurements that quantify attributes of each body system.

5.8.14.4 *Therapies*—Data elements that describe all preventive or non-medicine therapeutic, or both, services performed at the time of the episode or encounter or scheduled to be performed before the next episode or encounter.

5.8.14.5 *Procedures*—Data elements which describe all procedures performed for diagnostic, exploratory, or definitive treatment purposes including surgical, transfusions and physical, occupational, respiratory, rehabilitative, or mental health therapies provided as a result of the emergency.

5.8.14.6 *Disposition*— Data elements which describe the patient's destination and status at discharge, and a brief discharge summary.

5.8.14.7 *Charges*—Total charges for care received.

5.9 Authorship and authentication are explained as follows for documenting and managing the data included in the computer–based patient record.

5.9.1 Authorship identifies the practitioner who is the author responsible for the action/entry.

5.9.2 Authentication validates the author via a voluntary secondary process (signature, biometric identifier, computer key, etc.) and that the sources of data received are as claimed. (See Practice E1384, Guide E1985, and Specification E2084.)

5.9.3 The specifications for these types of processes are not part of the focus of this practice but will be included within the specifications for the EHR as a whole.

6. Emergency Onset and Stabilization Occurring at Scene and En route (Pre-hospital EMS)

NOTE 1—The data elements presented in this section document the initial emergency phase of emergency care. Some patients with life threatening or serious medical problems may be treated and transported by EMS to the next level of care in the emergency department. Similar patients may elect to bypass EMS (for example, some cardiac patients) and go directly to the emergency department. Thus the data elements included in this section focus on the information that is urgently needed when the emergency patient first requests help. Data elements which are necessary to document the EMS response are documented in parentheses as "EMS No." These EMS data elements were developed at a national consensus conference of EMS experts sponsored by NHTSA. Data elements applicable to patients who go directly to the emergency department are documented in parentheses as "DEEDS No." Data

elements describing aspects of the patient's medical history important to the emergency encounter/episode are documented in parentheses as "EMDS." When inconsistencies exist between the EMS, EMDS and DEEDS formats for recording date/time, address and other data elements common to all data files, they should be resolved in favor of the DEEDS formats which are consistent with HL7 messaging standards.

6.1 *Segment 1: Demographics*—To be updated by prehospital EMS or emergency department personnel depending upon whether treatment begins at the scene or at the ED.

6.1.1 *Patient Name*— The current name of the patient receiving emergency medical care services for whom the record is being created and about whom data are being collected. (EMS-No. 32) Family name, given name, middle name/initial, suffix, prefix, degree and name type code. (EMDS; DEEDS 1.02; Appendix X1, 01001)

6.1.2 *Patient Address*— Patient address to be recorded as street address, other designation (for example, apartment number), city, state/province, zip/postal code, country, type of address (permanent, mailing), other geographic designation (for example, catchment area ID), county/parish, census tract. (EMDS; EMS No. 34–37; DEEDS 1.08)

6.1.2.1 *Address Type*— An indication of the type of address. (EMDS; Practice E1384; DEEDS 1.08):

Home/Mailing	Appendix X1, 01095
Business	Appendix X1, 01077
Temporary	Appendix X1, 01105
Foreign Residence	Appendix X1, 01099

6.1.3 *Telephone Number*— Telephone number at which the patient can be contacted. (EMDS; EMS No. 38; DEEDS 1.09; Appendix X1)

6.1.3.1 *Contact Type*— The type of telephone number recorded for a person. (EMDS, DEEDS 1.09; Appendix X1):

Home	Appendix X1, 01100
Business	Appendix X1, 01080
Temporary	Appendix X1, 01108
FAX	
Beeper	
Cellular	
Answering Service	
E-mail	

6.1.4 *Date/Time of Birth*—Patient's date of birth as reported by the patient or on written documentation. Time of birth reported for newborns. (EMDS; EMS No. 40; DEEDS 1.04; Appendix X1, 01032):

YYYYMMDD HHMM

6.1.5 *Sex/Gender*—The sex of the patient at the start of care. (EMDS; EMS No. 42; DEEDS 1.05; Appendix X1, 01040):

Male
Female
Unknown or undetermined

6.1.6 *Race*—Patient's race coded according to Directive 15 of the Office of Management and Budget and Specification E1633. (EMS No. 43, DEEDS 1.06; Appendix X1, 01042):

American Indian or Alaskan Native
Asian or Pacific islander
Black
White
Unknown

6.1.7 *Ethnicity*—Patient's ethnicity coded according to Directive 15 of the Office of Management and Budget and Specification E1633. This same coding is adopted by HL7 Master Tables, and National Center for Vital Health Statistics recommended Core Data Set. (EMS No. 43; DEEDS 1.07; Appendix X1, 01045):

Hispanic
Not of Hispanic Origin
Unknown

6.1.8 *Social Security Number*—Social security number for patient as assigned by the U.S. Social Security Administration, if available and released by the patient according to the Federal Privacy Act. (EMS No. 39; DEEDS 1.11; Appendix X1, 01020)

6.2 *Segment 2—Legal Agreements:*

6.2.1 *Presence of Living Will/Advanced Directive Name*—The name of an advance directive that is important to future treatment. (EMDS; Appendix X1, 02030)

6.2.2 *Treatment Authorization*—Coded values to indicate the type, if any, of EMS treatment authorization. (EMS No. 81)

Protocol (standing orders)
On-line (radio telephone)
On-scene
Written orders (patient specific)
Not applicable
Unknown

6.3 *Segment 3: Financial Information.*

6.4 *Segment 4: Provider/Practitioners* —This information should be repeated as necessary to document each provider and practitioner who responded at the scene or en route.

6.4.1 *Provider Number*— State specific identifier for an EMS agency that responds to the patient at the scene. (EMS No. 24; Appendix X1, 14001.B006)

6.4.1.1 *Provider Type*— Type of EMS agency unit that responds:

Non-transporting EMS Responder
Transporting EMS Responder (DEEDS 4.04)

6.4.1.2 *Provider Vehicle Number*—EMS agency specific number to identify vehicle that responds to the patient at the scene. (EMS No. 24; DEEDS 4.03; Appendix X1, 14001.B0065)

6.4.2 *Practitioner Number*—State specific personnel certification/license number for a crew member. (EMS Nos. 26, 27, 28; Appendix X1, 14001.B011)

6.4.2.1 *Practitioner Type*—Type of personnel certification/license level for EMS crew member. (EMS Nos. 29, 30, 31; Appendix X1, 14001.B011.01):

First responder
EMT basic
EMT intermediate
EMT paramedic
Nurse
Physician
Other health care professional
None of the above
Unknown

6.4.2.2 *Practitioner Status*—Coded value to indicate the role of the crew member in caring for the patient:

Driver
Chief/in charge
Assistant
Other

6.4.3 *EMS Practitioner ID Who Performs EMS Procedure/Therapy*—Identification number for practitioner who performs a procedure. This number is linkable to a master file that

contains descriptive information about the practitioner. (Appendix X1, 14001.B011.02)

6.5 *Segment 5—Problem List:*

6.5.1 *Preexisting Conditions*—Coded values determined by EMS to indicate preexisting medical conditions known to the care provider (EMS No. 51, Appendix X1, 08075.17):

Asthma	Hypertension
Cancer	Psychiatric problems
Chronic renal failure	Seizure/convulsions
Chronic respiratory failure	Tracheostomy
Diabetes	Tuberculosis
Emphysema	

6.5.1.1 *Date of History*— Date of health history. (Appendix X1, 08075)

6.5.2 *Allergies*—Allergies suffered by the patient that will affect the course of emergency treatment. (included in EMS No. 50 Provider Impression list; Appendix X1, 08088)

6.6 *Segment 6: Immunization.*

6.7 *Segment 7—Exposure to Hazardous Substances:*

6.7.1 *Exposure to Hazardous Materials*—Coded values to indicate type of hazardous materials to which patient was exposed (Appendix X1, 07001)

6.8 *Segment 8: Family/Prenatal/Cumulative Health/ Medical/Dental Nursing History.*

6.9 *Segment 9: Assessments/Exams .*

6.10 *Segment 10: Care/Treatment Plans and Orders.*

6.11 *Segment 11: Diagnostic Tests.*

6.12 *Segment 12—Medications :*

6.12.1 *Current Medications Taken by Patient*—Coded value to indicate medications or potential toxic materials as reported by the patient taken during the last 24 h that may affect the course of emergency treatment. (Appendix X1, 08083)

6.12.2 *EMS Medication/Material Name*—Name of medication provided to patient by EMS practitioner as coded according to groupings used in the American Hospital Formulary Service (1993), nonprescription medications, or unorthodox treatments that may have an adverse effect on the patient. (EMS No. 80; Appendix X1, 12001.06):

Acetaminophen	Ipecac
Adenosine	Isoproterenol
Albuterol	Lidocaine
Amyl nitrate	Lorazepam
Aspirin	Magnesium sulfate
Atropine	Mannitol
Bretylium tosylate	Meperidine
Bumetanide	Metaproterenol
Calcium chloride	Methylprednisolone
Calcium gluconate	Metoclopramide
Charcoal, activated	Morphine
Dexamethasone	Naloxone
Dextrose and water (50 %)	Nifedipine
Diazepam	Nitroglycerin
Diphenhydramine	Procainamide
Dopamine	Sodium bicarbonate
Epinephrine	Succinylcholine
Furosemide	Terbutaline
Glucagon	Thiamine
Heparin	Verapamil

6.12.3 *Dosage of EMS Medication/Material* —The medication dose at each administration. Enter a number >0. (Appendix X1, 12001.30)

6.12.4 *EMS Medication Route*—The route by which the medication is administered. The following table of medications (HL7, Version 2.3, Table 0162, Route of Administration) is recommended. (Appendix X1, 12001.39):

Description	
Apply externally	Mucous membrane
Buccal	Nasal
Dental	Nasogastric
Epidural	Nasal prongs
Endotracheal tube	Nasotracheal tube
Gastronomy tube	Ophthalmic
Genitourinary irrigant	Otic
Immerse body part	Other/miscellaneous
Intraarterial	Perfusion
Intrabursal	Oral
Intracardiac	Rectal
Intracervical (uterus)	Rebreather mask
Intradermal	Soaked dressing
Inhalation	Subcutaneous
Intrahepatic artery	Sublingual
Intramuscular	Topical
Intranasal	Tracheostomy
Intraocular	Transdermal
Intraperitoneal	Translingual
Intrasynovial	Urethral
Intrathecal	Vaginal
Intrauterine	Ventimask
Intravenous	Wound
Mouth	

6.13 *Segment 13: Scheduled Appointments/Events*—Not applicable for this phase.

6.14 *Segment 14—Encounters/Episodes :*

Segment 14: Encounters/Episodes—Administrative/ Diagnostic Summary

6.14.1 *Estimated/Reported Age*—The patient's age as reported by the patient or estimated by the care provider. Age is not included in the EMDS or DEEDS data sets but it is very important for EMS when the patient's date of birth is not available. (EMS No. 41, Appendix X1, 14001.A106)

6.14.2 *EMS Pick-up Address*—Address (or best approximation) where patient was found, or, if no patient, address to which unit responded. Street address, other designation (for example, apartment number), city, state/province, zip/postal code, country, type of address (permanent, mailing), other geographic designation (for example, catchment area ID), county/parish, census tract. (EMDS; EMS Nos. 1–4; Appendix X1, 14001.A036)

6.14.3 *Location Type/Scene Description*—Type of location where the emergency event occurred coded in terms of the ICD-10 place of occurrence codes (WOO-Y34 except Y06 and Y07). (EMS No. 5; DEEDS 5.05; Appendix X1, 14001.B010):

Home
Residential institution
School, other institution and public administrative area
Sports and athletic area
Street and highway
Trade and service area
Industrial and construction area
Farm
Other specified place
Unspecified place

6.14.4 *Onset Date/Time*— Date and time when the injury occurred or the date and time of the onset of the acute illness that is most responsible for precipitating the patient's ED visit.

(EMS Nos. 6–7; DEEDS 5.02; Appendix X1, 14001.A027):

YYYYMMDD HHMM

6.14.5 *Date/Time Incident Reported*—Date the call is first received by a public safety answering point (PSAP) or other designated entity. (EMS Nos. 8–9; Appendix X1, 14001.B0001):

YYYYMMDD HHMM

6.14.6 *Time Dispatch Notified*—Time of first connection with EMS dispatch. (EMS No. 10, Appendix X1, 14001.B0002):

HHMM

6.14.7 *Incident Number*— Unique number statewide for each incident reported to dispatch. (EMS No. 21)

6.14.7.1 This number should be unique, if possible, within a state or region. If this is not possible, it must be unique within an agency, and then by combining it with a unique agency number, it will be possible to construct a unique identifying number for the incident.

6.14.8 *Date/Time EMS Unit Notified*—Time response unit is notified by EMS dispatch. (EMS Nos. 11–12; Appendix X1, 14001.B0002):

YYYYMMDD HHMM

6.14.9 *Time EMS Unit Responding*—Time that the response unit begins physical motion. (EMS No. 13):

HHMM

6.14.10 *Time of EMS Arrival at Scene*—Time EMS unit stops physical motion at scene (last place that the unit or vehicle stops prior to assessing the patient). (EMS No. 14; Appendix X1, 14001.B003):

HHMM

6.14.11 *Time of EMS Arrival at Patient*—Time response personnel establish direct contact with patient. (EMS No. 15):

HHMM

6.14.12 *Time EMS Unit Left Scene*—Time when the response unit began physical motion from scene. (EMS No. 16; Appendix X1, 14001.B0004):

HHMM

6.14.13 *Time of EMS Arrival at Destination*—Time when the patient arrives at destination or transfer point. (EMS No. 17; Appendix X1, 14001.B0005):

HHMM

6.14.14 *Time EMS Back in Service*—Time response unit back in service and available for response. (EMS No. 18; Appendix X1, 14001.B0006):

HHMM

6.14.15 *Service Type*— Type of scheduled or unscheduled service requested. (EMS No. 20):

Scene
Unscheduled interfacility transfer
Scheduled interfacility transfer
Standby
Rendezvous
Not applicable
Unknown

6.14.16 *Patient Care Record Number*—Unique number statewide for each patient care record (PCR). (EMS No. 23; Appendix X1, 14001.B0051):

6.14.16.1 Unique number for each patient treated by EMS. Ideally, this number should be unique within a state or region. If unique within a state, this number could also be the incident number and response number.

6.14.17 *Highest Available Level of Care*—This is a variable derived by the computer after comparing crew member identification with licensure information on a master list to indicate highest capability level, for example EMS, paramedic, for crew members on the run:

EMT basic
EMT intermediate
EMT paramedic
Nurse
Physician
Other health care professional
Unknown

6.14.18 *Cause-of-Injury Code (E-code)*—The cause-of-injury code (E-code) is used to indicate the external cause of the injury, poisoning, or adverse effect related to the current emergency. E-codes are assigned according to the subset of the E codes in ICD-9 that are appropriate for use in the field. When possible, the codes should be assigned to indicate what went wrong, what the patient was doing at the time, if any products were involved, and the relationship of the assailant to the victim if an assault occurred or what evidence exists to indicate self-intent, or both. (EMS No. 49; DEEDS 5.04; Appendix X1, 14001.A033):

Motor vehicle traffic accident
Pedestrian traffic accident
Motor vehicle non-traffic accident
Bicycle accident
Water transport accident
Aircraft related accident
Accidental drug poisoning
Accidental chemical poisoning
Accidental falls
Fire and flames
Smoke inhalation
Excessive heat
Excessive cold
Venomous stings (plants, animals)
Animal bites
Lightning
Drowning
Mechanical suffocation
Machinery accidents
Electrocution (non-lightning)
Radiation exposure
Firearm self inflicted (intentional)
Rape
Firearm assault
Stabbing assault
Child assaults
Firearm injury (accidental)
Other
Not applicable
Unknown

6.14.19 *Cause-of-Injury Code Status*—Coded value to indicate if the designated E-code is the principal cause of the injury or a contributing cause. (Appendix X1, 14001.A170.01)

Segment 14: Encounters/Episodes—Chief Complaint/ Present Illness/Injury

6.14.20 *Chief Complaint*— Patient narrative indicating chief complaint and reasons why patient requested emergency care. (EMS No. 48; Appendix X1, 14001.A023/14001.A016)

6.14.21 *Signs and Symptoms Present*—Signs and symptoms reported to or observed by care provider. (EMS No. 52; Appendix X1, 14001.B012):

Abdominal pain
Back pain
Bloody stools
Breathing difficulty
Cardio respiratory arrest
Chest pain
Choking
Diarrhea
Dizziness
Ear pain
Eye pain
Fever/Hyperthermia
Headache
Hypertension
Hypothermia
Nausea
Paralysis
Palpitations
Pregnancy/childbirth/miscarriage
Seizures/convulsions
Syncope
Unresponsive/unconscious
Vaginal bleeding
Vomiting
Weakness (malaise)

6.14.22 *Systolic Blood Pressure*—Patient's systolic blood pressure. (EMS No. 70; Appendix X1, 14001.B012.01):

(systolic blood pressure)
Not obtained
Unknown

6.14.23 *Diastolic Blood Pressure*—Patient's diastolic blood pressure. (EMS No. 71; Appendix X1, 14001.B012.01):

(diastolic blood pressure)
Not obtained
Unknown

6.14.24 *Pulse Rate*—Patient's palpated or auscultated pulse rate expressed in number per minute. (EMS No. 65; Appendix X1, 14001.B012.01):

(pulse rate)
Not obtained
Unknown

6.14.25 *Respiratory Rate*— Unassisted patient respiratory rate expressed as number per minute. (EMS No. 68; Appendix X1, 14001.B012.01):

(respiratory rate)
Not obtained
Unknown

6.14.26 *Respiratory Effort*—Coded values indicating the patient's respiratory effort. (This field is essential for children 18 years or less.) (EMS No. 69; Appendix X1, 14001.B012.01):

Normal
Increased, not labored
Increased and labored, or, decreased and fatigued
Absent
Not assessed

6.14.27 *Skin Perfusion*— Coded values indicating the patient's skin perfusion, expressed as normal or decreased. (This field is essential for children 18 years or less.) (EMS No. 72; Appendix X1, 14001.B012.01):

Normal
Decreased
Not assessed

6.14.28 *Pulse Oximetry*— Oximetry reading indicating level of oxygen saturation. (Appendix X1, 14001.B012.01)

6.14.29 *Apgar*—Coded values to measure newborn's responses after birth. (Appendix X1, 14001.B012.01)

6.14.30 *Glasgow Eye-Opening Component*—Patient's eye-opening component of the Glasgow coma scale. (EMS No. 73; DEEDS 4.14; Appendix X1, 14001.B012.01):

Best eye-opening response (all ages):
None
Opens eyes in response to painful stimulation
Opens eyes in response to verbal stimulation
Opens eyes spontaneously
Not assessed
Unknown

6.14.31 *Glasgow Verbal Response Component*—Patient's verbal response component of the Glasgow coma scale. (EMS No. 74; DEEDS 4.15; Appendix X1, 14001.B012.01):

Best verbal response for adult and older child:
None
Non-specific sounds
Inappropriate words
Confused conversation or speech
Oriented and appropriate speech
Not assessed
Unknown

Best verbal response for infant and young child; (values for EMS No. 74 are separated for patients 2–5 years and 0–23 months)
None
Moans to pain
Cries to pain, screams to pain
Irritable cries
Coos and babbles
Not assessed
Unknown

6.14.32 *Glasgow Motor Component*—Patient's motor component of the Glasgow coma scale. (EMS No. 75; DEEDS 4.16; Appendix X1, 14001.B012.01):

Best motor response for adults:
None
Extensor posturing in response to painful stimulation
Flexor posturing in response to painful stimulation
General withdrawal in response to painful stimulation
Localization of painful stimulation
Obeys commands with appropriate motor response
Not assessed
Unknown

Best motor response for infant and child:
None
Abnormal extension (decerebrate)
Abnormal flexion (decorticate)
Withdraws to pain
Withdraws to touch
Normal spontaneous movement
Not assessed
Unknown

6.14.33 *Glasgow Coma Score (GCS)*—Sum total of values for the Glasgow eye-opening and verbal and motor responses components. This score will be calculated by the computer at the time the components are entered. (EMS No. 76; Appendix X1, 14001.B012.01)

6.14.33.1 *Date-Time GCS Measured*—See Appendix X1, 14001.B012.02):

YYYYMMDD HHMM

6.14.34 *Revised Trauma Score (RTS)*—Sum total of values for the respiratory rate, systolic blood pressure, and Glasgow coma score components. This score will be calculated by the computer at the time the components are computerized. (EMS No. 77; Appendix X1, 14001.B012.01)

6.14.34.1 *Date-Time RTS Measured*—See Appendix X1, 14001.B012.02:

YYYYMMDD HHMM

6.14.35 *Time of Witnessed Cardiac Arrest*—Time of witnessed cardiac arrest. (EMS No. 61; Appendix X1, 14001.B012.02):

HHMM

6.14.36 *Witness of Cardiac/Respiratory Arrest*—Coded value to indicate the type of person who witnessed the cardiac/respiratory arrest. (EMS No. 62):

Bystander
EMS responder
Not applicable
Unknown

6.14.37 *Field Triage Criteria Implemented*—Coded values to indicate the field triage criteria implemented. (Appendix X1, 14001.B005/14001.B016)

Segment 14: Encounters/Episodes—Progress Notes/ Clinical Course

6.14.38 *Injury Description*—A brief description to indicate the clinical description of injury type and body site (as defined to calculate the Injury Severity Score ISS) to be organized as a matrix to indicate the type and area of injury for data collection at the scene. (EMS No. 53; DEEDS 5.03; Appendix X1, 14001.A043)

6.14.39 *Injury Intent*— Coded values to indicate the intent of the individual inflicting the injury. (EMS No. 54; DEEDS 5.07; Appendix X1, 1, 14001.A033):

Unintentional
Intentionally self-inflicted, confirmed
Intentionally self-inflicted, suspected
Assault, confirmed
Assault, suspected
Legal intervention (injury inflicted by police or other authorities during law enforcement)
Undetermined

6.14.40 *Safety Equipment*— Safety equipment in use or deployed by the patient at time of the injury (airbag, belts, helmet, etc.) (EMS No. 55; DEEDS 5.08; Appendix X1, 14001.A044):

Shoulder belt
Lap belt
Seat belt, not otherwise specified
Driver's side air bag
Passenger's side air bag
Front air bag, not otherwise specified
Side air bag, not otherwise specified
Air bag, not otherwise specified
Child safety seat
Helmet
Eye protection
Protective clothing
Personal flotation device
Other protective gear

6.14.41 *Suspected Alcohol/Drug Use*—Suspected alcohol or drug use by patient at the time of the emergency. (EMS No. 57; Appendix X1, 14001.B012):

Alcohol, yes
Drugs, yes
Alcohol/drugs, yes
No
Not applicable
Unknown

6.14.42 *Narrative*—A narrative describing the unique aspects of this patient's emergency, treatment and disposition not recorded elsewhere. (Appendix X1, 14001.A060)

6.14.43 *Care Provider Impression*—Coded values indicating the care provider's clinical impression which led to the management given to the patient (treatments, medications, procedures). (EMS No. 50; Appendix X1, 14001.B012)

Abdominal pain / problems
Airway obstruction
Allergic reaction
Altered level of consciousness
Behavioral / psychiatric disorder
Cardiac arrest
Cardiac rhythm disturbance
Chest pain / discomfort
Diabetic symptoms (hypoglycemia)
Electrocution
Hyperthermia
Hypothermia
Hypovolemia / shock
Inhalation injury (toxic gas)
Obvious death
Poisoning / drug ingestion
Pregnancy / OB delivery
Respiratory arrest
Respiratory distress
Seizure
Sexual assault / rape
Smoke inhalation
Stings / venomous bites
Stroke / CVA
Syncope / fainting
Traumatic injury
Vaginal hemorrhage
Other
Not applicable
Unknown

Segment 14: Encounters/Episodes—Therapies

6.14.44 Therapies as defined by Practice E1384 are not performed during the prehospital phase at the scene of the emergency.

Segment 14: Encounters/Episodes—Procedures

6.14.45 *Procedure/Therapy Name*—Coded value to identify the procedure/therapy performed. The values below will be updated to match ICD-10 PCS which will be the unified procedural terminology recommended by the National Center for Vital Health Statistics in November 1993 and due from the Centers for Medicare and Medicaid Services. (EMS No. 78; Appendix X1, 14001.B001):

Assisted ventilation (positive pressure)
Backboard
Bleeding controlled
Burn care
Cardiopulmonary resuscitation
Cervical immobilization
Cricothyrotomy
ECG monitoring
Endotracheal intubation
External cardiac massage
External defibrillation (includes auto)
Intravenous catheter
Intraosseous catheter
Intravenous fluids
MAST (military antishock trousers)
Nasopharyngeal airway insertion
Nasogastric tube insertion
Obstetrical care (delivery)
Oropharyngeal airway insertion
Oxygen by mask
Oxygen by cannula
Splint of extremity
Traction splint

6.14.45.1 *Procedure/Therapy Performed by*—Coded value to identify who performed the procedure/therapy. Usually this documentation is required only for those procedures considered invasive or related to advanced life support. (Appendix X1, 14001.B011.02)

6.14.46 *Total Procedure/Therapy Attempts*—Total number of attempts for each procedure attempted, regardless of success. (EMS No. 79)

6.14.47 *Date-Time of Procedure*—Report date and time for each procedure/therapy listed. (Appendix X1, 14001.B001.01):

YYYYMMDD HHMM

6.14.48 *Materials Used*— Coded values to indicate materials used to perform the procedure/therapy listed. (Appendix X1, 14001.E001.75)

6.14.49 *Time of First CPR*—Best estimate of time of first CPR. (EMS No. 58; Appendix X1, 14001.B012.02):

HHMM

6.14.50 *Provider of First CPR*—Coded value to indicate the type of person who performed first CPR on patient. (EMS No. 59; Appendix X1, 14001.B011.02):

Bystander
EMS responder
Not applicable
Unknown

6.14.51 *Time CPR Discontinued*—Time at which medical control or responding EMS unit terminated resuscitation efforts (chest compressions and CPR) in the field. (EMS No. 60; Appendix X1, 14001.B012.02):

HHMM

6.14.52 *Time of First Defibrillatory Shock*—Time of first defibrillatory shock. (EMS No. 63; Appendix X1, 14001.B012.02):

HHMM

6.14.53 *Return of Spontaneous Circulation*—Whether a palpable pulse or blood pressure was restored following cardiac arrest and resuscitation in the field. (EMS No. 64; Appendix X1, 14001.B012):

Yes
No
Not applicable

6.14.54 *Initial Cardiac Rhythm*—Initial monitored cardiac rhythm as interpreted by EMS personnel. (EMS No. 66; Appendix X1, 14001.B012.01):

Sinus rhythm
Other rhythm from 60-100 (Not otherwise listed)
Paced rhythm
Bradycardia
Extrasystoles
Narrow complex tachycardia
Wide complex tachycardia
Ventricular fibrillation
Asystole
Pulseless electrical activity
Not applicable
Unknown

6.14.55 *Rhythm at Destination*—Monitored cardiac rhythm upon arrival at destination (EMS No. 67; Appendix X1, 14001.B012.01):

Sinus rhythm
Other rhythm from 60-100 (Not otherwise listed)
Paced rhythm
Bradycardia
Extrasystoles
Narrow complex tachycardia
Wide complex tachycardia
Ventricular fibrillation
Asystole
Pulseless electrical activity
Not applicable
Unknown

6.14.56 *Serum Glucose*— Patient's blood sugar level. (Appendix X1, 14001.B012.01)

6.14.56.1 *Date-Time Serum Glucose Measured*—See Appendix X1, 14001.B012.02.

Segment 14: Encounters/Episodes—Disposition

6.14.57 *Destination Determination*—Coded values identifying the person determining the reason for the transport destination.

6.14.58 *Destination Determination*—Reason a transport destination was selected. (EMS No. 45):

Closest facility (none below)
Patient/family choice
Patient physician choice
Managed care
Law enforcement choice
Protocol
Specialty resource center
On-line medical direction
Diversion
Other
Not applicable
Unknown

6.14.59 *Destination/Transferred to*—Health care facility or pre-hospital unit/home that received patient from EMS responder providing this record. Facilities should be recorded by identification numbers which are unique statewide. (EMS No. 44; Appendix X1, 14001.F080):

Home
Police/jail
Medical office/clinic
Other EMS responder (ground)
Other EMS responder (air)
Hospital
Morgue
Not applicable

6.14.60 *Incident/Patient Disposition* —End result of EMS response. This will provide information about the reasons for which EMS is notified, correlated with the ultimate incident disposition. (EMS No. 47; Appendix X1, 14001.F050):

Treated, transported by EMS
Treated, transferred care
Treated, transported by private vehicle
Treated and released
No treatment required
Patient refused care
Dead at scene
Canceled
Not applicable
Unknown
No patient found

6.14.61 *Condition on Arrival at Destination*—Coded values to indicate the patient's condition on arrival at the hospital. (Appendix X1, 14001.F066)

Segment 14: Encounters/Episodes—Charges

6.15 *Sources of Emergency Data Related to Pre-hospital Emergency Care to be Included in or Linked to the Electronic Health Record:*

6.15.1 *EMS Patient Care Record*—An EMS record is initiated for each patient transported by an EMS service. EMS services include first responder, basic life support, advanced life support, air transport, other transport, and transfer. The data collected by the EMS record are described in Guide F1629.

6.15.2 *Police Crash Data*—The police crash data set describes the time of onset, the characteristics of the crash, the type of vehicles involved, the behavior of the occupants in terms of their utilization of protective devices, and the speed of the police response. All of these factors influence patient outcome. The data set as a whole may be linked retrospectively to injury records to evaluate medical and financial outcomes for victims of motor vehicle crashes. However, the computer-based patient record needs only the crash data that have a bearing on decisions related to choosing the most appropriate medical treatment.

6.15.3 *Poison Control*— The poison control data include information about the time, type, mode, form, name, and amount of poison ingested.

6.15.4 *Person-specific Uniform Crime Record*—Police crime data include information about time and the type of weapon used.

6.15.5 *Emergency Medical History Storage System (Medic Alert, etc.)*—Patients with unstable chronic conditions which may become emergencies (diabetes, cardiac, etc.) may store relevant portions of their medical history to facilitate health care during an emergency. This information is accessible through a validated access process by all medical personnel who need the information at the time of patient care.

6.15.6 *Other*—Other data sources also should be considered for linkage to the EMS record. These sources include data from workmen's compensation, OSHA data files, etc.

7. Emergency Diagnosis and Treatment at Emergency Department/Outpatient Care Facility

NOTE 2—The data elements reported below are collected for all patients treated in the emergency department. For those patients transported by ambulance, the emergency department represents the second phase of emergency care and the information below will be added to that already collected at the scene and en route. For those patients who go directly from the scene to the emergency department, data elements indicated as "DEEDS" or "EMDS" in Section 6 should be collected in addition to those listed below. Whenever possible, the data elements reported below have been defined to match the *Data Elements for Emergency Department Systems (DEEDS).* The DEEDS data element number is indicated in parentheses for each DEEDS data element.

7.1 *Segment 1—Demographics :*

7.1.1 *Alternate Individual Name*—Any name patient is known by other than current legal name. (EMDS; DEEDS 1.03; Appendix X1, 01010)

7.1.1.1 *Name Type*—A classification of the type of name or alias used by the person. (EMDS):

Maiden
Alias
Legal
Display
Adopted
Other

7.1.2 *Address Start Date*—The date or estimated date that the patient started using this address. (EMDS)

7.1.2.1 *Status*—An indication of the currency of a person's address. (EMDS):

Active
Inactive

7.1.3 *Telephone Number Primary Designation*—An indication if this is the primary telephone number for a person. (EMDS):

Yes
No

7.1.4 *Driver License Number*—A current driver's license number for the person. (EMDS)

7.1.4.1 *Drivers License State*—State which issued the person's drivers license. (EMDS)

7.1.5 *Emergency Contact Name*—Name of person whom patient designates to be the primary contact if notification is necessary. Name consists of the family name, given name, middle name or initial, suffix, prefix, degree, and name type code. (DEEDS 1.14; Appendix X1, 01110)

7.1.5.1 *Primary Designation*—An indication if this is the primary emergency contact for a person. (EMDS)

7.1.6 *Emergency Contact Address*—Address of person whom patient designates to be the primary contact if notification is necessary. Address includes the street address, other designation (apartment number), city, state or province, zip or postal code, country, type of address, other geographic designation, county/parish code, census tract. (DEEDS 1.15; Appendix X1, 01115)

7.1.7 *Emergency Contact Telephone Number*—Telephone number of person whom patient designates to be the primary contact if notification is necessary. (DEEDS 1.16; Appendix X1):

Home	Appendix X1, 01117
Business	Appendix X1, 01119

7.1.8 *Emergency Contact Relationship* —Emergency contact's relationship to patient. (EMDS; DEEDS 1.17; Appendix X1, 01112):

Stepparent
Stepchild
Legal guardian
Spouse
Child
Mother
Grandmother
Sibling
Other relative
Friend
Aunt
Uncle
Cousin
Father
Domestic partner
Employer
Grandfather
Neighbor
Other

7.1.9 *Occupation*—Description of the patient's current work defined using the 1990 U.S. Bureau of the Census classification system for 501 occupation codes. (DEEDS 1.12; Appendix X1, 01065)

7.1.10 *Industry*—Description of the industry or business in which patient currently works defined using the 1990 U.S. Bureau of the Census classification system for 236 industry codes. (DEEDS 1.13; Appendix X1, 01067)

7.1.11 *Living Arrangement*—Coded value to indicate the environment in which patient resides. (Appendix X1, 01085/14001.A056).

7.1.12 *Other*—Coded value to indicate religion when appropriate. (Appendix X1, 01047)

7.2 *Segment 2—Legal Agreements:*

7.2.1 *Legal Status of Patient*—Patient status on a police hold or involuntary commitment such as jail hold, etc. (Included in DEEDS 4.06 Source of Referral to ED; Appendix X1, 14001.A206)

7.2.2 *Executor Required*—An indication, for each directive, if an executor must be identified when the directive is specified by a person. (EMDS; Appendix X1, 02052):

Yes
No

7.2.3 *Person Directive*— The date the person specified or requested a particular advance directive. (EMDS)

7.3 *Segment 3—Financial Information:*

7.3.1 *Account Number*— Identifier assigned by facility billing or accounting office for all charges and payments for this ED visit. (DEEDS 1.10; Appendix X1, 03030)

7.3.2 *Insurance Coverage or Other Expected Source of Payment*—The entity or person expected to be responsible for the patient's bill for this ED visit. (DEEDS 3.01; Appendix X1, 03010):

Insurance company
Medicare
Medicaid
Workers' compensation
Other government payments
Self-pay
No charge
Other
Unknown

7.3.3 *Insurance Company*—Patient's insurance company or carrier. (DEEDS 3.02, Appendix X1, 03005.02)

7.3.4 *Insurance Company Address*—The address of patient's insurance company including street address, city, state, zip. (DEEDS 3.03; Appendix X1, 03010.10)

7.3.5 *Insurance Plan Type*—Insurance plan in which patient is enrolled. (DEEDS 3.04; Appendix X1, 03010.02/03010.04)

7.3.6 *Insurance Policy ID*—The number of the patient's insurance policy maintained by the specific health care organization which, according to the patient or a responsible party, provides the patient's overall longitudinal care. (DEEDS 3.05; Appendix X1, 03010.06)

7.3.6.1 *Insurance Claim Date*—The date of a recorded insurance claims for the patient. (Appendix X1, 03005)

7.3.7 *ED Payment Authorization Requirement*—An indicator of whether third party payer authorization for ED services was required. (DEEDS 3.06):

Not required
Required
Not applicable (includes no third party payer)
Unknown if required

7.3.8 *Status of ED Payment Authorization Attempt*—An indicator of whether contact with the third-party payer was attempted and whether contact was established. (DEEDS 3.07):

Contact not attempted
Contact attempted but not established
Contact attempted and established
Unknown whether contact was attempted or established

NOTE 3—A standard table that hierarchically expands the above codes is needed for further specification of authorization attempts. Until such a table is agreed on, a user-defined table can be implemented. For example, Category 1 could be expanded to include:

Not attempted because of urgency of clinical condition
Not attempted because payer not adequately identified

7.3.9 *Date/Time of ED Payment Authorization Attempt*—The date and time that authorization was sought from a third–party payer. (DEEDS 3.08):

YYYYMMDD HHMM

7.3.10 *ED Payment Authorization Decision*—This data element specifies the decision that was made regarding payment authorization for ED patient care services. (DEEDS 3.09):

Approved
Denied
Other
Unknown

NOTE 4—A standard table that hierarchically expands the above codes is needed for further specification of authorization decisions. Until such a table is agreed on, a user-defined table can be implemented. For example, Category 2 could be expanded to include:

Approval contingent on further evaluation
Approval for selected services only

7.3.10.1 *Date/Time of ED Payment Authorization Decision*—The date and time third–party payer provided a decision about authorizing payment for ED patient care services. (DEEDS 3.10):

YYYYMMDD HHMM

7.3.11 *Entity Contacted to Authorize ED Payment*—This data element identifies the name of the insurance company or other entity responsible to authorize payment for ED patient care services. (DEEDS 3.11)

7.3.12 *ED Treatment Authorization Code*—This data element specifies the identifier assigned by the third-party payer to track the authorization for ED patient care services. (DEEDS 3.12)

7.3.13 *Person Contacted to Authorize ED Payment*—The name of the person employed by or with a specific third-party payer who is contacted for authorization. (DEEDS 3.13)

7.3.14 *Telephone Number of Entity or Person Contacted to Authorize ED Payment*—The telephone or other telecommunications number of the entity or person contacted to authorize payment for ED patient care services. (DEEDS 3.14)

7.4 *Segment 4: Provider / Practitioners— Provider / Practitioner Identification Number:* Identifier for provider or practitioner.

7.4.1 On October 1, 1997, the Centers for Medicare and Medicaid Services (CMS) began issuing a National Provider Identifier (NPI) to all individual practitioners and organizations that provide health care. The NPI consists of two parts: a seven-position alphanumeric identifier and a one-position numeric check digit. A locally–assigned identifier may be entered until the NPI is issued. To protect confidentiality, disclosure of practitioner- or organization-specific data must be limited to authorized personnel.

7.4.2 Provider ID number is documented for the following: (Appendix X1, 04001.07)

7.4.2.1 *Primary Practitioner Organization*—Health care organization that provides the patient's overall longitudinal care. (DEEDS 2.07)

7.4.2.2 *ED Facility*— Identifier for the facility where the patient seeks or receives outpatient emergency care. (DEEDS 2.01)

7.4.2.3 *ED Referral Organization*—Health care organization to which patient is referred for follow-up or consultation. (DEEDS 8.12)

7.4.2.4 *Issuing Agency of ID No.*—The agency associated with this unique identifier of this provider (Appendix X1, 04001.07.01)

7.4.3 Practitioner ID number for this ED visit is documented for the following: (Appendix X1, 04001.15)

7.4.3.1 *Primary Practitioner*—Identifier for practitioner who provides the patient's overall longitudinal care. (DEEDS 2.03)

7.4.3.2 *ED Practitioner*— Identifier for ED practitioner who is responsible for the care of the patient. (DEEDS 2.08)

7.4.3.3 *First ED Acuity Assessment Practitioner*—Identifier for practitioner who first assessed the patient's acuity in the ED. (DEEDS 4.10)

7.4.3.4 *ED Clinical Finding Practitioner*—Identifier for practitioner who made the clinical observation. (DEEDS 5.17)

7.4.3.5 *ED Medication Ordering Practitioner*—Identifier for practitioner who orders ED medication. (DEEDS 7.02)

7.4.3.6 *ED Medication Administering Practitioner*—Identifier for practitioner who administers ED medication. (DEEDS 7.11)

7.4.3.7 *ED Consultant Practitioner* —Identifier for consulting practitioner who participates in patient's care. (DEEDS 2.11)

7.4.3.8 *ED Procedure Practitioner*—Identifier for practitioner who performs the procedure (DEEDS 6.06)

7.4.3.9 *ED Disposition Diagnosis Practitioner*—Identifier for practitioner who makes the ED disposition diagnosis. (DEEDS 8.25)

7.4.3.10 *ED Discharge Medication Ordering Practitioner*—Identifier for practitioner who issues ED discharge medication order. (DEEDS 8.14)

7.4.3.11 *ED Referral Practitioner*—Identifier for practitioner to whom the patient is referred for follow-up or consultation. (DEEDS 8.10)

7.4.3.12 *ED Outcome Observation Practitioner*—Identifier for practitioner who assesses ED patient's outcome. (DEEDS 8.33)

7.4.3.13 *ED Service Level Practitioner* —Identifier for ED practitioner whose service level is reported. (DEEDS 8.28)

7.4.3.14 *Inpatient Practitioner*—Identifier for practitioner to whose inpatient service ED patient is admitted. (DEEDS 8.03)

7.4.3.15 *Issuing Agency of ID No.*—The agency associated with this unique identifier of this practitioner. (Appendix X1, 04001.07.01)

7.4.4 *Provider/Practitioner Type*—Profession or occupation and specialty or subspecialty of provider/practitioner. (Appendix X1, 04001.05/04001.50)

7.4.4.1 The Insurance Subcommittee of the Accredited Standards Committee X12 is developing a provider taxonomy in conjunction with the Centers for Medicare and Medicaid Services (CMS) implementation of the National Provider System (Accredited Standards Committee X12, 1997). The taxonomy classifies practitioners by their occupation or service group and their specialty. The taxonomy permits further specification within specialities, such as subspecialty or age focus (for example, adolescents). Until the taxonomy is implemented, a local system may be used to encode practitioner type.

7.4.4.2 EMDS recommends the following classification of type. (EMDS):

Chiropractor
Dentist
Family Therapist
Medic/EMT
Nurse
Nutritionist/Dietitian
Optometrist
Paramedic
Pharmacist
Physical Therapist
Physician
Physician Assistant
Podiatrist
Psychologist
Radiation Therapy Technologist
Respiratory Therapist
Social Worker
Technician

7.4.5 Provider type is documented for (Appendix X1, 04001.05):

ED Facility/Unit (EMDS)
Hospital
Nursing Home
Clinic
Physicians Office
Other
Laboratory
Public Health Department
Interim Facility
Urgent Care Center

7.4.6 Practitioner type is documented for the following: (Appendix X1, 04001.20)

7.4.6.1 *Primary Practitioner*—DEEDS 2.04.

7.4.6.2 *ED Practitioner*— DEEDS 2.09.

7.4.6.3 *First ED Acuity Assessment Practitioner*—DEEDS 4.11.

7.4.6.4 *ED Clinical Finding Practitioner*—DEEDS 5.18.

7.4.6.5 *ED Medication Ordering Practitioner*—DEEDS 7.03.

7.4.6.6 *ED Medication Administering Practitioner*—DEEDS 7.12.

7.4.6.7 *ED Consultant Practitioner* —DEEDS 2.12.

7.4.6.8 *ED Procedure Practitioner*—DEEDS 6.07.

7.4.6.9 *ED Disposition Diagnosis Practitioner*—DEEDS 8.26.

7.4.6.10 *ED Discharge Medication Ordering Practitioner*—DEEDS 8.15.

7.4.6.11 *ED Referral Practitioner*—DEEDS 8.11.

7.4.6.12 *ED Outcome Observation Practitioner*—DEEDS 8.34.

7.4.6.13 *ED Service Level Practitioner* —DEEDS 8.29.

7.4.6.14 *Inpatient Practitioner*—DEEDS 8.04.

7.4.7 *Provider/Practitioner Name*—Name of the provider or practitioner who provides care to the patient. (Appendix X1, 04001, 04001.10)

7.4.8 Provider/practitioner name documented for the following:

7.4.8.1 *ED Facility/Unit,* where care is provided to the emergency patient. (EMDS)

7.4.8.2 *Primary Practitioner,* who provides the patient's overall longitudinal care. (DEEDS 2.02)

7.4.8.3 *ED Practitioner,* who is responsible for the care of the patient during this ED visit. (EMDS)

7.4.8.4 *ED Referral Practitioner,* to whom the patient is referred for follow-up or consultation. (DEEDS 8.09)

7.4.9 Provider/practitioner name is the key identifier as compared to, for example, the NPI which will represent the most acceptable of a complex of identifiers. (Appendix X1, 04001)

7.4.10 *Primary Practitioner Address*—Address of the physician or other practitioner who provides the patient's overall longitudinal care. (DEEDS 2.05; Appendix X1, 04001.25)

7.4.11 *Primary Practitioner Telephone Number*—Telecommunication number of the physician or other practitioner who, according to the patient or a responsible party, provides the patient's overall longitudinal care. (DEEDS 2.06; Appendix X1, 04001.30/04001.31/04001.32)

7.4.12 *Status of Primary Practitioner Relationship*—An indication if the relationship between a person and a primary practitioner is still current. (EMDS):

Active
Inactive

7.4.13 *ED Practitioner Current Role*—ED practitioner's role in patient's care during this ED visit. (DEEDS 2.10):

Physician Roles
ED attending or staff physician
ED resident (includes interns, house staff at all postgraduate levels, and fellows)
Non-ED-based attending or staff physician (includes primary care physicians and other attending or staff physicians called to the ED once the patient arrives)
Non-ED-based resident (includes interns, house staff at all postgraduate levels, and fellows working on the service of a non-ED-based attending or staff physician)

Nursing Roles
Registered Nurse
Nurse Practitioner
Attending nurse practitioner
Other Advanced Practice Nurse (clinical nurse specialist, nurse anesthetist, or nurse midwife)
Licensed practical nurse or licensed vocational nurse

Physician Assistant Role
Physician Assistant

Respiratory Care Role
Respiratory therapist

Nurse's Aides, Technicians, and Technologists
Nurse's aide
ED technician
Phlebotomy technician
ECG technician
Radiologic technologist or technician
Other technician or technologist

Social Service Role
Social worker

Student Practitioner Roles
Medical student
Registered Nurse Student
Nurse Practitioner student
Other advanced practice nurse student (clinical nurse specialist, nurse anesthetist or nurse midwife)
Licensed practical nurse or licensed vocational nurse student
Physician Assistant student
Nurse's Aide, technician, or technologist student
Other student practitioner

Other role
Other role

Unknown Role
Unknown Role

7.4.14 *Practitioner Comment*—A detailed comment about a person that provides additional information for other practitioners. (EMDS)

7.4.14.1 *Date/Time of Practitioner Comment*—The date and time that the comment about a person was submitted by a health care practitioner. (EMDS)

7.5 *Segment 5—Problem List:*

7.5.1 *Problem Name*— Coded value to indicate contagious conditions, complications, past medical history, current medications that may have an impact on the diagnosis and treatment of the emergency. (EMDS; Appendix X1, 05001.01)

7.5.2 *Problem Type*— A classification scheme for items on a person's problem list. (EMDS):

Symptom
Social
Legal
Other
Diagnosis

7.5.2.1 *Onset Date*—The date that the problem listed on the person's problem list was first encountered by the person. (EMDS; Appendix X1, 05001.03/14001.A053)

7.5.2.2 *Entered Date*— Date the problem was entered in the person's problem list. (EMDS; Appendix X1, 05001.07)

7.5.3 *Medication Allergy Reported in ED*—Delineation of the patient's history of an allergic reaction to a medication reported as relevant to the emergency by the patient or a responsible informant. (EMDS; DEEDS 4.32)

7.5.3.1 Established systems that can be used to classify and code specific medications include the national drug codes (NDC) maintained by the Food and Drug Administration (FDA) and the World Health Organization Drug Record Codes. In addition, numerous local coding systems are in use.

7.5.3.2 *Entered Date*— The date the allergy was first recorded for a person. (EMDS; Appendix X1, 08075)

7.5.3.3 *Reaction*—A clinical description of the reaction to a particular allergen or agent. (The complete list is included in Practice E1384) (EMDS):

Anaphylaxis
Angioedema
Bronchospasm
Chest Pain
Diarrhea
Dizziness/Light Headed
Headache
Hives/Urticaria
Nausea/Vomiting
Other
Other Rash
Stevens Johnson Syndrome
Vertigo
Weakness

7.6 *Segment 6—Immunization :*

7.6.1 *Immunization Name*—The name or identifier of the immunization procedure conducted that is relevant to the emergency event. (The complete list is included in Practice E1384.) (Appendix X1, 06001)

7.6.1.1 *Date of Last Tetanus Immunization*—The date of the patient's last tetanus immunization as reported by the patient or a responsible informant. (DEEDS 4.31; Appendix X1, 06001.01):

YYYYMMDD

7.7 *Segment 7: Exposure to Hazardous Substances.*

7.8 *Segment 8: Family/Prenatal/Cumulative Health/ Medical/Dental Nursing History.*

7.9 *Segment 9: Assessments/Exams .*

7.10 *Segment 10: Care/Treatment Plans and Orders.*

7.11 *Segment 11: Diagnostic Tests.*

7.12 *Segment 12: Medications*—The following data elements are used each time a practitioner documents information about the patient's current medications or those prescribed in the ED.

7.12.1 *Medication Identifier*—Established systems that can be used to classify and code specific medications include the National Drug Codes (NDC) maintained by the Food and Drug Administration (FDA) and the World Health Organization Drug Record Codes. In addition, numerous local coding systems are in use. (EMDS; DEEDS; Appendix X1, 12001.06)

7.12.1.1 *Current Therapeutic*—Identification of the patient's current medication use, including prescription and nonprescription medications. (DEEDS 5.09)

7.12.1.2 *ED*—Medication administered during ED visit. (DEEDS 7.04)

7.12.1.3 *ED Discharge*— Medication that is prescribed, renewed, or discontinued at ED discharge. (DEEDS 8.16)

7.12.2 *Medication Dose*— The medication dose at each administration. Enter a number >0.(EMDS; DEEDS; Appendix X1, 12001.30)

7.12.2.1 *Current Therapeutic*—DEEDS 5.10.

7.12.2.2 *ED*—DEEDS 7.05.

7.12.2.3 *ED Discharge*— DEEDS 8.17.

7.12.3 *Medication Dose Units*—Units for the dose administered. In HL7, the default system for encoding units consists of the ISO (International Organization for Standards) units abbreviations plus ISO extensions (ISO+) designated by HL7 (see HL7 Version 2.3, Fig. 7-7). (EMDS; DEEDS; Appendix X1, 12001.33)

7.12.3.1 *Current Therapeutic*—DEEDS 5.11.

7.12.3.2 *ED*—DEEDS 7.06.

7.12.3.3 *ED Discharge*— DEEDS 8.18.

7.12.4 *Medication Schedule*—The frequency and duration of administration of the medication. (DEEDS; Appendix X1, 12001.45)

7.12.4.1 *Current Therapeutic*—DEEDS 5.12.

7.12.4.2 *ED*—DEEDS 7.07.

7.12.4.3 *ED Discharge*— DEEDS 8.19.

7.12.5 *Medication Route*— The route by which the medication is administered. The following table of routes (HL7, Version 2.3, Table 0162, Route of Administration) is recommended. (EMDS; DEEDS; Appendix X1, 12001.39):

Description	
Apply externally	Mucous membrane
Buccal	Nasal
Dental	Nasal prongs
Epidural	Nasogastric
Endotracheal tube	Nasotracheal tube
Gastronomy tube	Ophthalmic
Genitourinary irrigant	Oral
Immerse body part	Other/miscellaneous
Inhalation	Otic
Intraarterial	Perfusion
Intrabursal	Rebreather mask
Intracardiac	Rectal
Intracervical (uterus)	Soaked dressing
Intradermal	Subcutaneous
Intrahepatic artery	Sublingual
Intramuscular	Topical
Intranasal	Tracheostomy
Intraocular	Transdermal
Intraperitoneal	Translingual
Intrasynovial	Urethral
Intrathecal	Vaginal
Intrauterine	Ventimask
Intravenous	Wound
Mouth	

7.12.5.1 *ED*—DEEDS 7.08.

7.12.5.2 *ED Discharge*— DEEDS 8.20.

7.12.6 *Date/Time ED Medication Ordered*—Date and time when ED medication is ordered. (DEEDS 7.01; Appendix X1, 12001):

YYYYMMDD HHMM

7.12.7 *Date/Time ED Medication Starts*—Date and time when ED medication administration begins (DEEDS 7.09; Appendix X1, 12001.57):

YYYYMMDD HHMM

7.12.8 *Time Component of Rate for Continuously Administered ED Medication*—Time component (denominator) of delivery rate for continuously administered ED medication. (EMDS; Appendix X1, 12001.42)

7.12.8.1 Enter a time if medication is administered at a continuous rate (for example, 1 h for theophylline administered at 0.5 mg/kg/hr).

7.12.9 *Date/Time ED Medication Stops*—Date and time when ED medication administration concludes. (EMDS; DEEDS 7.11; Appendix X1, 12001.60):

YYYYMMDD HHMM

7.12.10 *ED Discharge Medication Order Type*—Indicator of whether medication is prescribed, renewed, or discontinued at ED discharge. (DEEDS 8.13; Appendix X1, 12001.27):

Description
New order
Refill order request
Discontinue order request

7.12.11 *Amount of ED Discharge Medication to be Dispensed*—Amount of ED discharge medication to be dispensed when prescription is filled. Enter a number greater than 0, such as 40 when the prescription calls for 40 tablets to be dispensed. (DEEDS 8.21; Appendix X1, 12001.48)

7.12.12 *Number of ED Discharge Medication Refills*—Number of times prescription for ED discharge medication can be refilled. Enter an integer equal to or greater than 0. (EMDS; DEEDS 8.22; Appendix X1, 12001.51)

7.13 *Segment 13: Scheduled Appointments/Events.*

7.14 *Segment 14—Encounters/Episodes :*

Segment 14: Encounters/Episodes—Administrative/ Diagnostic Summary

7.14.1 *Internal ID*— Primary identifier used by facility to identify patient at admission (for example, medical record number). (DEEDS 1.01; Appendix X1, 14001.A003)

7.14.2 *Date-Time Patient First Documented in the ED*—The first date and time documented in the patient's record for this

emergency encounter. (DEEDS 4.01; Appendix X1, 14001):

YYYYMMDD HHMM

7.14.3 *Mode of Transport to ED*—Coded value to indicate the mechanism of transport for patient seeking emergency treatment. (DEEDS 4.02, Appendix X1, 14001.A021):

Ground ambulance
Helicopter ambulance
Fixed wing air ambulance
Ambulance, not otherwise specified
Walk-in following transport via private transportation
Walk-in following transport via public transportation
Walk-in following nonambulance, law enforcement transport
Walk-in, not otherwise specified
Other mode of transport
Unknown mode of transport

7.14.4 *Source of Referral to Emergency Department*—Coded value to indicate the individual or group who decided the patient should seek care at this ED. (DEEDS 4.05; Appendix X1, 14001.A070):

Self-referral
EMS transport decision
Practitioner or health care facility referral
Law enforcement referral
Acute care hospital transfer
Other health care facility transfer
Other
Unknown

7.14.5 *Time Assigned to Treatment Room*—Time patient is assigned to treatment room:

HHMM

7.14.6 *ED Disposition Diagnosis Description*—Practitioner's description of the condition or problem for which services were provided during patient's ED visit, recorded at the time of disposition. (DEEDS 8.23; Appendix X1, 14001.A170.03):

7.14.7 *ED Disposition Diagnosis Code*—The code assigned to the ED disposition diagnosis. (EMDS; DEEDS 8.24; Appendix X1, 14001.A170)

7.14.7.1 The predominant coding and classification system for morbidity remains the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* (DHHS, 1995).[10] *ICD-9-CM* codes are used for statistical data reporting, aggregate data analysis, and submission of claims for reimbursement. The North American Nursing Diagnosis Association classification and coding system is used for nursing diagnoses and is recommended by the ENA Emergency Nursing Uniform Data Set Task Force because of its relevance to ED patients (NANDA, 1995). The nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes.

Segment 14: Encounters/Episodes—Chief Complaint/ Present Illness/Injury

7.14.8 *First ED Acuity Assessment* —An ED practitioner's assessment of the patient's acuity when first evaluated in the ED. (DEEDS 4.08 Appendix X1, 14001.B016):

Requires immediate evaluation or treatment
Requires prompt evaluation or treatment
Time to evaluation or treatment not critical
Unknown

7.14.9 *Date/Time of First ED Acuity Assessment*—The date and time of the patient's first acuity assessment in the ED. (DEEDS 4.09; Appendix X1, 14001.B015):

YYYYMMDD HHMM

7.14.10 *Chief Complaint*— The patient's reason for seeking care or attention, expressed in terms that are as close as possible to those used by the patient or the responsible informant. (EMDS; DEEDS 4.06; Appendix X1, 14001.A023)

7.14.10.1 Coding systems to be adapted for this data element include the *International Classification for Primary Care (ICPC), Reason for Visit (RVC), Systematized Nomenclature of Medicine (SNOMED-CT), and the International Classification of Diseases (ICD).*

7.14.10.2 *Initial Encounter for Current Instance of Chief Complaint*—A marker that this is the patient's first encounter at any health care facility or with any practitioner for the current instance of the chief complaint. (EMDS; DEEDS 4.07; Appendix X1, 14001.A0031):

Yes
No (chief complaint attributable to illness or injury, but this is not the initial visit.
Other (chief complaint not attributable to illness or injury)
Unknown

7.14.11 *First ED Responsiveness Assessment*—The first ED assessment of the patient's level of consciousness, gauged by the individual's alertness, self-awareness, and reaction to environmental cues or sensory stimuli. (DEEDS 4.12; Appendix X1, 14001.B016)

7.14.11.1 *Alert*—The patient is fully responsive, aware of the environment, and capable of responding appropriately to questions about orientation to person, place, and time.

7.14.11.2 *Verbal Response*— The patient is not fully alert, but responds to verbal stimuli.

7.14.11.3 *Painful Response*— The patient does not respond to verbal stimuli but does respond to pain by withdrawing from the pain source, pushing in the direction of the pain source, flexing extremities, or extending extremities.

7.14.11.4 *Unresponsive*— The patient does not respond.

7.14.11.5 *Unknown.*

7.14.11.6 *Date/Time of First ED Responsiveness Assessment*—Date and time of the first ED assessment of the patient's level of consciousness. (DEEDS 4.13; Appendix X1, 14001.B015):

YYYYMMDD HHMM

7.14.12 *Measured Weight in ED*—Measured weight of patient in kilograms. (DEEDS 4.29; Appendix X1, 14001.B070.01)

7.14.13 *First ED Systolic Blood Pressure*—The patient's first systolic blood pressure in the ED measured in millimetres of mercury (mm[Hg]) by a manual or automatic method. (DEEDS 4.18; Appendix X1, 14001.B070.01):

Systolic blood pressure
Not measurable, but pulse palpable
Not measured
Unknown

[10] *International Classification of Diseases*, 9th edition, Clinical Modifications.

7.14.13.1 *Date/Time of First ED Systolic Blood Pressure*—Enter the date and time of the first ED systolic blood pressure. (DEEDS 4.19; Appendix X1, 14001.B070)

7.14.14 *First ED Diastolic Blood Pressure*—The patient's first diastolic blood pressure in the ED measured in millimetres of mercury (mm[Hg]) by a manual or automatic method. (DEEDS 4.20; Appendix X1, 14001.B070.01):

Diastolic blood pressure
Not measured
Unknown

7.14.15 *First ED Heart Rate*—The patient's first heart rate (/min) obtained in the ED. (DEEDS 4.21; Appendix X1, 14001.B070.01):

Heart Rate
Not measured
Unknown

7.14.15.1 *First ED Heart Rate Method*—The method used to measure the patient's first heart rate in the ED. (DEEDS 4.22; Appendix X1, 14001.B070.01):

Pulse rate measured by palpation
Pulse rate measured by automated device
Heart rate measured by palpation or auscultation
Heart rate measured by automated device
Unknown

7.14.15.2 *Date/time of First ED Heart Rate*—Date and time of the first heart rate taken in the ED. (DEEDS 4.23; Appendix X1, 14001.B070):

YYYYMMDD HHMM

7.14.16 *First ED Respiratory Rate*—DEEDS 4.24; Appendix X1, 14001.B070.01:

666 Agonal Respirations
777 Respiratory assistance with manual or mechanical ventilation
888 Not measured
999 Unknown

7.14.16.1 *Date/Time of First ED Respiratory Rate*—Date and time of the first respiratory rate measurement in the ED. (DEEDS 4.25; Appendix X1, 14001.B070)

7.14.17 *First ED Temperature Reading*—The patient's first temperature measurement in the ED to the nearest tenth of a degree or (DEEDS 4.26; Appendix X1, 14001.B070.01):

Not measured
Unknown

7.14.17.1 *First ED Temperature Reading Route*—The route of the patient's first temperature measured in the ED (DEEDS 4.27):

Oral
Tympanic
Rectal
Axillary
Urinary bladder probe
Other
Unknown

7.14.17.2 *Date and Time of First ED Temperature Reading*—Data and time of the first temperature in the ED. (DEEDS 4.28; Appendix X1, 14001.B070)

7.14.18 *Pregnancy Status Reported in ED*—The current pregnancy status of the patient as reported by the patient or a responsible informant. (DEEDS 4.30; Appendix X1, 14001.B070.01):

Yes
No
Not applicable
Unknown

7.14.18.1 *Fetal Heart Tones.* (Appendix X1, 14001.B070.01)

7.14.18.2 *Apgar Score (if Newborn)*—Coded values to measure newborn's responses after birth. (Appendix X1, 14001.B070.01)

7.14.19 *Skin Perfusion*— Coded values indicating the patient's skin perfusion, expressed as normal or decreased. (This field is essential for children 18 years or less.) (Appendix X1, 14001.B070.01):

Normal
Decreased
Not assessed

7.14.20 *Glasgow Coma Score (GCS)*—Sum total of coded values for eye opening, verbal, and motor responses to specific stimuli. (See 6.14.30-6.14.33; DEEDS 4.14–4.16; Appendix X1, 14001.B070.01)

7.14.20.1 *Date-Time of First ED Glasgow Coma Scale Assessment*—DEEDS 4.17; Appendix X1, 14001.B070.01.

7.14.21 *Mental Status*— Mental status as indicated by the mental status exam criteria (affect, hallucinations/delusions, suicidal ideation, homicidal ideation, basic intelligence, judgment, insight, sensorium). (Appendix X1, 14001.B070.01)

Segment 14: Encounters/Episodes—Progress Notes/ Clinical Course

7.14.22 Assessment of the patient's history and signs relevant to the patient's emergency diagnosis, treatment, and referral activity occurring at the time of illness/injury. The system shall allow for multiple assessments at different times by different practitioners.

7.14.22.1 *Date and Time of First ED Practitioner Evaluation*—Beginning date and time of the first evaluation by an ED practitioner responsible for performing a brief screening evaluation, simultaneous assessment and resuscitation, or a more comprehensive history and physical examination. (DEEDS 5.01; Appendix X1, 14001.A050):

YYYYMMDD HHMM

7.14.22.2 *Work/Activity Relatedness*—If applicable and known, a coded value to indicate if onset occurred or was caused at the work place, or both. Assign the appropriate code for all initial treatments of an injury, including transfers from another health care facility or referrals from elsewhere in the hospital. An entry should not be made when the ED visit is for follow up or for late effects of an old injury. (DEEDS 5.06; Appendix X1, 14001.A040)

7.14.22.3 *Sports*—Comprises exercise with functional purpose, for example, golf, jogging, riding, school sports and athletics, skiing, swimming, trekking, water-skiing. Includes activities described as a ball game, but excludes those described as play with ball.

7.14.22.4 *Leisure*—Comprises activity with purpose of entertainment or recreation, for example, hobby activities, going to the cinema, a dance or to a party. Includes activities described as play with ball, but excludes activities described as a ball game.

7.14.22.5 *Paid Work*—Comprises manual or professional work for salary, bonus, or other types of income. Paid work includes apprentice and vocational activity; breaks on employer premises (in hallway, rest room, cafeteria, storage area); working on, arriving at, or leaving employer parking lot; work for pay or compensation at home; working in family business, including family farm (activity should be clearly related to profit-oriented business); traveling on business, including to/from customer/business contacts; and engaged in work activity in which vehicle is considered the work environment. Paid work excludes engaged in recreational activities on employer controlled facilities; visiting for non-work purposes, not on official business; homemaker working at homemaking activities; working for self-non profit, that is, mowing lawn, repairing own roof, hobby or recreation activity; student engaged in school activities; operating vehicle (personal or commercial) for non-work purposes; commuting to or from work site; and illicit work, for example, drug trafficking.

7.14.22.6 *Unpaid Work*— Comprises duties for which one would not normally gain an income. Includes volunteer work and domestic duties such as caring for children and relatives, cleaning, cooking, gardening, and household maintenance. Excludes learning activities, for example, attending school session or lesson, undergoing education.

7.14.22.7 *Educational Activity*—Comprises learning activities, for example, in school or university. Excludes apprenticeship.

7.14.22.8 *Vital Activity*— Comprises resting, sleeping, eating, or engaging in other vital activities.

7.14.22.9 *Other Specified Activity.*

7.14.22.10 *Unknown Activity.*

7.14.23 *ED Clinical Finding Type*—The type of clinical finding reported (for example, history of present illness, past medical history, or physical examination). (DEEDS 5.14; Appendix X1, 14001.A053)

7.14.23.1 Table 1 is recommended to encode clinical finding types.

TABLE 1 Recommended Code for Clinical Finding Types

Code	Finding Type Description
HX0000	Patient history
HX0100	Source of history
HX0150	Chief complaint
HX0200	Family history
HX0250	History of present illness
HX0300	Problem list
HX0400	Past history
HX0405	General health
HX0410	Prior major illnesses and injuries
HX0415	Prior operations
HX0420	Prior hospitalizations
HX0425	Prior outpatient visits
HX0430	Current medications
HX0435	Allergies
HX0440	Growth and developmental history
HX0445	Immunization status
HX0450	Feeding/dietary status
HX0455	Physical functioning
HX0460	Mental and emotional well-being
HX0465	Cognitive functioning
HX0500	Social history
HX0505	Marital status and/or living arrangements
HX0515	Current employment
HX0520	Occupational history
HX0525	Alcohol use
HX0526	Usual number of drinks per drinking day
HX0527	Binge drinking episodes per month
HX0530	Tobacco use
HX0531	Cigarette packs smoked per day
HX0532	Cigarette pack-years
HX0535	Other nonmedical drug use
HX0540	Level of education
HX0545	Sexual history
HX0550	Travel history
HX0555	Other relevant social factors
HX0600	Review of systems
HX0605	Constitutional symptoms
HX0610	Eyes
HX0615	Ears, nose and sinuses, mouth and throat
HX0620	Cardiovascular
HX0625	Respiratory
HX0630	Gastrointestinal
HX0635	Genitourinary
HX0636	Reproductive
HX0637	Urinary
HX0640	Musculoskeletal
HX0645	Integumentary
HX0646	Skin
HX0647	Breasts
HX0650	Neurologic
HX0660	Psychiatric
HX0665	Endocrine
HX0670	Hematologic/lymphatic
HX0675	Allergic/immunologic
PE0000	Physical examination
PE0100	Blood pressure
PE0110	Pulse
PE0120	Respiratory rate
PE0130	Temperature
PE0140	Weight
PE0150	Glasgow Coma Scale (GCS)
PE0151	GCS eye component
PE0152	GCS verbal component
PE0153	GCS motor component
PE0200	Physical examination by body areas
PE0300	Head, including face
PE0400	Neck
PE0500	Chest
PE0510	Chest wall
PE0520	Breasts
PE0530	Axilla
PE0540	Heart
PE0560	Lungs (includes thoracic respiratory movements)
PE0600	Abdomen
PE0700	Groin
PE0800	Pelvis
PE0900	Genitalia
PE0930	Male genitalia
PE0960	Female genitalia
PE1000	Buttocks
PE1100	Anus and Rectum
PE1200	Back
PE1300	Upper extremity
PE1310	Hand
PE1330	Wrist
PE1350	Forearm
PE1360	Elbow
PE1370	Upper Arm
PE1380	Shoulder
PE1400	Lower extremity
PE1410	Foot
PE1430	Ankle
PE1450	Calf
PE1460	Knee
PE1470	Thigh
PE1480	Hip

TABLE 1 *Continued*

Code	Finding Type Description
PE2000	Physical examination by organ systems
PE2100	Eyes
PE2200	Ears, nose, mouth, and throat
PE2210	Ears
PE2220	Nose
PE2230	Mouth
PE2240	Throat
PE2300	Cardiovascular
P2310	Cardiac
P2310	Peripheral vascular
P2400	Respiratory
P2500	Gastrointestinal
P2600	Genitourinary
P2700	Musculoskeletal
P2800	Integumentary
P2900	Neurologic
P2910	Mental status
P2930	Sensation
P2950	Strength
P2970	Balance and coordination
P2990	Deep tendon reflexes
P3000	Psychiatric
P3100	Hematologic/lymphatic/immunologic

7.14.23.2 *Date of History*—Appendix X1, 08075.

7.14.24 *ED Clinical Finding*—History or physical examination finding. (DEEDS 5.15)

7.14.24.1 The finding, depending on the observation, may be a number (for example, 100 [apical rate]), a coded answer (for example, Class II [NYHA]), a date/time (for example, 040119960300), or a text description (for example, rales at right lung base), or any other valid data type.

7.14.24.2 *Date/Time of ED Clinical Finding Obtained*—Date and time when history or physical examination finding is obtained. (DEEDS 5.16):

YYYYMMDD HHMM

7.14.24.3 *ED Clinical Finding Data Source*—The identity of the source of historical information about the patient, for example, parent, caretaker, paramedic, law enforcement. (DEEDS 5.19):

Description
Patient
Paramedic/emergency medical technician
Parent
Spouse/partner
Other family member
Caretaker
Nurse
Physician
Other practitioner
Acquaintance
Bystander
Law enforcement personnel
Existing medical records
Other source
Unknown source

7.14.25 *Date/Time ED Consult Request Initiated*—The date and time when the ED physician or other appropriate source first attempts to contact a specified ED consultant or consulting service. (DEEDS 2.13; Appendix X1, 14001.A116.01):

YYYYMMDD HHMM

7.14.26 *Date and Time ED Consult Started*—The date and time when the ED consultant's services begin. (DEEDS 2.14):

YYYYMMDD HHMM

7.14.27 *Admission Consult Service*—The clinical service is one which is requested by the admitting service to provide advice regarding an aspect of the patient's health condition and who is being considered for admission to the facility (Appendix X1, 14001.A116).

Segment 14: Encounters/Episodes—Therapies

Segment 14: Encounters/Episodes—Procedures

7.14.28 *ED Procedure Indication*—An explanation of why the procedure was ordered. (DEEDS 6.01; Appendix X1, 05001)

7.14.28.1 No universal coding system exists for encoding the reason for ordering a procedure. Until such a system is developed, a local codes may be used, or alternatively, a text explanation of why the procedure was ordered may be entered.

7.14.29 *ED Procedure*— A service or intervention, not part of the routine history or physical examination, that is designed for diagnosis or therapy. (EMDS; DEEDS 6.02; Appendix X1, 14001.B039)

7.14.29.1 The predominant system for coding ED procedures in the United States is the *Physicians' Current Procedural Terminology.*[7] Several systems are available to code nursing interventions. Local codes or concise descriptions without codes can be used as required.

7.14.29.2 *Date/Time of ED Procedure Order*—Date and time the procedure was ordered. (EMDS; DEEDS 6.03; Appendix X1, 14001.B039.01)

YYYYMMDD HHMM

7.14.29.3 *Date/Time ED Procedure Starts*—Date and time the procedure began. (EMDS; DEEDS 6.04; Appendix X1, 14001.B039.01)

YYYYMMDD HHMM

7.14.29.4 *Date/Time ED Procedure Ends*—Date and time the procedure was finished. (DEEDS 6.05; Appendix X1, 14001.B039.01)

YYYYMMDD HHMM

7.14.29.5 *ED Diagnostic Procedure Result Type*—Type of diagnostic procedure result reported (for example, a complete blood count or a chest x-ray interpretation). (EMDS; DEEDS 6.09; Appendix X1, 14001.B039.01)

7.14.29.6 *ED Diagnosis Procedure Result*—Diagnostic procedure result. (EMDS; DEEDS 6.10; Appendix X1, 14001.B039.01)

7.14.29.7 *Date/Time ED Diagnostic Procedure Result Reported*—Date and time when diagnostic procedure result is reported. (EMDS; DEEDS 6.08; Appendix X1, 14001.B039.01)

Segment 14: Encounters/Episodes—Disposition

7.14.30 *Date/Time of Recorded ED Disposition*—Date and time when the ED practitioner's decision about the patient's disposition is first recorded. (DEEDS 8.01; Appendix X1, 14001.F040)

YYYYMMDD HHMM

7.14.31 *Date-Time Admitting Contacted for a Bed*—Date and time when process began to admit patient as an inpatient.

YYYYMMDD HHMM

7.14.32 *Date-Time Bed Assigned*—Date and time bed assigned to patient:

YYYYMMDD HHMM

7.14.33 *ED Disposition*— Patient's anticipated location or status following the ED visit. (DEEDS 8.02; Appendix X1, 14001.F080):

Disposition Descriptor
Discharged to home or self care (routine discharge)
Transferred/discharged to another short-term general hospital
Transferred/discharged to skilled nursing facility (SNF)
Transferred/discharged to intermediate care facility (ICF)
Transferred/discharged to another type of institution
Transferred/discharged to home under care of a home IV drug therapy provider
Transferred/discharged to home under care of certified home care provider/program
Left without receiving medical advice against leaving (includes left without being seen, eloped)
Left after receiving medical advice against leaving (that is, left AMA)
Admitted or transferred to observation unit (not a hospital admission)
Admitted to hospital floor bed
Admitted to intermediate care/telemetry unit
Admitted to intensive care unit
Admitted to operating room
Died
Other
Unknown

7.14.33.1 Users may expand this table to meet local needs for more detailed data. For example disposition categories could be expanded as follows:

Disposition Descriptor
Transferred/discharged to institution other than a prison or jail
Transferred/discharged to prison or jail
Left without advice, before triage and registration
Left without advice, after triage and before registration
Left without advice, after registration and before triage
Left without advice, after triage and registration
Left without advice, after primary assessment
Left with advice, before triage and registration
Left with advice, after triage and before registration
Left with advice, after registration and before triage
Left with advice, after triage and registration
Left with advice, after primary assessment
Admitted to nonisolation bed
Admitted to isolation bed
Admitted to medical intensive care unit
Admitted to cardiac care unit
Admitted to surgical intensive care unit
Admitted to burn unit
Admitted to neonatal intensive care unit
Admitted to pediatric intensive care unit

7.14.34 *Date-Time Patient Departs ED*—Date and time when the patient leaves the ED. (DEEDS 8.06; Appendix X1, 14001.F053):

YYYYMMDD HHMM

7.14.35 *Date-Time of Death*—Date and time of patient's death while patient in emergency department. (EMDS; Appendix X1, 01034):

YYYYMMDD HHMM

7.14.36 *Discharge Transport Mode*—Mode of patient transport after discharge (Appendix X1, 14001.F076)

7.14.37 *ED Follow-Up Care Assistance* —Follow-up care needs of ED patient at discharge from ED. (DEEDS 8.07; Appendix X1, 14001.F056):

No follow up care assistance necessary
Follow up care assistance available or arranged before ED discharge
Follow up care assistance arrangements pending
Other
Unknown

7.14.38 *Facility Receiving ED Patient*—Identifier for health care facility to which patient is transferred or discharged at conclusion of ED visit. (DEEDS 8.05; Appendix X1, 14001.F080)

7.14.38.1 On October 1, 1997, the Centers for Medicare and Medicaid Services (CMS) began issuing a National Provider Identifier (NPI) to all individual practitioners and organizations that provide health care. The NPI consists of two parts: a seven-position alphanumeric identifier and a one-position numeric check digit. A locally assigned identifier may be entered until the NPI is issued. To protect confidentiality, disclosure of practitioner- or organization-specific data must be limited to authorized personnel.

7.14.39 *Referral at ED Disposition* —Arranged or recommended service for patient to be provided by practitioner, health care organization, or agency after ED visit. (DEEDS 8.08; Appendix X1, 14001.F046)

7.14.39.1 Data on referrals are needed for continuity of care and patient follow-up. These data also are used in quality-of-care monitoring and evaluation, health care administration, and clinical and health services research. Until a standardized, comprehensive, and practical set of service descriptors is available and widely accepted, this data element must be adapted for local use.

7.14.40 *ED Service Level*— Extent of services provided by ED physician, nurse, or other practitioner during the patient's ED visit. (DEEDS 8.27)

7.14.40.1 *The Physicians' Current Procedural Terminology (CPT)* evaluation and management (E/M) codes are used to document physician services other than procedures (American Medical Association [AMA], 1997). The key components of an E/M service level code assignment are history, physical examination, and medical decision making. Nursing intensity is an essential data element in the Nursing Minimum Data Set (Werley and Lang, 1988); however, further work is needed to develop systems for measuring nursing intensity.

7.14.41 *Patient Problem Assessed in ED Outcome Observation*—Patient's complaint or condition for which outcome is observed. (DEEDS 8.30; Appendix X1, 14001.F066)

7.14.41.1 Because a variety of problems (for example, a symptom, physical sign, abnormal laboratory finding, or diagnosed condition) have measurable outcomes, a variety of coding systems is needed. Users can select from available national or international coding systems (for example, *International Classification of Diseases, 9th Revision, Clinical Modification*. North American Nursing Diagnosis Association classification [NANDA], and the Logical Observation Identifiers Names and Codes [LOINC] Database), locally developed codes, or descriptive text entries to specify patient problems. Additional work is needed to choose or develop coding systems to provide comprehensive coverage of all patient problems that are assessed in the ED.

7.14.41.2 *ED Outcome Observation*—Change in patient's specified health problem as assessed by practitioner during ED visit or at follow-up. (DEEDS 8.31)

7.14.41.3 Interest in obtaining standardized data on ED patient outcomes is widespread, but methods of gathering and analyzing these data are underdeveloped. More research is needed to define problem-specific outcome measures that are valid, reliable, and sensitive to changes in health status that occur during ED encounters. Additional research is needed to determine the extent to which measurable changes in health status are related to ED care. Further work is required to incorporate outcome measurements into routine ED practice. Until a valid, reliable, and practical set of outcome measures is available and widely accepted, this data element should be used for locally defined outcome observation systems. An outcome can be assessed at any time during or following the ED visit, but outcomes are most likely to be assessed at ED disposition. For nursing outcomes, the ENA Emergency Nursing Task Force recommends entering "Resolved," "Stabilized," or "Not Resolved" for each nursing diagnosis.

7.14.41.4 *Date/Time of ED Outcome Observation*—Date and time when practitioner's outcome observation is made. (DEEDS 8.32):

YYYYMMDD HHMM

7.14.42 *ED Patient Satisfaction Report Type*—Aspect of ED care for which patient satisfaction is reported. (DEEDS 8.35)

7.14.42.1 Few ED patient records include data on patient satisfaction. However, in many ED settings, these data can be obtained as a byproduct of patient satisfaction questionnaires or interviews administered to the patient or a responsible informant following the ED visit. These instruments are used to assess patient's satisfaction with various dimensions of ED care, such as the technical quality of care, interpersonal aspects of care, accessibility and availability of care, and physical setting comfort. Many instruments designed to measure patient satisfaction have been developed, but no consensus exists regarding the dimensions of care that should be measured or how to measure them. Until a standard system for coding the type of patient satisfaction is available and widely accepted, this data element must be adapted for locally selected patient satisfaction reporting codes. One option is to develop and use a locally-defined set of patient satisfaction report types.

7.14.42.2 *ED Patient Satisfaction Report*—Patient's reported satisfaction with the specified aspect of ED care. (DEEDS 8.36)

7.14.42.3 Another option is to develop a text description of the patient's reported satisfaction with the specified aspect of care.

Segment 14: Encounters/Episodes—ED Charges

7.14.43 *Total ED Facility Charges*—Total facility charges billed for this ED visit, including charges for facility overhead, nursing care, medications, and diagnostic tests. Excludes all professional fees, such as those charged by the attending emergency physician, advanced practice nurse (for example, Clinical Nurse Specialist, Nurse Practitioner), physician assistant, radiologist, pathologist, and ED consultant. (DEEDS 3.15; Appendix X1, 14001.G002)

7.14.44 *Total ED Professional Fees*—Total professional fees billed for this ED visit, including fees charged by the attending emergency physician, advanced practice nurse (for example, Clinical Nurse Specialist, Nurse Practitioner), physician assistant, radiologist, pathologist, and ED consultant. Excludes any ED facility charges. (DEEDS 3.16)

7.15 *Sources of Emergency Data for Computer–Based Patient Record:*

7.15.1 *Emergency Department/Outpatient Emergency Facility Record*—Different types of data are collected after the patient arrives at an emergency outpatient emergency facility. This information includes patient registration, symptoms, complaints, diagnostic information, medical treatment, and disposition. During severe emergencies, diagnostic and treatment information may be collected simultaneously with the patient registration information.

7.15.1.1 *Patient Registration*—Patient registration data are uploaded from the EMS record when the patient is transported by EMS or collected at the time of admission from patients who go directly to the emergency department for treatment.

7.15.1.2 *Symptoms/Complaints/Diagnostic* —Diagnostic tests are ordered by means of clinical orders, described in Practice E1384. The time, date, and results of such tests will be filed in the Diagnostic Test Segment of the care record.

7.15.1.3 *Medical Treatment*—Attending and consulting medical/mental health professionals may be utilized during a given emergency episode.

7.15.2 *Emergency Department Log Data Set*—The log is produced from a very rudimentary computer-based abstract of the patient record. Having the log computerized provides a database, which is a valuable management tool. It allows a number of reports to be produced to meet accrediting and licensing needs.

7.15.2.1 *Description*—The emergency department log documents the activity of the ED. It records patient identifiers, mode of arrival, presenting complaint, date and time of admission, discharge diagnosis, etc. All of the information may be exported from the patient record to create the log.

8. Emergency Surgical and Medical Therapy at the Inpatient Acute Care (Secondary or Tertiary Care) Facility

NOTE 5—This section includes the data elements that update the patient's emergency record to add the unique events occurring during the inpatient phase of the emergency.

8.1 *Segment 1: Demographics*—Information entered during the first and second phases of the emergency should be updated when necessary during this phase.

8.1.1 *Inpatient Identification Number*—A unique identification number applicable to the patient only (DEEDS 1.01; Appendix X1, 14001.A003)

8.2 *Segment 2: Legal Agreements* —See 7.2.

8.3 *Segment 3: Financial Information*—See 7.3.

8.4 *Segment 4: Provider/Practitioners* —The following information is documented for each provider or practitioner involved in the patient's treatment after admission as an inpatient.

8.4.1 *Provider/Practitioner Identification Number*—Identifier for provider or practitioner involved in providing inpatient care. On October 1, 1997, the Centers for Medicare and Medicaid Services (CMS) began issuing a National Provider Identifier (NPI) to all individual practitioners and organizations that provide health care. The NPI consists of two parts: a seven-position alphanumeric identifier and a one-position numeric check digit. A locally assigned identifier may be entered until the NPI is issued. To protect confidentiality, disclosure of practitioner- or organization-specific data must be limited to authorized personnel. Provider ID for this hospital admission documented for: (Appendix X1, 04001.07)

8.4.1.1 *Hospital Identification Number*—A unique institutional number statewide to allow for tracking and linkage of multiple records. (DEEDS 8.05)

8.4.1.2 *Facility Receiving Inpatient After Discharge*—Identifier for health care facility to which patient is transferred or discharged at conclusion of inpatient visit.

8.4.1.3 *Issuing Agency of ID No.*—The agency associated with this unique identifier of this provider. (Appendix X1, 04001.07.01)

8.4.2 Practitioner Identifier for this hospital admission documented for (Appendix X1, 04001.15)

8.4.2.1 *Inpatient Practitioner*—Identifier for practitioner whose inpatient service ED patient is admitted to. (DEEDS 8.03)

8.4.2.2 *Practitioner Who Performs Assessment*—Identifier number of the practitioner performing/updating the assessment of patient history of the emergency.

8.4.2.3 *Practitioner Who Performs Procedure/Therapy*—Identifier number for practitioner who performs the procedure/therapy.

8.4.2.4 *Practitioner Generating Order/Plan*—Identifier of the practitioner generating the order/treatment plan.

8.4.2.5 *Consultant/Specialist*—Identifier of the specialist who examines the patient in the hospital inpatient facility.

8.4.2.6 *Inpatient Discharge Practitioner*—Identifier for practitioner of record at discharge who is responsible for the discharge summary.

8.4.2.7 *Issuing Agency of ID No.*—The agency associated with this unique identifier of this practitioner. (Appendix X1, 04001.07.01)

8.4.3 *Provider/Practitioner Type*—Profession or occupation and specialty or subspecialty of provider/practitioner. (Appendix X1 04001.05/04001.50). The Insurance Subcommittee of the Accredited Standards Committee X12 is developing a provider taxonomy in conjunction with the Centers for Medicare and Medicaid Services (CMS) implementation of the National Provider System (Accredited Standards Committee X12, 1997). The taxonomy classifies practitioners by their occupation or service group and their specialty. The taxonomy permits further specification within specialties, such as subspecialty or age focus (for example, adolescents). Until the taxonomy is implemented, a local system may be used to encode practitioner type. Provider type is documented for (Appendix X1 04001.05).

8.4.3.1 *Hospital of Admission.*

8.4.3.2 *Facility Receiving Inpatient After Discharge.*

8.4.3.3 Practitioner type is documented for: (Appendix X1, 04001.20)

8.4.3.4 *Inpatient Practitioner*—(DEEDS 8.04).

8.4.3.5 *Practitioner Who Performs Assessment.*

8.4.3.6 *Practitioner Who Performs Procedure/Therapy.*

8.4.3.7 *Practitioner Generating Order/Plan.*

8.4.3.8 *Consultant/Specialist.*

8.4.3.9 *Inpatient Discharge Practitioner.*

8.4.4 *Practitioner(s) Status Code*—Coded value to indicate level of responsibility for inpatient (for example, in charge, provided care, etc.)

8.5 *Segment 5: Problem List.*

8.6 *Segment 6: Immunization.*

8.7 *Segment 7: Exposure to Hazardous Substances.*

8.8 *Segment 8: Family/Prenatal/Cumulative Health/Medical/Dental Nursing History.*

8.9 *Segment 9: Assessment/Exams .*

8.10 *Segment 10: Care/Treatment Plans and Orders.*

8.11 *Segment 11: Diagnostic Tests.*

8.12 *Segment 12: Medications*—The following data elements are used each time a practitioner documents information about the patient's medications as an inpatient.

8.12.1 *Medication Identifier*—See 7.12.1. (Appendix X1, 12001.06)

8.12.1.1 *Inpatient*—Medication administered during ED visit.

8.12.1.2 *Inpatient Discharge*—Medication that is prescribed, renewed, or discontinued at inpatient discharge.

8.12.2 *Medication Dose*— The medication dose at each administration. Enter a number >0. (See 7.12.2) (Appendix X1, 12001.30)

8.12.2.1 *Inpatient.*

8.12.2.2 *Inpatient Discharge.*

8.12.3 *Medication Dose Units*—See 7.12.3. (Appendix X1, 12001.33)

8.12.3.1 *Inpatient.*

8.12.3.2 *Inpatient Discharge.*

8.12.4 *Medication Schedule*—The frequency and duration of administration of the medication. (See 7.12.4) (Appendix X1, 12001.42)

8.12.4.1 *Inpatient.*

8.12.4.2 *Inpatient Discharge.*

8.12.5 *Medication Route*— See 7.12.5. (Appendix X1, 12001.39)

8.12.5.1 *Inpatient.*

8.12.5.2 *Inpatient Discharge.*

8.12.6 *Date/Time Inpatient Medication Ordered*—Date and time when inpatient medication is ordered. (Appendix X1, 12001):

YYYYMMDD HHMM

8.12.7 *Date/Time Inpatient Medication Starts*—Date and time when inpatient medication administration begins.) (Appendix X1, 12001.57):

YYYYMMDD HHMM

8.12.8 *Time Component of Rate for Continuously Administered Inpatient Medication*—Time component (denominator)

of delivery rate for continuously administered inpatient medication. (See 7.12.8.1) (Appendix X1, 12001.42)

8.12.9 *Date/Time Inpatient Medication Stops*—Date and time when ED medication administration concludes. (Appendix X1, 12001.60):

YYYYMMDD HHMM

8.12.10 *Inpatient Discharge Medication Order Type*—Indicator of whether medication is prescribed, renewed, or discontinued at inpatient discharge. (See 7.12.10) (Appendix X1, 12001.27)

8.12.11 *Amount of Inpatient Discharge Medication to be Dispensed*—Amount of inpatient discharge medication to be dispensed when prescription is filled. Enter a number greater than 0, such as 40 when the prescription calls for 40 tablets to be dispensed. (Appendix X1, 12001.48)

8.12.12 *Number of Inpatient Discharge Medication Refills*—Number of times prescription for ED discharge medication can be refilled. Enter an integer equal to or greater than 0. (Appendix X1, 12001.51)

8.13 *Segment 13: Scheduled Appointments/Events.*

8.14 *Segment 14: Encounters/Episodes* .

Segment 14: Encounters/Episodes—Administrative/ Diagnostic Summary

8.14.1 *Date-Time Patient Admitted as an Inpatient*—Date and time the patient is admitted as an inpatient. (Appendix X1, 14001)

8.14.2 *Type of Admission*—Coded value to indicate whether patient admission was unscheduled or scheduled with less than 24-h notice. (Appendix X1, 14001.A063)

8.14.3 *Source of Admission*—Coded value to indicate where patient came from prior to being admitted as an inpatient. (Appendix X1, 14001.A070)

8.14.4 *Name of Clinical Service*—Coded value to indicate clinical services provided to patient for conditions that affected the hospital stay. (Appendix X1, 14001.A110, 14001.A163.06)

8.14.5 *Date-Time Admission to Clinical Service*—Date-time when room, board, and continuous nursing service are begun for specific clinical service. (Appendix X1, 14001.A163.06.01)

8.14.6 *Date-Time Discharge from Clinical Service*—Date-time when room, board, and continuous nursing service are discontinued for specific clinical service. (Appendix X1, 14001.A110.01, 14001.A163.06)

8.14.7 *Patient Transfer Type*—Coded value to indicate movement of inpatient either physically or administratively between nursing inter clinical care units and services. (Appendix X1, 14001.A113, 14001.A163.01)

8.14.8 *Inpatient Disposition Diagnosis Description*—Practitioner's description of the condition or problem for which services were provided during patient's inpatient stay, recorded at the time of disposition. (Appendix X1, 14001.F020, 14001.F105)

8.14.8.1 *Inpatient Disposition Diagnosis Code*—The code assigned to the inpatient disposition diagnosis. (Appendix X1, 14001.F016, 14001.F023, 14001.F030)

8.14.8.2 The predominant coding and classification system for morbidity remains the *International Classification of Diseases, 9th Revision, Clinical Modification (ICD-9-CM)* (DHHS, 1995). *ICD-9-CM* codes are used for statistical data reporting, aggregate data analysis, and submission of claims for reimbursement. The North American Nursing Diagnosis Association classification and coding system is used for nursing diagnoses and is recommended by the ENA Emergency Nursing Uniform Data Set Task Force because of its relevance to ED patients (NANDA, 1995). The nursing diagnosis is a clinical judgment about individual, family, or community responses to actual or potential health problems or life processes.

8.14.8.3 *Discharge Diagnosis Code Status*—Coded value to indicate if the code is the principal or other reason for admission/treatment. (Appendix X1, 14001.F030.01)

8.14.8.4 *Qualifier for Diagnosis Code*—Coded value to indicate for each diagnosis whether onset occurred before or after admission.

8.14.8.5 *Cause of Death*— Coded value to indicate primary cause of death. (Appendix X1, 14001.F036.1)

8.14.9 *Cause-of-Injury Code (E-Code)*—The cause of injury code (E-code) for the external cause of the primary injury, poisoning, or adverse effect related to the current emergency. E-codes are assigned according to the subset of the E-codes in ICD-9 that are appropriate for use in the field. When possible, the codes should be assigned to indicate what went wrong, what the patient was doing at the time, if any products were involved, and the relationship of the assailant to the victim if an assault occurred or what evidence exists to indicate self-intent, or both. (Appendix X1, 14001.F033, 14001.F036)

8.14.9.1 *Cause of Injury Code Status*—Coded value to indicate if the code is the principal cause of the injury or a contributing cause. (Appendix X1, 14001.F036.1)

Segment 14: Encounters/Episodes—Chief Complaint/ Present Illness/Injury

8.14.10 *Diagnosis Narrative*—Description of admitting diagnosis. (Appendix X1, 14001.A170.03)

Segment 14: Encounters/Episodes—Progress Notes/ Clinical Course

8.14.11 Assessment of the patient's history and signs relevant to the patient's emergency diagnosis, treatment, and referral activity occurring at the time of the illness/injury. The system must allow for multiple assessments at different times by different practitioners.

8.14.11.1 *Date/Time Inpatient Consult Request Initiated*—The date and time when the inpatient practitioner first attempts to contact a specified consultant or consulting service. (Appendix X1, 14001.A116.01):

YYYYMMDD HHMM

8.14.11.2 *Date and Time Inpatient Consult Started*—The date and time when the inpatient consultant's services begin. (Appendix X1, 14001.A116.01):

YYYYMMDD HHMM

Segment 14: Encounters/Episodes—Therapies

8.14.12 *Inpatient Therapy Indication* —An explanation of why the therapy was ordered.

8.14.12.1 No universal coding system exists for encoding the reason for ordering a procedure. Until such a system is

developed, a local codes may be used, or alternatively, a text explanation of why the procedure was ordered may be entered. (Appendix X1, 14001.01.03)

8.14.13 *Inpatient Therapy*—A service or intervention, not part of the routine history or physical examination, that is designed for diagnosis or therapy. (Appendix X1, 14001.D001)

8.14.13.1 The predominant system for coding inpatient procedures in the United States is the *Physicians' Current Procedural Terminology*. Several systems are available to code nursing interventions. Local codes or concise descriptions without codes can be used as required.

8.14.13.2 *Date/Time of Inpatient Therapy Order*—Date and time the surgical procedure was ordered:

YYYYMMDD HHMM

8.14.13.3 *Patient Arrival Time*—Time patient arrives for surgery (Appendix X1, 14001.E001)

8.14.13.4 *Date/Time Inpatient Therapy Starts*—Date and time the procedure began. (Appendix X1, 14001.D001.01):

YYYYMMDD HHMM

8.14.14 *Date/Time Inpatient Therapy Ends*—Date and time the procedure was finished. (Appendix X1, 14001.D001.01.01):

YYYYMMDD HHMM

8.14.14.1 *Inpatient Therapy Result Type*—Type of diagnostic procedure result reported.

8.14.14.2 *Inpatient Therapy Result*—Diagnostic procedure result. (Appendix X1, 14001.D001.01.15)

8.14.14.3 *Date/Time Inpatient Therapy Result Reported*—Date and time when diagnostic surgical procedure result is reported.

Segment 14: Encounters/Episodes—Procedures

8.14.15 *Inpatient Surgical Procedure Indication*—An explanation of why the surgery was ordered. (Appendix X1, 14001.A173/14001.D001.03)

8.14.15.1 No universal coding system exists for encoding the reason for ordering a procedure. Until such a system is developed, a local codes may be used, or alternatively, a text explanation of why the procedure was ordered may be entered.

8.14.16 *Inpatient Surgical Procedure*—A surgical intervention that is designed for diagnosis or therapy. (Appendix X1, 14001.E001.69/14001.F013)

8.14.16.1 The predominant system for coding inpatient procedures in the United States is the *Physicians' Current Procedural Terminology*.

8.14.16.2 *Date/Time of Inpatient Surgical Procedure Order*—Date and time the surgical procedure was ordered. (Appendix X1, 14001.E001.69.001):

YYYYMMDD HHMM

8.14.16.3 *Date/Time Inpatient Surgical Procedure Starts*—Date and time the procedure began. (Appendix X1, 14001.E001.30):

YYYYMMDD HHMM

8.14.16.4 *Date/Time Inpatient Surgical Procedure Ends*—Date and time the procedure was finished. (Appendix X1, 14001.E001.32):

YYYYMMDD HHMM

8.14.16.5 *Inpatient Surgical Procedure Result Type*—Type of diagnostic procedure result reported.

8.14.16.6 *Inpatient Surgical Procedure Result*—Diagnostic procedure result. (Appendix X1, 14001.E001.69.02)

8.14.16.7 *Date/Time Inpatient Surgical Procedure Result Reported*—Date and time when diagnostic surgical procedure result is reported.

8.14.16.8 *Materials Used*— Materials used to perform the surgical procedure listed. (Appendix X1, 14001.E001.75)

8.14.16.9 *Number of Days on Ventilator* —Number of days patient required ventilator support.

Segment 14: Encounters/Episodes—Disposition

8.14.17 *Date/Time of Recorded Inpatient Disposition*—Date and time when the inpatient practitioner's decision about the patient's disposition is first recorded. (Appendix X1, 14001.F040):

YYYYMMDD HHMM

8.14.17.1 *Inpatient Disposition*—Patient's anticipated location or status following the inpatient stay. (Appendix X1, 14001.F050):

Disposition Descriptor

Discharged to home or self care (routine discharge)
Transferred/discharged to another short-term general hospital
Transferred/discharged to skilled nursing facility (SNF)
Transferred/discharged to intermediate care facility (ICF)
Transferred/discharged to another type of institution
Transferred/discharged to home under care of a home IV drug therapy provider
Transferred/discharged to home under care of certified home care provider/program
Left without receiving medical advice against leaving (includes left without being seen, eloped)
Left after receiving medical advice against leaving (that is, left AMA)
Died
Other
Unknown

8.14.18 *Date-Time Patient Discharged from Hospital After Admission*—Date and time when the patient leaves the hospital after admission for inpatient care. (Appendix X1, 14001.F053)

YYYYMMDD HHMM

8.14.19 *Date-Time of Death*—Date and time of patient's death while admitted as an inpatient. (Appendix X1, 14001.01034)

YYYYMMDD HHMM

8.14.20 *Discharge Transport Mode*—Mode of patient transport after discharge. (Appendix X1, 14001.F076)

8.14.21 *Inpatient Follow-Up Care Assistance*—Follow-up care needs of inpatient at time of discharge. (Appendix X1, 14001.F083)

8.14.22 *Referral at Inpatient Disposition*—Arranged or recommended service for patient to be provided by practitioner, health care organization, or agency after inpatient stay. (Appendix X1, 14001.F070)

8.14.22.1 Data on referrals are needed for continuity of care and patient follow-up. These data also are used in quality-of-care monitoring and evaluation, health care administration, and clinical and health services research. Until a standardized, comprehensive, and practical set of service descriptors is available and widely accepted, this data element must be adapted for local use.

8.14.23 *Inpatient Service Level*—Extent of services provided by inpatient practitioners providing care during the patient's inpatient stay.

8.14.23.1 *The Physicians' Current Procedural Terminology (CPT)* evaluation and management(E/M) codes are used to document physician services other than procedures (American Medical Association [AMA], 1997). The key components of an E/M service level code assignment are history, physical examination, and medical decision making. Nursing intensity is an essential data element in the Nursing Minimum Data Set (Werley and Lang, 1988); however, further work is needed to develop systems for measuring nursing intensity.

8.14.24 *Inpatient Problem Outcome Assessment*—Patient's complaint or condition for which outcome is observed. (Appendix X1, 14001.A053)

8.14.24.1 *Problem Identifier*—Because a variety of problems (for example, a symptom, physical sign, abnormal laboratory finding, or diagnosed condition) have measurable outcomes, a variety of coding systems is needed. Users can select from available national or international coding systems (for example, *International Classification of Diseases, 9th Revision, Clinical Modification*, North American Nursing Diagnosis Association classification [NANDA], and the Logical Observation Identifiers Names and Codes [LOINC] Database), locally developed codes, or descriptive text entries to specify patient problems.

8.14.24.2 *Problem Outcome Observation* —Change in patient's specified health problem as assessed by practitioner during inpatient stay or at follow-up.

8.14.24.3 Interest in obtaining standardized data in inpatient outcomes is widespread, but methods of gathering and analyzing these data are underdeveloped. More research is needed to define problem-specific outcome measures that are valid, reliable, and sensitive to change in health status. Additional research is needed to determine the extent to which measurable changes in health status are related to care. Further work is required to incorporate outcome measurements into routine practice. Until a valid, reliable, and practical set of outcome measures is available and widely accepted, this data element should be used for locally defined outcome observation systems. An outcome can be assessed at any time.

8.14.24.4 *Date/Time of Inpatient Outcome Observation*—Date and time when practitioner's outcome observation is made:

YYYYMMDD HHMM

8.14.25 *Inpatient Patient Satisfaction Report Type*—Aspect of inpatient care for which patient satisfaction is reported.

8.14.25.1 Few patient records include data on patient satisfaction. However, in many settings, these data can be obtained as a by-product of patient satisfaction questionnaires or interviews administered to the patient or a responsible informant following the visit. These instruments are used to assess patients' satisfaction with various dimensions of care, such as the technical quality of care, interpersonal aspects of care, accessibility and availability of care, and physical setting comfort. Many instruments designed to measure patient satisfaction have been developed, but no consensus exists regarding the dimensions of care that should be measured or how to measure them. Until a standard system for coding the type of patient satisfaction is available and widely accepted, this data element must be adapted for locally selected patient satisfaction reporting codes. One option is to develop and use a locally-defined set of patient satisfaction report types.

8.14.25.2 *Inpatient Patient Satisfaction Report*—Patient's reported satisfaction with the specified aspect of inpatient care. (DEEDS 8.36)

8.14.25.3 Another option is to develop a text description of the patient's reported satisfaction with the specified aspect of inpatient care.

8.14.26 *Name of Discharge Functional Independence Measure (FIM)*—Coded value at time of patient discharge from inpatient care to indicate test criteria for levels of movement, daily activities of living, cognitive functioning, etc. (Appendix X1, 14001.F069)

8.14.26.1 *Value of FIM Element*—Coded value to indicate level of functioning relative to the measurement criteria reported. (Appendix X1, 14001.F069.01)

Segment 14: Encounters/Episodes—Charges

8.14.27 *Total Inpatient Facility Charges*—Total facility charges billed for this inpatient visit, including charges for facility overhead, nursing care, medications, and diagnostic tests. Excludes all professional fees, such as those charged by the attending emergency physician, advanced practice nurse (for example, Clinical Nurse Specialist, Nurse Practitioner), physician assistant, radiologist, pathologist, and inpatient consultant. (Appendix X1, 14001.G002)

8.14.28 *Total Inpatient Professional Fees*—Total professional fees billed for this inpatient visit. Excludes any inpatient facility charges.

8.15 *Sources of Inpatient Data for or to Link to the Computer–Based Patient Record-Inpatient Medical Record*—The inpatient medical record documents the detailed clinical information describing the sequence of diagnostic and treatment procedures provided to the patient after admission to an inpatient acute or tertiary care facility.

9. Other Documentation of Instances of Emergency Care

9.1 Emergency care is also documented in the registries for trauma and head/spinal cord injuries.

9.1.1 *Trauma Head/Spinal Cord Injury Registry Data Set*—The registry data sets relevant to emergency care include the trauma and the head/spinal cord injury registries. Sometimes poisonings are also tracked.

9.1.1.1 *Description*— Registry data includes a subset of the data provided by emergency medical services at the scene, en route, at the emergency department, and after admission as an inpatient. In addition it usually includes detailed clinical information that is useful to support activities related to trauma epidemiology, quality assurance, case management, medical outcome, injury prevention, and risk management. Some registries include level of functioning information at the time of discharge.

10. Keywords

10.1 computer-based patient record; emergency department data set; emergency medical care; inpatient data set; prehospital EMS data set

APPENDIX

(Nonmandatory Information)

X1. LIST OF E1744 LINKS TO E1384 INDEX VALUES

X1.1 The following is a list of data elements classified according to the segments of the computer-based patient record presented in Practice E1384.

SEGMENT I	DEMOGRAPHIC/ADMINISTRATIVE
01001.	Name
01010.	Alias
01020.	SSAN
01032.	Date-time of birth
01034.	Date-time of death
01040.	Sex
01042.	Race
01045.	Ethnic group
01047.	Religion
01065.	Occupation
01067.	Current vocational status
01077.	Work address
01080.	Work phone
01085.	Usual living arrangement
01095.	Patient home address
01099.	Code for foreign residence
01100.	Patient home phone
01105.	Patient temporary address
01108.	Patient temporary address phone
01110.	Emergency contact name
01112.	Emergency contact relationship
01115.	Emergency contact address
01117.	Emergency contact phone
01119.	Emergency contact business phone
SEGMENT II	LEGAL AGREEMENTS
02030.	Directive to physician
02052.	Durable power of attorney status
SEGMENT III	FINANCIAL
03005	Insurance claim date
03005.02.	Claim ID
03010.	Payer
03010.02.	Payer type/class
03010.04.	Patient insurance group no.
03010.06.	Insurance subscriber ID
03010.10.	Address of sponsor
03030.	Billing account no.
SEGMENT IV	PROVIDERS
04001	Provider name
04001.05.	Provider type
04001.07.	Provider ID no.
04001.07.01	Issuing agency of provider ID no.
04001.10.	Practitioner name
04001.15.	Practitioner ID number(NPI)
04001.20.	Practitioner occupation/specialty
04001.25.	Practitioner office address
04001.30.	Practitioner office phone
04001.31.	Practitioner FAX phone
04001.32.	Practitioner E-mail address
SEGMENT V	PROBLEM LIST
05001	Problem ID
05001.01	Problem name
05001.03	Onset date
05001.07	Entered date
SEGMENT VI	IMMUNIZATIONS
06001	Immunization name
06001.01	Date of last tetanus immunization
SEGMENT VII	EXPOSURE TO HAZARDOUS SUBSTANCES
07001	Exposure to hazardous materials
SEGMENT VIII	HISTORY
08075	Date of history
08075.17	Preexisting conditions
08083	Current medications
08088	Allergies
SEGMENT XII	MEDICATIONS
12001.	Date-Time of prescription/medication order
12001.06.	Medication name
12001.27.	Status of prescription/order
12001.30.	Dose
12001.33.	Unit
12001.39.	Route
12001.42.	Interval/Frequency
12001.45.	Instructions for use (SIG)
12001.48.	Total doses prescribed/refill
12001.51.	No. refills authorized
12001.57.	Medication start date-time
12001.60.	Medication stop date-time
SEGMENT XIV	ENCOUNTER/EPISODES
Segment 14A: Administrative/Diagnostic Summary	
14001.	Date-time of encounter/admission
14001.A0031.	Episode identifier
14001.A003	Internal ID
14001.A013	Provider type
14001.A016.	Reason for visit
14001.A021.	Mode of arrival
14001.A023.	Chief complaint
14001.A027.	Datetime of injury
14001.A030.	Nature of injury
14001.A033.	Mode of injury/illness
14001.A036.	Location where injured/ill
14001.A040.	Injured on job Y/N?
14001.A043.	Injury circumstances
14001.A044.	Protective equipment used
14001.A050.	Date of physical exam
14001.A053.	Problems
14001.A056.	Current living arrangements

14001.A060.	Comments
14001.A063.	Admission type
14001.A070.	Location admitted/referred/sent from
14001.A106.	Age
14001.A110.	Admitting service
14001.A110.01	Date/time admitted to service
14001.A116	Admission consult service
14001.A116.01.	Date assigned
14001.A163.	Transfer date
14001.A163.01.	Transfer type
14001.A163.02.	Transferred to nursing unit
14001.A163.06.	Clinical service
14001.A163.06.01	Date/time admitted to clinical service
14001.A170.	Diagnosis/problem
14001.A170.01.	Type(admitting,pri,sec)
14001.A170.03.	ED discharge diagnosis description
14001.A173.	Indicated surgery
14001.A206.	Police hold

Segment 14B: Trauma Care/History of Present Illness

Pre-hospital Care

14001.B0001.	Date/time incident reported
14001.B0002.	Time dispatch notified
14001.B0004.	Time EMS unit left scene
14001.B0005.	Time EMS arrival at destination
14001.B0006.	Time EMS back in service
14001.B001.	Pre-hospital equipment/procedures
14001.B001.01	Procedure date-time
14001.B003.	Narrative
14001.B0051.	Run number
14001.B006.	Agency ID
14001.B0065.	Vehicle ID
14001.B010.	Scene description
14001.B011.	Crew ID
14001.B011.01.	Skill level
14001.B011.02.	Procedure performed
14001.B012.	Observation
14001.B012.01.	Observation value pre-hospital condition Pupils Neck veins Skin
14001.B012.02.	Observation date-time

Emergency Room Care

14001.B015.	Time of triage
14001.B016.	Condition at triage
14001.B039.	ER procedures
14001.B039.01	Date/time of ED procedure order

Critical Care

14001.B070.	Vital signs/tracking variable date-time
14001.B070.01.	Tracking variable name
14001.B070.01.01.	Value Temp
14001.B070.01.02.	Unit Pulse rate Airway clear/obs Resp rate

Segment 14D: Therapies

14001.D001	Inpatient therapy
14001.D001.01	Date/time inpatient therapy starts
14001.D001.01.01	Date/time inpatient therapy ends
14001.D001.03	Inpatient therapy indication
14001.D001.01.15	Inpatient therapy results

Segment 14E: Operative Procedures

14001.E001	Patient arrival time
14001.E001.30.	Operation start time
14001.E001.32.	Operation complete time
14001.E001.69	Inpatient surgical procedure
14001.E001.69.001	Date/time of inpatient surgical procedure order
14001.E001.69.02	Inpatient surgical procedure results
14001.E001.75	Materials used

Segment 14F: Disposition

14001.F013.	Operative procedure
14001.F013.03.	Type (pri,sec,etc)
14001.F030	Inpatient discharge diagnosis code
14001.F030.01	Inpatient discharge diagnosis code status
14001.F036.	Etiology
14001.F036.1.	Type (pri,sec,etc)
14001.F040.	Disposition datetime
14001.F046.	Disposition type
14001.F050.	Disposition
14001.F053.	Departure date/time
14001.F056.	Follow-up action
14001.F066.	Condition on discharge/departure
14001.F069	Name of discharge functional independence measure (FIM)
14001.F069.01	Value of FIM Element
14001.F070.	Reason for discharge
14001.F076.	Disposition transport type
14001.F080.	Disposition destination
14001.F083.	Patient disposition instructions
14001.F105.	Narrative discharge summary

Segment 14G: Charges

14001.G002	Total encounter charges