ACS COT FIREARMS STUDY

Bridging the gaps: a multi-center, prospective study to improve our understanding of the individual and community level risk factors for non-lethal firearm injuries in the U.S

DATA DICTIONARY

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Funded by the National Collaborative on Gun Violence Research
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INTRODUCTION

The American College of Surgeons (ACS) Committee on Trauma was awarded a grant from the National Collaborative on Gun Violence Research (NCGVR) to study individual and community-level risk factors for firearm injuries treated at Level I and II TQIP centers across the US. The study, *Bridging the gaps: a multi-center, prospective study to improve our understanding of the individual and community level risk factors for non-lethal firearm injuries in the U.S*, aims to understand the circumstances and risk factors of non-lethal firearm injuries across urban communities and to identify potential modifiable factors. This dictionary defines the data elements that will be used for this study. **These data are reported using a data submission platform provided without cost by the ACS Trauma Quality Programs (TQP).**

PATIENT INCLUSION CRITERIA:

All patients who sustained a firearm injury, regardless of intent and regardless of whether the patient meets the *NTDS Patient Inclusion Criteria*.

NTDS DATA ELEMENTS:

For patients who meet the Patient Inclusion Criteria for this study but who do not meet the *NTDS Patient Inclusion Criteria*, the following NTDS data elements must be reported in addition to the data elements defined in this dictionary. Please reference the *2021 NTDS Data Dictionary*, revised November 2020, for full definitions:

- Patient's Home ZIP/Postal Code
- Date of Birth
- Age
- Age Units
- Race
- Ethnicity
- Sex
- Injury Incident Date
- Injury Incident Time
- Incident Location ZIP/Postal Code
- Transport Mode
- Other Transport Mode
- Pre-Hospital Cardiac Arrest
- ED/Hospital Arrival Date
- ED/Hospital Arrival Time
- Initial ED/Hospital Pulse Rate
- Initial ED/Hospital Systolic Blood Pressure
- Initial ED/Hospital GCS-Eye
- Initial ED/Hospital GCS-Verbal
- Initial ED/Hospital GCS-Motor
- Initial ED/Hospital GCS-Total
- Initial ED/Hospital GCS-Assessment Qualifiers
- Initial ED/Hospital GCS-40 Eye
- Initial ED/Hospital GCS-40 Verbal
- Initial ED/Hospital GCS-40 Motor
- Drug Screen
- Alcohol Screen
- Alcohol Screen Results
- ED Discharge Disposition
- ED Discharge Date
- ED Discharge Time
- Alcohol Use Disorder
- Substance Use Disorder
- AIS Code
- AIS Version
- Primary Method of Payment

COMMON NULL VALUES

DEFINITION

These values are to be used with each of the data elements described in this document which have been defined to accept the null values.

ELEMENT VALUES

1. Not Applicable
2. Not Known/Not Recorded

ADDITIONAL INFORMATION

- Not Applicable (NA): This null value applies if, at the time of patient care documentation, the information requested was not applicable to the patient, the hospitalization or the patient care event. For example, the ***Patient Caregiver*** data element should only be reported on patients 18 years of age or younger. If the patient is over 18 years of age, “Not Applicable” should be entered for this element.

- Not Known/Not Recorded (NK/NR): This null value applies if, at the time of patient care documentation, information was not known (to the patient, family, health care provider) or no value for the element was recorded for the patient. This documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, “Not Known/Not Recorded” should be entered when there is no information available to determine whether or not the patient had ***Firearm Ownership or Access***.

EMPLOYMENT STATUS

DEFINITION

Employment and/or student status of the patient at the time of injury.

ELEMENT VALUES

1. Employed
2. Homemaker
3. Unemployed
4. Unreported employment
5. Student
6. Retired
7. Disabled

ADDITIONAL INFORMATION

- Select all that apply.
- Only report on patients 19 years of age or older.
- Report “Not Applicable” for patients 18 years of age or younger.
- **Element Value Definitions:**
    - *Element Value* “1. Employed” indicates the patient has a full or part-time job or occupation.
    - *Element Value* “2. Homemaker” indicates the patient is not employed and primarily performs activities around the home (cleaning, cooking, laundry) and caregiving of other family members.
    - *Element Value* “3. Unemployed” indicates the patient does not have a paid, formal job but is available for employment and/or seeking employment.
    - *Element Value* “4. Unreported employment” refers to jobs or activities sometimes referred to as “off the books” or “cash under the table.” These roles are often not reported to the government or taxable, and often not protected by safety, protection, or other labor laws. Examples include babysitting or informal childcare, day farm or construction labor, migrant farm work, illicit labor (prostitution, dealing illicit substances), and housework or yardwork not associated with an employer.
    - *Element Value* “5. Student” indicates the patient is participating in formal education at any age (high school, college, adult education), whether full-time or part-time.
    - *Element Value* “6. Retired” indicates the patient was formerly employed but is now retired from their primary occupation. They may also have new employment or part-time jobs (indicating both employed and retired).
    - *Element Value* “7. Disabled” indicates the patient receives disability support due to an injury or medical condition that limits the ability to work.

DATA SOURCE HIERARCHY GUIDE

1. Face Sheet
2. Billing Sheet
3. History & Physical

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other valid value
2	Element cannot be *Element Value* “2. Homemaker” along with *Element Value* "1. Employed" or "4. Unreported employment"
2	Element cannot be *Element Value* “3. Unemployed” along with *Element Value* "1. Employed" or "4. Unreported employment"

PATIENT CAREGIVERS

DEFINITION

Primary caregiver(s) for the patient at the time of injury.

ELEMENT VALUES

1. Parents
2. Single-mother
3. Single-father
4. Foster parent(s)
5. Grandparent(s)
6. Other family member
7. Other friend/adult
8. Facility (private or state)
9. Independent from caregivers

ADDITIONAL INFORMATION

- Select all that apply.
- Only report on patients 18 years of age or younger.
- The null value "Not Applicable" is reported for patients over 18 years of age.
- Caregivers must be individuals that the patient lives with and provides oversight and caregiving responsibilities. For instance, if the patient is living with a grandparent who provides the primary oversight but his or her parent has legal custody, the grandparent is the primary caregiver. More than one person may meet criteria for primary caregiver.
- **Element Value Definitions:**
    - *Element Value* "1. Parents" include biological, step and adoptive parents who provide the oversight and caregiving for the patient. They may or may not live together, but both provide caregiving to the patient and have shared living arrangements.
    - *Element Value* "2. Single-mother" indicates the patient's biological, step, or adoptive mother. The patient may have minimal contact with the father through limited visitation or overnight visits, but the father has a limited role in providing oversight or caregiving responsibilities.
    - *Element Value* "3. Single-father" indicates the patient's biological, step, or adoptive father. The patient may have minimal contact with the mother through limited visitation or overnight visits, but the mother has a limited role in providing oversight or caregiving responsibilities.
    - *Element Value* "4. Foster parent(s)" indicates the patient is being cared for by one or more foster parents.
    - *Element Value* "5. Grandparent(s)" indicates the patient is being cared for by one or more biologic, step, or adoptive grandparent. The patient may have limited contact with his or her mother or father with limited visitation or overnight visits, but the parents have a limited role in providing oversight or caregiving. Example:
        - He has lived with his grandmother ever since his mother died of cancer. His occasionally sees his dad but lives with and is cared for by his grandmother.

- *Element Value* “6. Other family member” indicates the patient is cared for by another biologic, step or adoptive family member(s) other than a parent or grandparent. Example:
    - His aunt and uncle have been raising him in their home after his dad went to prison when he was young, and his mom died.
- *Element Value* “7. Other friend/adult” indicates that the patient is cared for by a non-family member that might be a friend’s family or other adult that is not related to the patient or a foster parent. Example:
    - She was getting in arguments and in trouble at home. Her mom reportedly kicked her out and she had been living with her boyfriend’s family the past 3 months before he shot her.
- *Element Value* “8. Facility” indicates the patient is in the care of the state or a private facility such as a mandated group home, detention center, treatment center, jail or prison at the time of injury. Example:
    - The patient was living in a group home for special needs teenagers and was shot on the sidewalk after getting in a fight on the bus.
- *Element Value* “9. Independent from caregivers” indicates the patient primarily lives independently and cares for him or herself. This can be in the setting of being in the military, college, or living independently or with roommates but providing self-care. This also applies to teenagers who are runaways or homeless. Example:
    - He lives at the base where he has been in basic training since joining the military for the past 4 months when he shot himself.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Nursing notes
3. Physician notes
4. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be *Element Value* “8. Facility (private or state)”, “9. Independent from caregivers”, “Not Applicable” or “Not Known/Not Recorded” along with any other valid value

MILITARY STATUS

DEFINITION

Patient previously or currently serves in the U.S. Armed Forces.

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- Service includes membership in any of the 5 branches of the U.S. Armed Forces (Air Force, Army, Coast Guard, Marine Corps, Navy)

DATA SOURCE HIERARCHY GUIDE

1. Face sheet
2. Billing sheet
3. Admission form
4. History & Physical
5. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable”
1	Single Entry Max Exceeded

ETOH USE PRECEDING INJURY

DEFINITION
Patient consumed ETOH in the hours preceding the injury.

ELEMENT VALUES
1. Yes
2. No
3. Suspected alcohol use

ADDITIONAL INFORMATION
- **Element Value Definitions:**
  - *Element Value* "1. Yes" indicates that the alcohol level is positive (>0) at the time of presentation to the initial medical center after injury.
  - *Element Value* "3. Suspected alcohol use" indicates that the patient or witnesses report ETOH consumption in the hours preceding the incident (i.e. the patient had been drinking at a party prior to being shot), or there is circumstantial evidence of ETOH consumption prior to injury (i.e. EMS reported multiple empty bottles of alcohol scattered around the patient), but there was no ETOH level drawn.
- The hours preceding the injury can be interpreted broadly but should be within approximately the 6-8 hours before injury.

DATA SOURCE HIERARCHY GUIDE
1. Lab results
2. History & Physical
3. Triage/Trauma Flowsheet

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

MENTAL ILLNESS

DEFINITION
History of a diagnosis and/or treatment for mental illness at the time of injury, OR diagnosis of a mental illness during hospitalization.

ELEMENT VALUES
1. Yes
2. No

ADDITIONAL INFORMATION
- *Element Value* "1. Yes" indicates having a prior or current diagnosis, or reported treatment in the past year, of mental health disorder(s) listed in the medical record or reported by the patient or family member (unless it is specifically reported the illness has resolved). These include disorders and syndromes listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Examples of disorders include major depression, schizophrenia, bipolar disorder, post-traumatic stress disorder, obsessive compulsive disorder, generalized anxiety disorder, eating disorders, attention deficit / hyperactive disorder, personality disorders.
- **Exclude**: alcohol and other substance dependence or cognitive disorders.

DATA SOURCE HIERARCHY GUIDE
1. History & Physical
2. Physician notes
3. Nursing notes
4. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

MENTAL ILLNESS TYPE

Description
Patient's mental illness type(s).

Element Values
1. Major depression
2. Anxiety
3. Bipolar disorder
4. Post-traumatic stress disorder (PTSD)
5. Obsessive compulsive disorder (OCD)
6. Schizophrenia
7. Personality disorder
8. Eating disorder
9. Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)
10. Other DSM-5 Mental Illness

Additional Information
- Select all that apply.
- The null value "Not Applicable" is reported if ***Mental Illness*** is *Element Value* "2. No".
- The specific diagnosis must be written or listed in the medical record. Examples of documentation:
    - Her parents reported she was in a treatment program for anorexia last summer and in outpatient care with a psychiatrist for ongoing therapy for the eating disorder prior to her injury - Select *Element Value* "8. Eating disorder"
    - He was diagnosed with PTSD after returning from abroad where he served in combat- Select *Element Value* "4. Post-traumatic stress disorder (PTSD)"
    - Past medical history list includes anxiety, bipolar disorder – Select *Element Value* "2. Anxiety" and "3. Bipolar disorder"
- For cases in which the victim was noted as being treated for a mental health problem(s), but the actual diagnosis is not documented, report "Not Known/Not Recorded."

Data Source Hierarchy Guide
1. History & Physical
2. Physician notes
3. Nursing notes
4. Social work notes

Associated Edit Checks

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2	Element must be and can only be "Not Applicable" when ***Mental Illness*** is *Element Value* "2. No"
2	Element must be "Not Known/Not Recorded" when ***Mental Illness*** is "Not Known/Not Recorded"

COGNITIVE DISORDERS

DEFINITION

History of a diagnosis and/or treatment for cognitive disorders at the time of injury OR diagnosis of a cognitive disorder during hospitalization.

Element Values

1. Yes
2. No

Additional Information

- *Element Value* “1. Yes” indicates if the patient has a diagnosis of, or treatment in the past year for, a cognitive disorder that impairs cognitive function such as memory, decision-making and judgment not due to acute substance abuse. These can include dementia, neurologic or medical disorders, prior stroke or traumatic brain injury with residual cognitive effects, develop mental or intellectual disabilities, and syndromes that impact cognitive development (for example, Down syndrome).

  Example:
  - His wife reports that he started showing signs of dementia with memory loss and being more temperamental and “not himself” over the past few months. His family doctor recently told them he had dementia. He had a gun in his closet that he just grabbed before he shot himself.

Data Source Hierarchy Guide

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social work notes

Associated Edit Checks

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable”
1	Single Entry Max exceeded

ARREST AND/OR INCARCERATION

DEFINITION

Patient was previously incarcerated or arrested, or the patient is currently under arrest or incarcerated for a crime at the time of injury.

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- Include arrests regardless of guilt.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Social work notes
3. Nursing notes
4. Physician notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable”
1	Single Entry Max exceeded

PRIOR VIOLENT ASSAULTS OR INJURIES

DEFINITION
Patient experienced a violent assault or injury prior to the current firearm injury.

ELEMENT VALUES
1. Yes
2. No

ADITIONAL INFORMATION
- *Element Value* "1, Yes" indicates the patient has experienced a violent assault or injury with the use of physical force or power by someone else. This can include assaults that patient did not seek medical attention for but reported (i.e. a victim of intimate partner violence reporting being punched in the face resulting in a black eye in the past, but he/she did not seek medical care for). Examples:
  - She reports that her ex-boyfriend had kicked her and threatened her with a gun in the past.
  - The patient was noted to have a scar on the chest and a retained bullet in his chest on imaging. His father reports that he was shot by someone a year ago and hospitalized at another hospital.

DATA SOURCE HIERARCHY GUIDE
1. History & Physical
2. Physician notes
3. Nursing notes
4. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

PRIOR VIOLENT ASSAULT OR INJURIES TYPE

DEFINITION
Patient's prior violent assault or injuries type(s).

ELEMENT VALUES
1. Gunshot wound
2. Knife/stabbing
3. Sexual assault
4. Blunt
5. Strangulation or suffocation

ADDITIONAL INFORMATION
- Select all that apply.
- The null value "Not Applicable" is reported if ***Prior Violent Assaults or Injuries*** is *Element Value* "2. No".
- **Element Value Definitions:**
    - *Element Value* "1. Gunshot wound" indicates the patient experienced an injury due to being shot with a firearm.
    - *Element Value* "2. Knife/stabbing" indicates the patient experienced an injury due to a stabbing or puncture/penetration with another object.
    - *Element Value* "3. Sexual assault" indicates the patient experienced sexual contact that occurred without explicit consent including rape, attempted rape, forced unwanted sexual touching, and forced performance of sexual acts.
    - *Element Value* "4. Blunt" can include any injury or assault due to kicking, hitting with fists or another object, hitting with an automobile, or pushing. This may include being hit with a firearm (i.e. pistol whipping) but not shot.
    - *Element Value* "5. Strangulation or suffocation" includes choking or smothering that results in obstruction of airway.

DATA SOURCE HIERARCHY GUIDE
1. History & Physical
2. Physician notes
3. Nursing notes
4. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2	Element must be and can only be "Not Applicable" when ***Prior Violent Injuries*** is *Element Value* "2. No"
2	Element must be "Not Known/Not Recorded" when ***Prior Violent Injuries*** is "Not Known/ Not Recorded"

PRIOR SUICIDE ATTEMPT, THREAT OR SELF-HARM

DEFINITION

Patient has a history of self-harm behavior(s), suicide attempt(s), threat(s), or ideation.

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- *Element Value* "1. Yes" indicates that the patient, a family member, or caregiver indicates a history of self-harm suicide attempts or threats. It may also indicate that there is a prior event documented in the medical or psychiatric history within the medical record.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

PRIOR SUICIDE ATTEMPT, THREAT OR SELF-HARM TYPE

DEFINITION

Patient's prior suicide attempt, threat, or self-harm type(s).

ELEMENT VALUES

1. Suicide attempt(s)
2. Self-harm behavior(s)
3. Suicide threat(s)
4. Suicidal ideation

ADDITIONAL INFORMATION

- Select all that apply.
- The null value "Not Applicable" is reported if ***Prior Suicide Attempt, Threats, or Self-Harm*** is *Element Value* "2. No".
- **Element Value Definitions:**
    - *Element Value* "1. Suicide attempt" indicates the patient intended to end their life with an intentional, self-inflicted act (i.e. gunshot wound, stabbing, overdose, jump from a high surface, hanging, etc.) Example:
        - Her husband reports that she previously attempted suicide with a Tylenol overdose two years ago and was hospitalized before they moved.
    - *Element Value* "2. Self-harm behavior" indicates the patient has intended to hurt his or herself without the intention of ending his or her life (i.e. skin cutting). Example:
        - She started cutting herself when she was in middle school.
    - *Element Value* "3. Suicide threat" indicates the patient provided verbal or written indications that he or she was planning or has a plan to commit suicide. Example:
        - His wife reports that he had previously threatened he might kill himself a few times in the past couple years, but she never thought he would do it.
    - *Element Value* "4. Suicidal ideation" indicates the patient has thought about committing suicide without the expressed intent to do so or with a defined plan. Example:
        - The patient reported to the psychiatrist that she had thoughts of wanting to be dead and "end it" in the past, but she never had plans to do it.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2	Element must be and can only be "Not Applicable" when ***Prior Suicide Attempt, Threat, or Self-harm*** is *Element Value* "2. No"
2	Element must be "Not Known/Not Recorded" when ***Prior Suicide Attempt, Threat, or Self-harm*** is "Not Known/Not Recorded"

ADVERSE CHILDHOOD EXPERIENCE (ACE)

DEFINITION

Patient has experienced or is experiencing a significant adverse childhood event (ACE).

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- Only report on patients 18 years of age or younger.
- The null value “Not Applicable” is reported for patients over 18 years of age.
- These events can be reported by the patient, family members, caregivers, or clinical providers.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
1	Single Entry Max exceeded

ADVERSE CHILDHOOD EXPERIENCE(S) (ACEs) TYPE

DEFINITION

Patient's adverse childhood experience(s) (ACEs) type(s).

ELEMENT VALUES

1. Emotional abuse
2. Physical abuse
3. Sexual abuse / sexual assault
4. Mother treated violently (exposure to IPV)
5. Substance abuse in household
6. Mental illness in household
7. Parental separation or divorce
8. Incarcerated household member
9. Emotional neglect
10. Physical neglect

ADDITIONAL INFORMATION

- Select all that apply.
- Only report on patients 18 years of age or younger.
- The null value "Not Applicable" is reported for patients over 18 years of age.
- The null value "Not Applicable" is reported if ***Adverse Childhood Experience*** is *Element Value* "2. No".
- **Element Value Definitions:**
    - *Element Value* "1. Emotional abuse" indicates a parent, stepparent, or adult living in the home swore at, insulted, put down, or acted in a way that made the patient afraid that he or she might be physically hurt.
    - *Element Value* "2. Physical abuse" indicates a parent, stepparent, or adult living in the home pushed, grabbed, slapped, threw something at, or hit the patient so hard that the patient had marks or injury.
    - *Element Value* "3. Sexual abuse/sexual assault" indicates an adult, relative, family friend, or stranger who was at least 5 years older than the ever touched or fondled the patient in a sexual way, made the patient touch his/her body in a sexual way, attempted to have any type of sexual intercourse with the patient.
    - *Element Value* "4. Mother treated violently (exposure to IPV)" indicates the patient's mother or stepmother was pushed, grabbed, slapped, had something thrown at her, kicked, bitten, hit with a fist, hit with something hard, repeatedly hit for over at least a few minutes, or ever threatened or hurt by a knife or gun by the patient's father (or stepfather) or mother's boyfriend/dating partner.
    - *Element Value* "5. Substance abuse in the household" indicates a household member was a problem drinker or alcoholic or a household member used street drugs.
    - *Element Value* "6. Mental illness in the household" indicates a household member was depressed or mentally ill or a household member attempted suicide.
    - *Element Value* "7. Parental separation or divorce" indicates the patient's parents were ever separated or divorced.
    - *Element Value* "8. Incarcerated household member" indicates a household member went to prison.
    - *Element Value* "9. Emotional neglect" indicates the patient did not feel loved or cared for in the home that contributes to feelings of poor self-worth, and emotional needs and nurturing were not met by parents or primary caregivers.

- *Element Value* “10. Physical neglect” indicates the parents or caregivers did not provide food, clothing, shelter, medical care or education for a child when they have the means to do so.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2	Element must be and can only be “Not Applicable” when ***Adverse Childhood Experiences*** is “Not Applicable” or *Element Value* “2. No”
2	Element must be “Not Known/Not Recorded” when ***Adverse Childhood Experiences*** is “Not Known/Not Recorded”

TRAUMATIC EVENTS

DEFINITION

Patient has experienced or is experiencing a significant traumatic event.

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- The event can be reported by the patient, family members, caregivers or clinical providers.
- Applies to patients of all age groups and may be experienced during childhood and/or adulthood.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
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4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable”
1	Single Entry Max exceeded

TRAUMATIC EVENTS TYPE

DEFINITION

Traumatic events type(s).

ELEMENT VALUES

1. Major illness or injury
2. Previously or currently in child protective services
3. Exposure to community violence
4. Homelessness or housing insecurity
5. Food insecurity
6. Other Traumatic Event

ADDITIONAL INFORMATION

- Select all that apply.
- Applies to patients of all age groups. They may be experienced during childhood and/or adulthood.
- **Element Value Definitions:**
  - *Element Value* "1. Major illness or injury" indicates a patient has experienced a significant traumatic injury or illness that significantly impacted or continues to impact his or her baseline function or quality of life such as a severe traumatic brain injury, amputation, malignancy, etc.
  - *Element Value* "2. Previously or currently in child protective services" indicates the patient is or was removed from the home or primary caregivers by child protective services (CPS) during childhood for suspected abuse.
  - *Element Value* "3. Exposure to community violence" indicates the patient witnessed or heard gunshots or other forms of violent assault in the community (non-family) or knows a friend or family member who was injured or killed by community violence.
  - *Element Value* "4. Homelessness or housing insecurity" indicates the patient lacks a primary residence by rentorship or ownership defined by living on the streets (primary homelessness); moving between temporary shelters, including houses of friends, family and emergency accommodation (secondary homelessness); living in private boarding houses without a private bathroom and/or security of tenure (tertiary homelessness).
  - *Element Value* "5. Food insecurity" indicates the patient has limited or uncertain availability of nutritionally adequate and safe foods or limited or uncertain ability to acquire acceptable foods in socially acceptable ways (i.e. not able to afford or purchase food to sustain nutritional needs, thus obtaining from donations, exchanges or not meeting nutritional needs with malnutrition due to financial insecurities).

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
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ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2	Element must be and can only be “Not Applicable” when ***Traumatic Events*** is *Element Values* “2. No”
2	Element must be “Not Known/Not Recorded” ***Traumatic Events*** is “Not Known/Not Recorded”

FIREARM OWNERSHIP AND ACCESS

DEFINITION

Patient has access to a firearm that they own, is at their place of residence, or the residence of a close friend or family member.

ELEMENT VALUES

1. Yes
2. No

ADDITIONAL INFORMATION

- None

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

FIREARM OWNERSHIP AND ACCESS TYPE

DEFINITION

Firearm ownership and access type(s).

ELEMENT VALUES

1. Self (patient owns)
2. Family member or co-habitant in the place of residence that the patient lives owns
3. Family member or individual close to the patient in another place of residence owns

ADDITIONAL INFORMATION

- Select all that apply.
- The null value “Not Applicable” is reported if ***Firearm Ownership and Access*** is *Element Value* “2. No”.
- **Element Value Definitions:**
  - *Element Value* “1. Self (patient owns)” indicates the patient owns the firearm (regardless of legality). Examples:
    - He was hunting with his shotgun and inadvertently discharged the gun, shooting himself in the leg.
    - He was given the gun by someone in the neighborhood to keep.
  - *Element Value* “2. Family member or co-habitant in the place of residence that the patient lives owns” indicates someone that the patient lives with (family member, spouse, boyfriend, roommate, etc.) owns the firearm, whether this is in a formal residential home or apartment, or other residential setting (tent on the sidewalk, group home, etc.). Example:
    - She shot herself after getting in an argument with her son and grabbing her husband’s gun from the closet.
  - *Element Value* “3. Family member or individual close to the patient in another place of residence owns” indicates that someone outside of the residence of the patient owns the firearm and it was accessed outside of the patient’s home. Example:
    - She was staying with her best friend when they found a gun that belonged to her friend’s father. They were playing with it when it went off and injured her.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Physician notes
3. Nursing notes
4. Social Work notes

Associated Edit Checks

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2	Element must be and can only be "Not Applicable" when ***Firearm Ownership and Access*** is *Element Value* "2. No"
2	Element must be "Not Known/Not Recorded" when ***Firearm Ownership and Access*** is "Not Known/Not Recorded"

INTENT OF INJURY

DEFINITION

Intent of the gunshot wound injury.

ELEMENT VALUES

1. Assault
2. Self-inflicted (suicide attempt)
3. Unintentional
4. Law enforcement-related

ADDITIONAL INFORMATION

- Select all that apply.
- The following intents should be ascertained from the patient report, witness, or investigation (family, friend, police, EMS):
- **Element Value Definitions:**
  - *Element Value* "1. Assault" indicates the intentional use of a firearm against another person, group, or community.
  - *Element Value* "2. Self-inflicted" indicates the intentional use a firearm against oneself (i.e. suicide attempt).
  - *Element Value* "3. Unintentional" indicates a shooting that was not intended or directed (i.e. accidental).
  - *Element Value* "4. Law enforcement-related" indicates a shooting in which the patient is shot by a law enforcement officer or other peace officer (persons with specified legal authority to use deadly force), including military law enforcement, acting in the line of duty whether intentional or unintentional, justified or unjustified.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Known/Not Recorded" along with any other value
2	Element cannot be "Not Applicable"

SETTING OF INJURY

DEFINITION

Setting in which the gunshot wound injury took place.

ELEMENT VALUES

1. House, apartment, rooming house, including driveway, porch, yard, garage
2. Street/road, sidewalk, alley
3. Highway, freeway
4. Motor vehicle regardless of where motor vehicle is located (excluding school bus and public transit)
5. Bar, nightclub
6. Service station
7. Bank, credit union, ATM location
8. Liquor store
9. Other commercial establishment (i.e. grocery store, restaurant, retail outlet, laundromat) including their parking lots
10. Industrial or construction areas (i.e. factory, warehouse)
11. Office building
12. Parking lot / public parking garage
13. Abandoned house, building or warehouse
14. Sports or athletic arena (i.e. stadium, baseball field, gymnasium, recreation center)
15. School bus
16. Childcare center, daycare, preschool
17. Elementary school, middle school (i.e., K-8) including school dormitory, residential school
18. High school, including school dormitory, residential school
19. College/University, including dormitory, fraternity/sorority
20. Unspecified school
21. Public transportation or station (e.g., bus, train, plane, airport, depot, taxi)
22. Synagogue, church, temple
23. Hospital or medical facility
24. Supervised residential facility (e.g., shelter, halfway house, group home)
25. Farm
26. Jail, prison, detention facility
27. Park, playground, public use area
28. Natural area (e.g., field, river, beaches, woods)
29. Hotel/motel
30. Railroad tracks (other than on public transportation (21) or within station)
31. Bridge
32. Cemetery, graveyard, or other burial ground

ADDITIONAL INFORMATION

- None

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"
1	Single Entry Max exceeded

RELATIONSHIP TO SHOOTER

DEFINITION

Relationship of the shooter or perpetrator that is responsible for injuring the patient.

ELEMENT VALUES

1. Patient (self)
2. Acquaintance or friend
3. Known assailant but relationship not disclosed
4. Stranger
5. Intimate partner or ex-partner
6. Co-worker
7. Family member (non-intimate partner)
8. Law enforcement officer

ADDITIONAL INFORMATION

- Select all that apply except for *Element Value* "1. Patient (self)" or *Element Value* "3. Stranger" which must be submitted without any other values.
- **Element Value Definitions:**
    - *Element Value* "2. Acquaintance or friend" indicates the patient was shot by someone he or she knew that was considered a friend or known acquaintance in a social setting (neighbor, basketball team member, classmate, etc.). Example:
        - He was shot by someone he knew and played poker with every week after they got into an argument during the game.
    - *Element Value* "3. Known assailant but relationship not disclosed" indicates situations in which the patient indicates he or she knows the shooter but does not disclose who it is or the relationship of the shooter. Example:
        - When I asked if he knew who shot him, he shook his head and said 'yes' and said it was someone that had threatened him in the past, but he would not provide the perpetrators name or how he knew him.
    - *Element Value* "4. Stranger" indicates the patient and/or witnesses saw the assailant and the suspect is not known to the patient. Example:
        - He was walking down the street and encountered a fight that broke out and saw someone with a gun but doesn't know the shooter.
    - *Element Value* "5. Intimate partner or ex-partner" indicates the shooter is a current or former spouse, boyfriend or girlfriend, or dating partner.
      Example:
        - He was at home with girlfriend and reported they got into an argument after drinking at a party and she shot him.
    - *Element Value* "6. Co-worker" indicates the patient was shot by a co-worker or former co-worker from their place of employment. Example:
        - She was shot when a former co-worker came into the warehouse and started shooting people. He was reportedly laid off the week prior.

- *Element Value* “7. Family member (non-intimate partner)” indicates the patient was shot by a family member that does not include their intimate partner, including biologic, adoptive or family members through marriage (i.e. step-brother, sister-in-law). Example:
    - Her family reports she was shot by her cousin unintentionally when playing with a firearm.
- *Element Value* “8. Law enforcement officer” indicates an officer/representative in law enforcement that may commit a firearm assault, whether intentional or unintentional, justifiable or non-justifiable, while performing duties related to his or her job in law enforcement, and is only reported when Intent of Injury is *Element Value* “4. Law enforcement-related”. Example:
    - Officers who dropped off the patient reported they got in a shoot-out with the patient after he kidnapped his daughter, and he was shot by an officer during the event.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be *Element Value* “1. Patient (Self)”, “4. Stranger”, or “Not Known/Not Recorded” along with any other value
2	Element cannot be “Not Applicable”
2	Element must be *Element Value* “8. Law enforcement office” when ***Intent of Injury*** is *Element Value* “4. Law enforcement-related”

TYPE OF FIREARM USED

DEFINITION

Type of firearm used to injure the patient.

Element Values

1. Handgun
2. Shotgun
3. Rifle
4. BB or pellet gun

Additional Information

- Select all that apply
- *Element Value* "3. Rifle" can include all types of rifles, including semi-automatic and automatic rifles.

Data Source Hierarchy Guide

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

Associated Edit Checks

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Known/Not Recorded" along with any other value
2	Element cannot be "Not Applicable"

OWNER OF FIREARM USED

DEFINITION

Owner of the firearm that was used to injure the patient.

ELEMENT VALUES

1. Patient (self)
2. Intimate partner
3. Other family member
4. Acquaintance, friend or colleague
5. Stranger

ADDITIONAL INFORMATION

- Only submit when ***Intent of Injury*** is *Element Value* “2. self-inflicted (suicide attempt)” or “3. Unintentional.”
- The null value “Not Applicable” is reported if ***Intent of Injury*** is only *Element Value* “1. Assault” or “4. Law enforcement-related."

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element must be and can only be “Not Applicable” when ***Intent of Injury*** is only *Element Value* “1. Assault” or “4. Law enforcement-related”
1	Single Entry Max exceeded

FIREARM STORAGE

DEFINITION
Method of firearm security and storage at the time of injury.

ELEMENT VALUES
1. Locked in gun safe, lockbox, or gun lock
2. Locked in a stored unit (i.e. drawer, glove box, etc.) that is not specifically meant for firearm storage
3. Unlocked

ADDITIONAL INFORMATION
- Only submit when ***Intent of Injury*** is *Element Value* “2. self-inflicted (suicide attempt)” or “3. Unintentional.”
- The null value “Not Applicable” is reported if ***Intent of Injury*** is *Element Value* “1. Assault” or “4. Law enforcement-related."
- This is in reference to the firearm implicated in the injury.
- **Element Value Definitions:**
    - *Element Value* “1. Locked in gun safe, lockbox, or gun lock” indicates the firearm is stored in a designated firearm safe, gun lock, or lockbox device. Example:
        - Her husband reports that she kept her handgun locked in a gun safe. After they got in an argument she just went upstairs, opened it and shot herself with the gun.
    - *Element Value* “2. Locked in a stored unit (i.e. drawer, glove box, etc.) that is not specifically meant for firearm storage” indicates the firearm is kept in a locked area that is not a specified firearm safety/storage device such as a locked drawer, closet or glovebox. Example:
        - His parents found him shot in their bedroom with the gun they kept in their locked bedside drawer.
    - *Element Value* “3. Unlocked” indicates the firearm is kept in an accessible location without a lock or restrictive device (i.e. under a bed, drawer, closet, purse, unlocked glovebox of car). Example:
        - The 8-year-old brother found a gun that was kept in his mom’s purse and accidentally shot his sister when playing with the gun.
- The null value “Not Applicable” is reported if ***Intent of Injury*** is *Element Value* “1. Assault” or “4. Law enforcement-related."

DATA SOURCE HIERARCHY GUIDE
1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element must be and can only be "Not Applicable" when ***Intent of Injury*** is *Element Value* "1. Assault" or "4. Law enforcement-related"
1	Single Entry Max exceeded

CONTEXT OF INJURY- ASSAULT

DEFINITION

The context in which the assault-related injury was sustained.

ELEMENT VALUES

1. Community violence
2. Bystander
3. Interpersonal altercation
4. Drug related
5. Intimate partner violence (direct or indirect victim)
6. Family violence
7. Mass shooting
8. Random
9. Hate crime
10. Intervening
11. Law enforcement shot in line of duty
12. Commission of a crime
13. Sexual Assault
14. Robbery

ADDITIONAL INFORMATION

- Select all that apply.
- The null value "Not Applicable" is reported when ***Intent of Injury*** does not include *Element Value* "1. Assault."
- **Element Value Definitions:**
  - *Element Value* "1. Community violence" indicates the patient was shot due to intentional acts of interpersonal violence committed in public areas by individuals who are not intimately related to the victim. Examples of this type of violence include gang disputes, drive-by shootings, brawls, and shootings that take place at school or in the neighborhood. Example:
    - He was shot in a drive-by-shooting while on his porch after a group of teenagers drove by and started shooting at him.
  - *Element Value* "2. Bystander" indicates the patient was injured by a gunshot when another person or people were targeted for injury. Example:
    - She was standing at the light rail station waiting for a train and someone started shooting at another person and hit the patient as she was trying to run away.
  - *Element Value* "3. Interpersonal altercation" indicates the patient was shot in an altercation, disagreement or dispute with a stranger, acquaintance, or friend and was shot in the setting or as a result of a dispute. Example:
    - He got in a car accident with someone else. Apparently, they got in an argument and the person in the other car shot him on the side of the road.
  - *Element Value* "4. Drug-related" indicates the patient was shot in the setting of an illicit substance transaction or dispute. Example:
    - The police report he was shot when someone came to his home for a drug transaction.

- *Element Value* “5. Intimate partner violence (direct or indirect victim)” (IPV) indicates the patient was shot by a current or former intimate partner (spouse, fiancé, girlfriend/ boyfriend) ex-partner, or stalker, or the patient was shot in an IPV-related shooting (i.e. a child, friend or family member). Example:
  - She was shot outside her workplace by her ex-boyfriend who she had recently left.
- *Element Value* “6. Family violence” indicates the patient was shot by a member of the family in an altercation that is not the intimate partner or ex-partner of the patient, nor was it related to IPV. Example:
  - He was shot by his uncle when he got angry at him while watching a football game.
- *Element Value* “7. Mass shooting” indicates the patient is shot during a shooting in which 4 or more people are shot. Example:
  - She was shot with five other family members by her ex-husband who had been threatening her. (This would also qualify as IPV as well).
- *Element Value* “8. Random” indicates an act in which the suspect is not concerned with who is being harmed, just that someone is being harmed, such as a person who shoots randomly at passing cars from a highway bridge. Example:
  - He and his wife were shot when someone just came into a store and started firing at people at random.
- *Element Value* “9. Hate crime” indicates the patient was shot due to actual or perceived gender, religion, sexual orientation, race, ethnicity. Example:
  - She was shot by a man outside a bar after he found out she was transgender and started yelling homophobic slurs at her.
- *Element Value* “10. Intervening” indicates the patient was shot trying to protect or inter vene on another person being attacked or threatened. Example:
  - He was shot when he jumped on someone that was threatening to shoot a woman on a bus.
- *Element Value* “11. Law enforcement shot in line of duty” indicates any officer or security guard shot while working in such capacity. Example:
  - He is a police officer who was shot by someone at a protest.
- *Element Value* “12. Commission of a crime” indicates the patient was shot while reportedly committing a crime such as a robbery, assault, etc. (not by a law enforcement officer). Example:
  - He was shot by a homeowner after he had reportedly broken into the house attempting to steal something.
- *Element Value* "13. Sexual assault" indicates the patient was shot while being a victim of a sexual assault or rape. Example:
  - The patient was threatened with a firearm while being sexually assaulted and shot while trying to escape.
- *Element Value* "14. Robbery" indicates the patient was shot while being robbed (including car-jacking). Example:
  - He was held up after going to the ATM and shot while being robbed.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Known/Not Recorded” along with any other value
2	Element cannot be “5. Intimate partner violence (direct or indirect victim)” or “6. Family Violence” when ***Relationship to Shooter*** is *Element Value* “4. Stranger”
2	Element must be and can only be “Not Applicable” when ***Intent of Injury*** is not *Element Value* “1. Assault”

CONTEXT OF INJURY- SELF-INFLICTED

DEFINITION

The circumstances that preceded the self-inflicted injury.

ELEMENT VALUES

1. Intoxication
2. Declining mental illness
3. Cognitive impairment (other than acute in toxication)
4. Declining medical or physical condition
5. Personal crisis
6. Murder-suicide attempt

ADDITIONAL INFORMATION

- Select all that apply.
- The null value “Not Applicable” is reported when ***Intent of Injury*** does not include *Element Value* “2. Self-inflicted (suicide attempt)."
- **Element Value Definitions:**
    - *Element Value* “1. Intoxication” indicates the patient was under the influence of an illicit substance or ETOH as indicated by a positive toxicity screen (illicit substance, ETOH level >0.08) or reported by the patient or witness. Example:
        - He had been drinking heavily at a party and recently felt “stressed.” He went home and shot himself after. He said he had no recollection of the event and had not felt or expressed suicidal ideation before this.
    - *Element Value* “2. Declining mental illness” indicates the patient was experiencing major depression, psychosis, or another mental health crisis at the time of injury as indicated by the patient, witnesses (family, intimate partner), or as documented by clinicians in the medical record. E.g. She had been struggling with depression to the point where she would barely leave the house and had been making comments that she would be better off dead recently. Examples:
        - He reported he had been increasingly depressed and withdrawn from friends and family. He had been seeing a psychiatrist and on medications, but felt he wasn’t getting better and commented that he just wanted to die.
        - The patient was recently diagnosed with schizophrenia and heard voices to kill himself.
    - *Element Value* “3. Cognitive impairment (other than acute intoxication)” indicates the patient was experiencing impaired judgement or memory due to a medical or neurocognitive disorder (i.e. dementia, effects from a prior traumatic brain injury). Example:
        - He had become more confused, angry, and impulsive as his dementia progressed, and was agitated saying things that didn’t make sense the day he shot himself.
    - *Element Value* “4. Declining medical or physical condition” indicates the patient has a debilitating or terminal medical or physical condition that leads them to attempt suicide. Example:
        - She was recently diagnosed with stage IV colon cancer and started her treatments. She left a note prior to shooting herself that she didn’t want to go through treatments and wanted to die on her own terms.

- *Element Value* “5. Personal crisis” can include a divorce, argument, financial distress, threat of arrest, loss of employment, loss of a loved one, loss of a home that may precede the self-inflicted injury (i.e., had a bad argument the day before the incident, divorce papers served that day, or victim laid off the week before) or be an impending event (i.e. house was to be foreclosed on the day after the incident or court date for a criminal offense three days after the suicide). Crisis should be interpreted from the eyes of the victim. This is particularly relevant for young victims whose crises, such as a bad grade or a dispute with parents over a curfew, may appear to others as relatively minor. Examples:
  - Five days prior to the suicide attempt, the patient was questioned about his suspected sexual abuse of his two nephews by police.
  - A 15-year-old adolescent had a heated argument with his mother, stormed out of the room, and shot himself.
  - The patient attempted suicide the day her husband told her he was leaving her for another woman.
- *Element Value* “6. Murder-suicide attempt” indicates the patient attempted to kill him or herself after assaulting or murdering another individual. Example:
  - Patient went to his workplace and shot two other people before turning the gun on himself.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. Lab results
3. EMS run report
4. Trauma/Triage Flowsheet
5. Physician notes
6. Nursing notes
7. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be “Not Applicable” or “Not Known/Not Recorded” along with any other value
2	Element must be and can only be “Not Applicable” when ***Intent of Injury*** is not *Element Value* “2. Self-inflicted (suicide attempt)”

CONTEXT OF INJURY-UNINTENTIONAL

DEFINITION

Context in which the unintentional injury was sustained.

ELEMENT VALUES

1. Handling
2. Playing with gun
3. Hunting
4. Gun fell or discharged when presence of firearm was unknown
5. Celebration
6. Target or sport shooting
7. Training to use a firearm

ADDITIONAL INFORMATION

- Select all that apply.
- The null value "Not Applicable" is reported when ***Intent of Injury*** does not include *Element Value* "3. Unintentional".
- **Element Value Definitions:**
  - *Element Value* "1. Handling" indicates situations in which the shooter is intending to pick up a gun, remove it from a holster or pants/belt, clean or load it. Example:
    - He had a gun concealed and tucked in his waist belt of the pants and unintentionally shot himself when he pulled it out.
  - *Element Value* "2. Playing with gun" indicates events when a child or adult is pretending to use the firearm in acts of imitation or play without the intent of firing it. Example:
    - The patient and her brother found a gun in a box in the garage and the brother accidentally shot her while playing with it.
  - *Element Value* "3. Hunting" indicates the patient was shot when the shooter was intending to shoot an animal for the purpose of hunting, or there was an inadvertent discharge while hunting. Example:
    - He was hunting and he unintentionally discharged the gun when taking it off his shoulder to shoot.
  - *Element Value* "4. Gun fell or discharged when the presence of firearm was unknown" indicates the patient was shot from an accidental discharge when being unaware of the presence of the firearm. For instance, the gun was in a bag or on a shelf and it discharged when an individual reached for another item, or a first responder was assisting an injured or altered individual that had a firearm on his or her presence. Example:
    - She was pulling down a bag from a shelf in her closet and a handgun fell off the shelf, discharging and shooting her.
  - *Element Value* "5. Celebration" indicates firing of a gun in the air for celebratory purposes such as celebrating a sports win, birthday, holiday or other celebratory event. Example:
    - He was hit with a bullet when his neighbors were firing guns in the air celebrating a football game.

- *Element Value* "6. Target or sport shooting" indicates situations when the patient is shot while at a shooting range or other setting (such as shooting at targets in a field) where firearms are used for sport. Example:
    - He was in a field with friends target shooting and a bullet ricocheted of a metal post and hit him.
- *Element Value* "7. Training to use a firearm" indicates situations when the patient is shot in settings where individuals are learning how to shoot or handle firearms such as a concealed carry course, firearm training at a private range or place of employment (such as police academy, law enforcement or military training center), or a friend or family member teaching an individual how to use a firearm. Example:
    - He is a police officer and was at a tactical training course with firearms and was unintentionally shot by a fellow officer.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable" or "Not Known/Not Recorded" along with any other value
2	Element must be and can only be "Not Applicable" when ***Intent of Injury*** is not *Element Value* "3. Unintentional"

CONTEXT OF INJURY DESCRIPTION

DEFINITION

Description of patient's Context of Injury.

ELEMENT VALUES

- Free text description

ADDITIONAL INFORMATION

- Briefly describe the events/circumstances at the time of injury. This may include a few sentences describing the preceding circumstances leading up to or contributing to the injury, the relationship of the perpetrator, the setting of injury, or other details surrounding the incident. These details can be accumulated from multiple areas of the medical record. Example of a description you might write:
    - She had recently move out of an apartment she shared with her boyfriend and had obtained a protective order against him for domestic violence that included physical violence and threats. She was treated previously in the ED for blunt trauma to the face. She reported that he had firearms and had threated her in the past with them but didn't know if they were confiscated by police. She was now living with her sister. After getting off work as a teacher he shot her on the porch of her sister's house and then reportedly shot and killed himself.
- **Exclude:** names, specific locations (street addresses), dates or any personally identifying information.

DATA SOURCE HIERARCHY GUIDE

1. History & Physical
2. EMS run report
3. Trauma/Triage Flowsheet
4. Physician notes
5. Nursing notes
6. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be "Not Applicable"

FUNCTIONAL STATUS

DEFINITION

The maximum level of functional status the patient achieved at the time of discharge.

ELEMENT VALUES

1. Unable to perform basic activities of daily living
2. Basic activities of daily living
3. Instrumental activities of daily living
4. Advanced activities of daily living

ADDITIONAL INFORMATION

- The null value "Not Applicable" is reported if the patient expired prior to being discharged from the hospital.
- **Element Value Definitions:**
    - Element Value "1. Unable to perform basic activities of daily living" indicates the patient is unable to perform even basic activities and requires assistance for these functions.
    - Element Value "2. Basic activities of daily living" indicates the patient had the ability to perform basic self-care activities (eating, dressing, bathing, toileting)
    - Element Value "3. Instrumental activities of daily living" indicates the patient had the ability to live independently (housework, cooking, laundry, managing transportation)
    - Element Value "4. Advanced activities of daily living" indicates the patient had the ability to fulfill societal, community, and family roles and participate in recreational or occupational tasks

DATA SOURCE HIERARCHY GUIDE

1. Physical therapy notes
2. Occupational therapy notes
3. Physician notes
4. Nursing notes
5. Discharge summary

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
1	Single Entry Max exceeded

REHABILITATION/POST-DISCHARGE NEEDS

DEFINITION

Rehabilitation services the patient was recommended to receive at the time of discharge.

ELEMENT VALUES

1. None
2. Inpatient sub-acute rehabilitation
3. Outpatient physical therapy
4. Outpatient occupational therapy
5. Outpatient speech therapy
6. Outpatient rehabilitation medicine

ADDITIONAL INFORMATION

- Select all that apply.
- The null value “Not Applicable” is reported if the patient expired prior to being discharged from the hospital.

DATA SOURCE HIERARCHY GUIDE

1. Discharge summary
2. Physical therapy notes
3. Occupational therapy notes
4. Case management notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be *Element Value* “1. None”, “Not Applicable”, or “Not Known/Not Recorded” along with any other valid value

HOME HEALTH NEEDS

DEFINITION

Home health needs recommended at the time of discharge.

ELEMENT VALUES

1. None
2. Home health nursing
3. Wound care
4. Infusion therapy
5. Rehabilitation therapies

ADDITIONAL INFORMATION

- Select all that apply.
- The null value "Not Applicable" is reported if the patient expired prior to being discharge from the hospital.
- **Element Value Definitions:**
    - *Element Value* "1. Home health" indicates services that are received in the home or place of residence after a patient is discharged.
    - *Element Value* "2. Home health nursing" indicates services received in the home that includes services such as medication management, vital sign monitoring, chronic disease management, family teaching and hospice.
    - *Element Value* "3. Wound care" indicates specific services by a wound care nurse or specialist for the care of traumatic, surgical, pressure, and other types of wounds.
    - *Element Value* "4. Infusion therapy" indicates specialized services for administration of IV medications, fluids, or nutrition.
    - *Element Value* "5. Rehabilitation therapies" indicates physical therapy, occupational therapy, or speech therapy.

DATA SOURCE HIERARCHY GUIDE

1. Discharge summary
2. Physical therapy notes
3. Occupational therapy notes
4. Case management notes
5. Social work notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be *Element Value* "1. None", "Not Applicable", or "Not Known/Not Recorded" along with any other valid value

PSYCHOSOCIAL ANCILLARY SERVICES

DEFINITION

Additional services recommended at the time of discharge for psychosocial needs.

ELEMENT VALUES

1. None
2. Social work or case manager
3. Child protective services
4. Psychologist
5. Psychiatry
6. Hospital or community-based violence intervention programs
7. Intimate partner violence services
8. Housing services (shelter, transitional housing)

ADDITIONAL INFORMATION

- Select all that apply.
- The null value "Not Applicable" is reported if the patient expired prior to being discharge from the hospital.

DATA SOURCE HIERARCHY GUIDE

1. Discharge summary
2. Social work notes
3. Physician notes

ASSOCIATED EDIT CHECKS

Level	Message
2	Element cannot be blank
2	Element cannot be *Element Value* "1. None", "Not Applicable", or "Not Known/Not Recorded" along with any other valid value