



**WISCONSIN DEPARTMENT**  
*of* **HEALTH SERVICES**

**Wisconsin State Trauma Registry**

**Data Dictionary**

**Version 5.2**

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**Applicable to admissions starting**

**January 1, 2018**

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## About this Data Dictionary

The primary purpose of this Data Dictionary is to assist Wisconsin trauma registrars in reporting trauma cases to the Wisconsin Trauma Care System (WTCS). If questions arise and are unable to be answered from the materials provided in this data dictionary or other resources cited within, please contact [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov).

This is the 2018 edition of the dictionary and incorporates changes in requirements from the National Trauma Data Bank (NTDB); the Wisconsin Trauma Care System; and any changes in data entry resulting from updates by the state trauma registry vendor.

DHS 118.09 provides the authority for the Department of Health Services to collect and analyze trauma system data to evaluate the delivery of adult and pediatric trauma care, develop injury prevention strategies for all ages, and provide resources for research and education. DHS 118.09(3) directs all hospitals, ambulance service providers and first responder services to submit data to the department on a quarterly basis determined by the department.

The purpose of Wisconsin's Trauma Care System is to reduce death and disability resulting from traumatic injury. The data in the trauma registry is used for performance improvement activities at the state, regional and local level.

This document is created, updated, and maintained by the Department of Health Services, Division of Public Health, Office of Health Informatics. Updated versions of this document may be released throughout a calendar year; however the inclusion criteria and required data elements will only be updated on an annual basis and will not change throughout the year.

# Wisconsin State Trauma Registry

## Inclusion Criteria

**Applicable to patients admitted: January 1, 2018 to December 31, 2018**

Level I, II, III, & IV trauma centers will submit data from their trauma registries for all patients meeting the following criteria:

### *Glossary to Flow Chart:*

1

Patients with an activated trauma level/code are included in the Wisconsin Trauma Registry, regardless of any injuries.

2

The patient must have sustained at least one of the following injury diagnostic codes defined as follows:

- International Classification of Diseases, Tenth Revision (ICD-10-CM):
- S00-S99 with 7<sup>th</sup> character modifiers of A, B, or C ONLY. (Injuries to specific body parts – initial encounter)
- T07 (Unspecified multiple injuries)
- T14 (injury of unspecified body region)
- T20-T28 with 7<sup>th</sup> character modifier of A ONLY (burns by specific body parts – initial encounter)
- T30-T32 (burn by TBSA percentages)
- T7.A1-T79.A9 with 7<sup>th</sup> character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)

**AND**

3

Excluding the following isolated injuries

- S00 (Superficial injuries of the head)
- S10 (Superficial injuries of the neck)
- S20 (Superficial injuries of the thorax)
- S30 (Superficial injuries of the abdomen, pelvis, lower back and external genitals)
- S40 (Superficial injuries of shoulder and upper arm)
- S50 (Superficial injuries of elbow and forearm)
- S60 (Superficial injuries of wrist, hand and fingers)
- S70 (Superficial injuries of hip and thigh)

- S80 (Superficial injuries of knee and lower leg)
- S90 (Superficial injuries of ankle, foot and toes)

Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7th digit modifier code of D through S, are also excluded.

## AND

4

Must include one of the following in addition to steps 2 & 3

- **Hospital admission as defined by your facility specific trauma registry inclusion criteria**
  - \*NOTE patients transferred into your facility and/or admitted to rule out traumatic injury are not required if it is determined the patient had a non-traumatic diagnosis. However, if rule 1 applies, the patient is still included in the system.
    - **EXAMPLE:** A patient is admitted due to suspicion of a possible head injury from a traumatic encounter. However, after further evaluation it is determined this patient experienced a CVA. If Rules 1, 2, and 3 do not apply to this patient, their inclusion is not required.

## OR

- **Death resulting from the traumatic injury, independent of hospital admission or transfer status**

## OR

- **Patient transfer via EMS transport from one hospital to another**
  - Including air ambulance

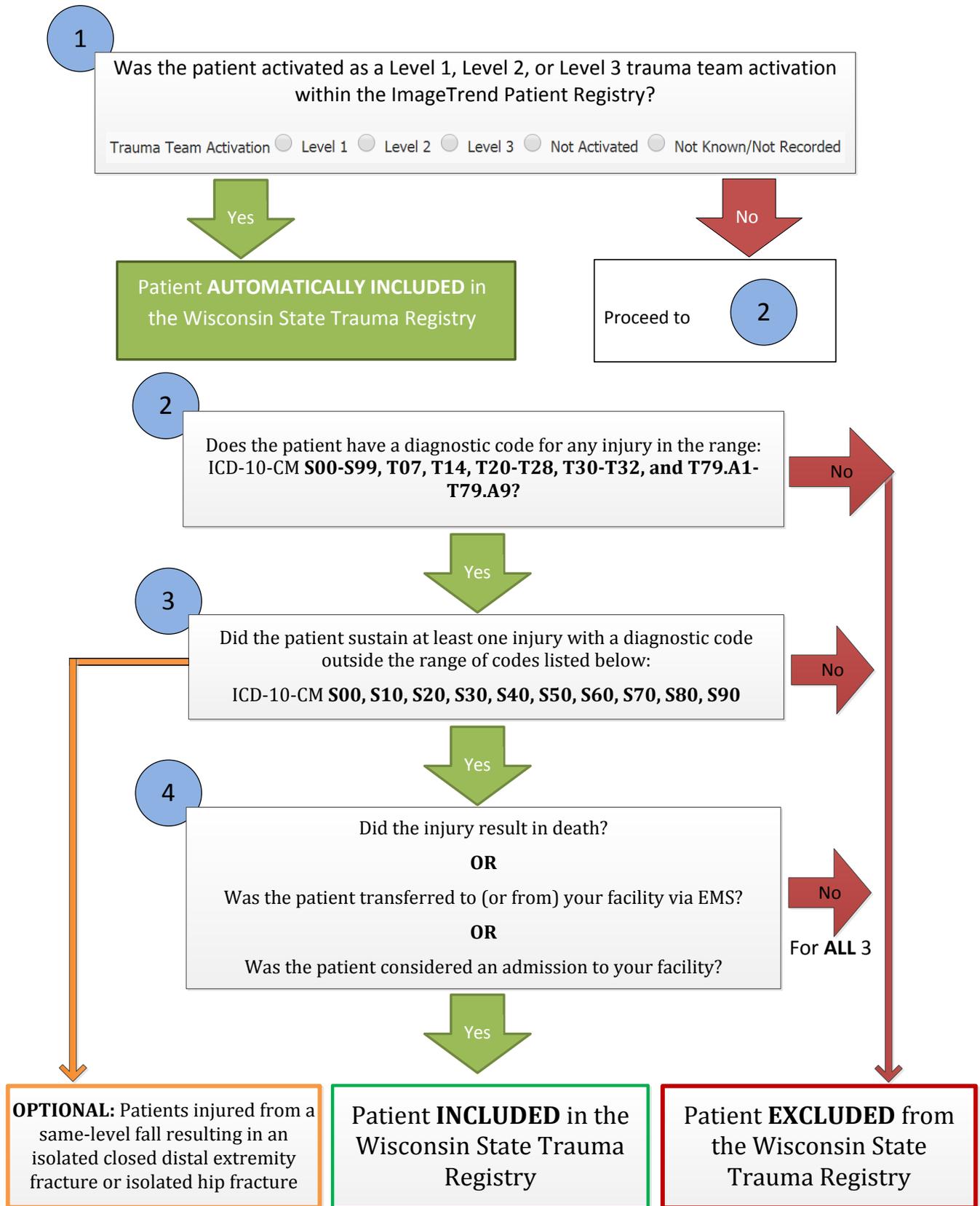
## OPTIONAL

Falls from same level resulting in an isolated closed distal extremity fracture or isolated hip fractures are included at the discretion of individual facilities. While these injuries may meet the NTDB inclusion criteria, Wisconsin is not requiring their inclusion at this time

Facilities may determine to include patients in their registry that meet their facility inclusion criteria. Examples of acceptable additional criteria include:

1. Suicide attempts with superficial self-inflicted cuts
2. Hangings
3. Patients who are transferred from another facility for trauma care, via private vehicle, walk-ins or police transported patients.

# 2018 Inclusion Criteria Flowchart



## Common Null Values

These values are to be used as the null Values:

1. Not Applicable applies if, at the time of the patient care documentation, the information requested was “Not Applicable” to the patient. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transport to the hospital.
2. Not Known/Not Documented/Not Recorded/Unknown are interchangeable: This null value applies if, at the time of patient care documentation, information was “not known” to the patient, family, healthcare provider or no value for the element was recorded for the patient. This null value should be used in situations when the documentation was incomplete or missing.

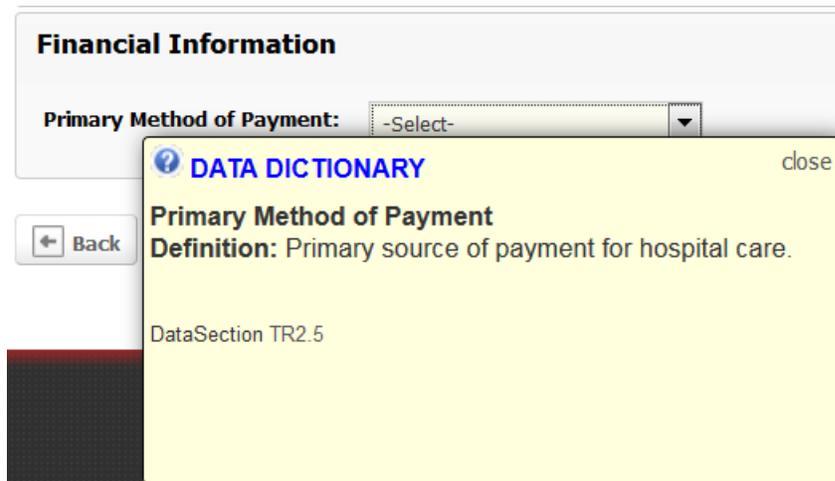
The fields that all hospitals participating in the Wisconsin Trauma System must complete are listed as Wisconsin Core fields. Fields above and beyond “Core” fields are optional and may be collected at the discretion of the individual facilities.

The data elements listed within this document are available for either direct user entry, or auto-population based on the information collected. Any element not listed in this document is either not currently required by the State of Wisconsin, or does not allow for direct entry within the ImageTrend system.

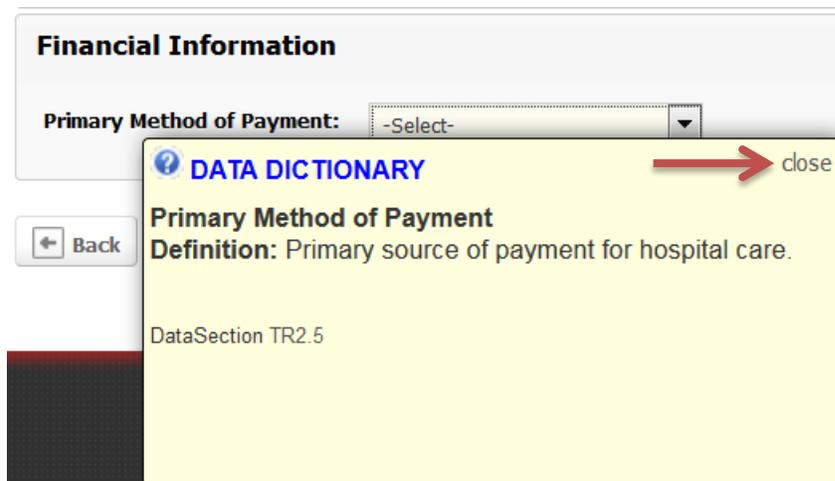
## Definitions in the Data Entry Form

All definitions contained in this data dictionary are available on all data entry forms within the Wisconsin Trauma Registry. If a data element does not have a definition, please notify [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov). To view an element's definition within the data entry form, perform the following. The below example locates the element definition for TR2.5, Primary Method of Payment:

1. Enter the data entry form and locate your desired data element
2. Select the title of the data element



3. To return to the data entry form, select "close" in the definition window



# Dictionary Element Legend

This data dictionary contains required fields for 2018 diagnoses. The data items on the following pages are listed by category. Each data item description contains:

Current Dictionary Version #

Data Dictionary Section and Element #

<b>STATE</b>	Will appear if the element is required by the State of Wisconsin
<b>NTDB</b>	Will appear if the element is required by the NTDB
<b>3RD PARTY</b>	Will appear if the element is required for upload by 3 <sup>rd</sup> parties

## ImageTrend Tab Location; Element Number; Element Title

### Definition

The definition of the data element, as shown on the data entry form within the ImageTrend registry

### Field Values

Lists all available values for data element entry

### Additional Information

Any additional information about the data element

### Data Source Hierarchy Guide

Lists the appropriate sources for this information

### Associated Edit Checks (NTDB)

If the element is NTDB required, the associated validity rules will be displayed here.

# **SECTION A:**

National Trauma Data Bank (NTDB) Elements

STATE

NTDB

3RD PARTY

## Demographics TR1.20 – Patient ZIP

### Definition

The Patient’s Home Zip/Postal Code of primary residence.

### Field Values

Relevant value for data element

### Additional Information

- Can be stored as a 5 or 9 digit code (XXXXX-XXXX) for US and Canada, or can be stored in the postal code format of the applicable country.
- May require adherence to HIPAA regulations
- If ZIP/Postal Code is “Not Applicable”, complete variable: Alternate home residence.
- If ZIP/Postal Code is “Not Known/Not Recorded”, complete variables Patient’s Home Country, Patient’s Home State (US only), Patient’s Home County (US only) and Patient’s Home City (US only)
- If ZIP/Postal code is known, must also complete Patient’s Home Country
- Not Known is indicated by typing “99999”

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0001	1	Invalid value
0002	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Demographics TR1.19 - Patient's Home Country

### Definition

The country where the patient resides

### Field Values

Relevant value for data element (two digit alpha country code)

### Additional Information

- Selections are made from a dropdown menu
- Values are country names (e.g., United States)
- If a patient's home country is not United States, then the null value "Not Applicable" is used for: Patient's home state, patient's home county, and patient's home city.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0101	1	Invalid Value
0102	2	Field cannot be blank
0104	2	Field cannot be Not Applicable
0105	2	Field cannot be Not Known/Not recorded when Home Zip/Postal Code is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded

STATE

NTDB

3RD PARTY

## Demographics TR1.23 - Patient's Home State

### Definition

The State (territory, province, or District of Columbia) where the patient resides.

### Field Values

Relevant value for data element (two digit numeric FIPS code)

### Additional Information

- Only completed when ZIP/Postal Code is "Not Known/Not Recorded" and country is US.
- Used to calculate FIPS code.
- Element will default to Wisconsin when ZIP is 99999

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0201	1	Invalid Value
0202	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Demographics TR1.22 - Patient's Home County

### Definition

The patient's county (or parish) of residence

### Field Values

Relevant value for data element (three digit numeric FIPS code)

### Additional Information

- Only completed when ZIP/Postal code is "Not Known/Not Recorded" and country is US.
- Used to calculate FIPS code.
- When ZIP is 99999, element will populate as "Not Known".

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0301	1	Invalid Value
0302	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Demographics TR1.21 - Patient's Home City

### Definition

The patient's city (or township, or village) of residence.

### Field Values

Relevant value for data element (five digit FIPS code)

### Additional Information

- Only completed when ZIP code is "Not Recorded/Not Known."
- Used to calculate FIPS code.
- When ZIP is 99999, element will populate as "Not Known"

### Data Source Hierarchy Guide

1. ED Admission Form
2. Billing Sheet /Medical Records Coding Summary Sheet
3. EMS Run Sheet
4. Triage Form/ Trauma Flow Sheet
5. ED Nurse's Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0401	1	Invalid Value
0402	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Demographics TR1.13 - Alternate Residence

### Definition

Documentation of the type of patient without a Home ZIP/Postal code.

### Field Values

1. Homeless
2. Undocumented Citizen
3. Migrant Worker

### Additional Information

- Only completed when ZIP/Postal code is “Not Applicable”
- Homeless is defined as a person who lacks housing. The definition also includes a person living in transitional housing or a supervised public or private facility providing temporary living quarters.
- Undocumented citizen is defined as a national of another country who has entered or stayed in another country without permission.
- Migrant worker is defined as a person who temporarily leaves his/her principal place of residence within a country in order to accept seasonal employment in the same or different country.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0501	1	Value is not a valid menu option
0502	2	Field cannot be blank

STATE

NTDB

3RD PARTY

**Demographics TR1.7 - Date of Birth****Definition**

The patient's date of birth

**Field Values**

Relevant value for data element

**Additional Information**

- Collected as MM-DD-YYYY
- If date of birth is Unknown, leave blank and complete variables Age and Age Units
- If date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.
- Used to calculate patient age in minutes, hours, days, months, or years.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. Case Management/Social service notes

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
0601	1	Invalid Value
0602	1	Date out of range
0603	2	Field cannot be blank
0605	3	Field should not be Not Known/Not Recorded
0606	2	Date of Birth is later than EMS Dispatch Date
0607	2	Date of Birth is later than EMS Unit Arrival on Scene Date
0608	2	Date of Birth is later than EMS Unit Scene Departure Date
0609	2	Date of Birth is later than Injury Date
0610	2	Date of Birth is later than ED Discharge Date
0611	2	Date of Birth is later than Hospital Discharge Date
0612	2	Date of Birth + 120 years must be less than Injury Date
0613	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Demographics TR1.12 – Patient Age****Definition**

The Patient's age at the time of Injury (Best approximation)

**Field Values**

Relevant value for data element

**Additional Information**

- Auto-calculated unless date of birth is unknown or is the same as date of ED Arrival. If date of birth is not known, leave blank.
- Used to calculate patient age in minutes, hours, days, months or years.
- If date of birth is “not known/not recorded” complete variables Age and Age Units
- If date of birth equals ED/Hospital Arrival Date, then the age and Age Units variables must be completed.
- Must also complete variable: Age Units.

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
0701	1	Age is outside the valid range of 0 – 120
0703	2	Field cannot be blank
0704	3	Injury Date minus Date of Birth should equal submitted Age as expressed in the Age Units specified.
0705	4	Age is greater than expected for the Age Units specified. Age should not exceed 60 minutes, 24 hours, 30 days, 24 months, or 120 years. Please verify this is correct.
0707	2	Field must be Not Applicable when Age units is Not Applicable
0708	2	Field must be Not Known/Not Recorded when Age Units is Not Known/Not Recorded

STATE

NTDB

3RD PARTY

## Demographics TR1.14 –Age Units

### Definition

This is the unit of measure associated with age

### Field Values

1. Hours
2. Days
3. Months
4. Years
5. Minutes

### Additional Information

- Age Units is either auto-populated using the date of birth and the incident injury date or is manually entered when either the Date of Birth is unknown or the patient arrives on the first day of life.
- Used to calculate patient age in minutes, hours, days, months, or years
- If Date of Birth is “Not Known/Not Recorded”, complete variables age and age units
- If Date of Birth equals ED/Hospital Arrival Date, then the Age and Age Units variables must be completed.
- Must also complete variable: Age

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
0801	1	Value is not a valid menu option
0803	2	Field cannot be blank
0805	2	Field must be Not Applicable when Age is Not Applicable
0806	2	Field must be Not Known/Not Recorded when Age is Not Known/Not Recorded

STATE

NTDB

3RD PARTY

**Demographics TR1.16 - Race****Definition**

The patient's race

**Field Values**

1. Asian
2. Native Hawaiian or Other Pacific Islander
3. Other Race
4. American Indian
5. Black or African American
6. White
7. Not Known/Not Recorded

**Additional Information**

- Patient race should be based on self-report or identified by a family member
- Based on the 2010 US Census Bureau.
- Select all that apply.
- Hispanic is not a race. If the Race is not documented or unknown, you should report "Not Known/Not Recorded"

**Data Source Hierarchy Guide**

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow sheet
5. EMS Run Report
6. History & Physical

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
0901	1	Value is not a valid menu option
0902	2	Field cannot be blank
0903	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Demographics TR1.17 - Ethnicity

### Definition

The patient's ethnicity

### Field Values

1. Hispanic or Latino
2. Not Hispanic or Latino
3. Not Known/Not Recorded

### Additional Information

- Patient ethnicity should be based upon self-report of identified by a family member.
- The maximum number of ethnicities that may be reported for an individual patient is 1.
- Based on the 2010 US Census Bureau

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet.
5. History & Physical
6. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
1001	1	Value is not a valid menu option
1002	2	Field cannot be blank
1003	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Demographics TR1.15 - Sex

### Definition

The patient's sex

### Field Values

1. Male
2. Female
3. Not Known/Not Recorded

### Additional Information

- Patients who have undergone a surgical and/or hormonal sex reassignment should be coded using the current assignment
- This field cannot be not applicable

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet.
5. History & Physical
6. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
1101	1	Value is not a valid menu option
1102	2	Field cannot be blank
1103	2	Field cannot be Not Applicable

## **NTDS INJURY INFORMATION**

STATE

NTDB

3RD PARTY

## Demographics TR5.1 – Incident Injury Date

### Definition

The date the injury occurred

### Field Values

Relevant value for data element

### Additional Information

- Collected as MM-DD-YYYY
- Estimates of date of injury should be based on report by patient, witness, family or healthcare provider. Other Proxy measures (e.g., 911 call times) should not be used.
- If not known, leave blank.

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
1201	1	Date is not valid
1202	1	Date out of range
1203	2	Field cannot be blank
1204	4	Injury Incident Date is earlier than Date of Birth
1205	4	Injury Incident Date is later than EMS Dispatch Date
1206	4	Injury Incident Date is later than EMS Unit Arrival on Scene Date
1207	4	Injury Incident Date is later than EMS Unit Scene Departure Date
1208	4	Injury Incident Date is later than ED/Hospital Arrival Date
1209	4	Injury Incident Date is later than ED Discharge Date
1210	4	Injury Incident Date is later than Hospital Discharge Date
1211	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Demographics TR5.18 – Incident Injury Time****Definition**

The time the injury occurred

**Field Values**

Relevant value for data element

**Additional Information**

- Collected as HH:MM Military time.
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g., 911 call times) should not be used.
- If not known, leave blank.

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
1301	1	Time is not valid
1302	1	Time out of range
1303	2	Field cannot be blank
1304	4	Injury Incident Time is later than EMS Dispatch Time
1305	4	Injury Incident Time is later than EMS Unit Arrival on Scene Time
1306	4	Injury Incident Time is later than EMS Unit Scene Departure Time
1307	4	Injury Incident Time is later than ED/Hospital Arrival Time
1308	4	Injury Incident Time is later than ED Discharge Time
1309	4	Injury Incident Time is later than Hospital Discharge Time
1310	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Injury TR2.10 – Work Related****Definition**

Indication of whether the injury occurred during paid employment

**Field Values**

1. Yes
2. No
3. Not Known/Not Recorded

**Additional Information**

- If work related, two additional data fields must be completed: Patient’s Occupational Industry and Patient’s Occupation.
- Selecting “Yes” will show Occupational Industry (TR2.6) and Occupation (TR2.11)

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet
5. Billing Sheet

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
1401	1	Value is not a valid menu option
1402	2	Field cannot be blank
1405	4	Work-Related should be 1 (Yes) when Patient’s Occupation is not “Not Applicable” or “Not Known/Not Recorded”
1406	4	Work-Related should be 1 (Yes) when Patient’s Occupational Industry is not “Not Applicable” or “Not Known/Not Recorded”
1407	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Injury TR2.6 – Occupational Industry

### Definition

The occupational industry associated with the patient’s work environment.

### Field Values

- |  |                                  |
|--|----------------------------------|
| 1. Finance, Insurance, and Real Estate | 9. Government                    |
| 2. Manufacturing                       | 10. Natural Resources and Mining |
| 3. Retail Trade                        | 11. Information Services         |
| 4. Transportation and Public Utilities | 12. Wholesale Trade              |
| 5. Agriculture, Forestry, Fishing      | 13. Leisure and Hospitality      |
| 6. Professional and Business Services  | 14. Other Services               |
| 7. Education and Health Services       | 15. Not Applicable               |
| 8. Construction                        | 16. Not Known/Not Recorded       |

### Additional Information

- Only Completed if injury is work-related
- If Work related, also complete Patient’s Occupation
- Element will default to Not Applicable is used if not work related.

### Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
1501	1	Value is not a valid menu option
1504	2	Field cannot be blank

**PATIENT'S OCCUPATIONAL INDUSTRY:** The occupational history associated with the patient's work environment.

*Field Value Definitions:*

**Finance and Insurance** -The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:

- 1.Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
- 2.Pooling of risk by underwriting insurance and annuities.
- 3.Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

**Manufacturing** -The Manufacturing sector comprises establishments engaged in the mechanical, physical, or chemical transformation of materials, substances, or components into new products. Establishments in the Manufacturing sector are often described as plants, factories, or mills and characteristically use power-driven machines and materials-handling equipment. However, establishments that makes new products by hand, such as bakeries, candy stores, and custom tailors, may also be included in this sector.

**Retail Trade** -The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public.

This sector comprises two main types of retailers:

1. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
2. Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

**Transportation and Public Utilities** -The Transportation and Warehousing sector includes industries providing transportation of passengers and cargo, warehousing and storage for goods, scenic and sightseeing transportation, and support activities related to modes of transportation. The Utilities sector comprises establishments engaged in the provision of the following utility services: electric power, natural gas, steam supply, water supply, and sewage removal.

**Agriculture, Forestry, Fishing** -The Agriculture, Forestry, Fishing and Hunting sector comprises establishments primarily engaged in growing crops, raising animals, harvesting timber, and harvesting fish and other animals from a farm, ranch, or their natural habitats. The establishments in this sector are often described as farms, ranches, dairies, greenhouses, nurseries, orchards, or hatcheries.

**Professional and Business Services** -The Professional, Scientific, and Technical Services sector comprises establishments that specialize in performing professional, scientific, and technical activities for others. These activities require a high degree of expertise and training. The establishments in this sector specialize according to expertise and provide these services to clients in a variety of industries and, in some cases, to households. Activities performed include: legal advice and representation; accounting, bookkeeping, and payroll services; architectural, engineering, and specialized design services; computer services; consulting services; research

services; advertising services; photographic services; translation and interpretation services; veterinary services; and other professional, scientific, and technical services.

**Education and Health Services** -The Educational Services sector comprises establishments that provide instruction and training in a wide variety of subjects. This instruction and training is provided by specialized establishments, such as schools, colleges, universities, and training centers. These establishments may be privately owned and operated for profit or not for profit, or they may be publicly owned and operated. They may also offer food and/or accommodation services to their students. The Health Care and Social Assistance sector comprises establishments providing health care and social assistance for individuals. The sector includes both health care and social assistance because it is sometimes difficult to distinguish between the boundaries of these two activities.

**Construction** -The construction sector comprises establishments primarily engaged in the construction of buildings or engineering projects (e.g., highways and utility systems). Establishments primarily engaged in the preparation of sites for new construction and establishments primarily engaged in subdividing land for sale as building sites also are included in this sector. Construction work done may include new work, additions, alterations, or maintenance and repairs.

**Government** – Civil service employees, often called civil servants or public employees, work in a variety of fields such as teaching, sanitation, health care, management, and administration for the federal, state, or local government. Legislatures establish basic prerequisites for employment such as compliance with minimal age and educational requirements and residency laws.

**Natural Resources and Mining** -The Mining sector comprises establishments that extract naturally occurring mineral solids, such as coal and ores; liquid minerals, such as crude petroleum; and gases, such as natural gas. The term mining is used in the broad sense to include quarrying, well operations, beneficiating (e.g., crushing, screening, washing, and flotation), and other preparation customarily performed at the mine site, or as a part of mining activity.

**Information Services** -The Information sector comprises establishments engaged in the following processes:

- (a) producing and distributing information and cultural products,
- (b) providing the means to transmit or distribute these products as well as data or communications,
- (c) processing data.

**Wholesale Trade** -The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The merchandise described in this sector includes the outputs of agriculture, mining, manufacturing, and certain information industries, such as publishing.

**Leisure and Hospitality** -The Arts, Entertainment, and Recreation sector includes a wide range of establishments that operate facilities or provide services to meet varied cultural, entertainment, and recreational interests of their patrons. This sector comprises (1) establishments that are involved in producing, promoting, or participating in live performances, events, or exhibits intended for public viewing; (2) establishments that preserve and exhibit objects and sites of historical, cultural, or educational interest; and (3) establishments that operate facilities or provide services that enable patrons to participate in recreational activities or pursue amusement, hobby, and leisure-time interests. The Accommodation and Food Services sector comprises establishments

providing customers with lodging and/or preparing meals, snacks, and beverages for immediate consumption. The sector includes both accommodation and food services establishments because the two activities are often combined at the same establishment.

**Other Services** -The Other Services sector comprises establishments engaged in providing services not specifically provided for elsewhere in the classification system. Establishments in this sector are primarily engaged in activities, such as equipment and machinery repairing, promoting or administering religious activities, grant-making, advocacy, and providing dry-cleaning and laundry services, personal care services, death care services, pet care services, photofinishing services, temporary parking services, and dating services.

STATE

NTDB

3RD PARTY

## Injury TR2.11 – Occupation

### Definition

The occupation of the patient

### Field Values

- |   |   |
|---|---|
| 1. Business and Financial Operations Occupations      | 12. Management Occupations                        |
| 2. Architecture and Engineering Occupations           | 13. Computer and Mathematical Occupations         |
| 3. Community and Social Services Occupations          | 14. Life, Physical and social science occupations |
| 4. Education, Training and Library Occupations        | 15. Legal Occupations                             |
| 5. Healthcare Practitioners and Technical Occupations | 16. Arts, Design, Entertainment, Sports and Media |
| 6. Protective Service Occupations                     | 17. Healthcare support Occupations                |
| 7. Building and Grounds Cleaning and Maintenance      | 18. Food Preparation and Serving Related          |
| 8. Sales and Related Occupations                      | 19. Personal Care And Service Occupations         |
| 9. Farming, fishing and forestry occupations          | 20. Office and Administrative Support Occupations |
| 10. Installation, maintenance and repair occupations. | 21. Construction and Extraction Occupations       |
| 11. Transportation and Material moving occupations    | 22. Production Occupations                        |
|   | 23. Military Specific Occupations                 |
|   | 24. Not Applicable                                |
|   | 25. Not Known/Not Recorded                        |

### Additional Information

- Only Completed if injury is work-related
- If Work related, also complete Patient’s Occupation
- Based on 1999 US Bureau of Labor Statistics Standard Occupational Classification
- Not Applicable is used if not work related

### Data Source Hierarchy Guide

1. Billing Sheet
2. Face Sheet
3. Case Management/Social Services Notes
4. EMS Run Report
5. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
1601	1	Value is not a valid menu option
1604	2	Field cannot be blank

STATE

NTDB

3RD PARTY

**Injury TR200.3 – ICD-10 Primary External Cause Code; Additional External Cause Code**

**Definition**

External Cause code used to describe the mechanism (or external factor) that caused the injury event

**Field Values**

Relevant ICD-10-CM code value for injury event

**Additional Information**

- The primary external cause code should describe the main reason a patient is admitted to the hospital.
- External cause codes are used to auto-generate two calculated fields: Trauma Type (Blunt, Penetrating, Burn) and intentionality (Based upon CDC Matrix)
- ICD-10-CM codes will be accepted for this data element. Activity codes should not be reported in this field.
- ImageTrend does not have separate elements for Primary and Secondary External cause codes. Both primary and secondary codes should be entered into this field.

**Data Source Hierarchy Guide**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
8901	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
8902	2	Field cannot be blank
8904	2	Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10 CM only)
8905	3	ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)
8906	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)
8907	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Injury TR200.5 – ICD-10 Place of Occurrence External Cause Code

### Definition

Place of occurrence external cause code used to describe the place/site/location of the injury event (Y92.x).

### Field Values

Relevant ICD-10-CM code value for injury event

### Additional Information

- Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code
- Multiple Cause Coding Hierarchy: If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:
  - External cause codes for child and adult abuse take priority over all other external cause codes
  - External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse
  - External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism
  - External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism
  - The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical
5. Progress Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9001	1	Invalid value (ICD-10 CM only)
9002	2	Field cannot be blank
9003	3	Place of Injury code should be Y92.X/Y92.XX/Y92.XXX (where X is (A-Z [Excluding I,O] or 0-9) (ICD-10 CM only)
9004	1	Invalid value (ICD-10 CA only)
9005	3	Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)
9006	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Injury TR5.6 – Incident Location ZIP/Postal Code

### Definition

The ZIP/Postal code of the incident location

### Field Values

Relevant value for data element

### Additional Information

- Can be stored as a 5 of 9 Digit code (XXXXX-XXXX)
- If “Not Applicable” or “Not Recorded/Not Known,” complete variables: Incident State (US Only), Incident County (US only), Incident City (US only) and Incident Country.
- May require adherence to HIPAA regulations.
- If ZIP/Postal code is known, then must complete incident Country.
- Not Known is indicated by typing “99999”

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2001	1	Invalid value
2002	2	Field cannot be blank
2006	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Injury TR5.11 – Incident Country

### Definition

The country where the patient was found or to which the unit responded (or best approximation)

### Field Values

Relevant value for data element (two digit alpha country code)

### Additional Information

- Only completed when incident location ZIP code is “Not Applicable” or “Not Recorded/Not Known”
- Values are two character fields representing a country (e.g., US)

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2101	1	Invalid value
2102	2	Field cannot be blank
2104	2	Field cannot be Not Applicable
2105	2	Field cannot be “Not Known/Not Recorded” when Incident Location ZIP/Postal code is not “Not Known/Not Recorded”

STATE

NTDB

3RD PARTY

## Injury TR5.7 – Incident State

### Definition

The state, territory, or province where the patient’s injury occurred was found or to which the unit responded (or best approximation).

### Field Values

Relevant value for data element (two digit numeric FIPS code)

### Additional Information

- Only completed when Incident Location ZIP code is “Not Applicable” or “Not Recorded/Not Known”
- Used to calculate FIPS code
- Element will default to Wisconsin when ZIP is 99999

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. ED Nurses’ Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2201	1	Invalid value
2203	2	Field cannot be blank

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NTDB

3RD PARTY

## Injury TR5.9 – Incident County

### Definition

The county or parish where the patient was found or to which the unit responded (or best approximation)

### Field Values

Relevant value for data element (three digit FIPS code)

### Additional Information

- Only completed when incident location zip is “Not Applicable” or “Not recorded/Not Known”
- Used to calculate FIPS code.
- The null value “Not Applicable” is used if incident Location ZIP/Postal Code is reported.

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. ED Nurses’ Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2301	1	Invalid value
2303	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Injury TR5.10 – Incident City

### Definition

The city or township where the patient was found or to which the unit responded

### Field Values

Relevant value for data element (five digit numeric FIPS code)

### Additional Information

- Only completed when Incident Location ZIP/Postal code is “Not Applicable” or “Not Known/Not Recorded/Unknown” and country is US
- Used to calculate FIPS code
- If Incident location resides outside of formal city boundaries, report nearest city/town.
- The null value “Not Applicable” is used if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value “Not Applicable”
- When ZIP is “99999”, element will populate as “Not Known”

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2401	1	Invalid value
2403	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Injury – Protective Devices, Airbag Deployment, Child Specific Restraint

### Definition

Protective devices (Safety Equipment) in use or worn by the patient at the time of the injury.

### Field Values & Data Elements

#### TR 29.24: Protective Devices

1. None
2. Three Point Restraint
3. Lap Belt
4. Personal Flotation Device
5. Protective Non-Clothing Gear (e.g., shin guard)
6. Eye Protection,
7. Child Care Restraint (booster seat or child car seat)
8. Helmet
9. Airbag Present
10. Protective Clothing
11. Shoulder Belt
12. Other
13. Not Known/Not Recorded

#### TR 29.32: Airbag Deployment

1. Airbag Deployed Front
2. Airbag Deployed Other
3. Airbag Deployed Side
4. Airbag Not Deployed
5. Not Applicable
6. Not Known/Not Recorded

#### TR 29.31: Child Specific Restraint

1. Child Booster Seat
2. Child Car Seat
3. Infant Car Seat
4. Not Known/Not Recorded

### Additional Information

- Check all that apply.
- Hold the control key to select multiple items within the software.
- Evidence of the use of safety equipment may be reported or observed.

- Lap belt should be used to include those patients that are restrained but not further specified.
- Evidence of the use of air bag deployment may be reported or observed.
- Airbag deployed front should be used for patients with documented airbag deployments, but are not further specified.
- Selecting Airbag Present will display Airbag Deployment (TR29.32).
- Selecting Child Restraint (booster seat or child car seat) will display Child Specific Restraint (TR29.31).
- When Three Point Restraint is selected, Lap Belt and Shoulder Belt will auto-select.

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2501	1	Value is not a valid menu option
2502	2	Field cannot be blank
2505	3	Protective Device should be 6 (Child Restraint) when Child Specific Restraint is not "Not Applicable" or "Not Known/Not Recorded"
2506	3	Protective Device should be 8 (Airbag Present) when Airbag Deployment is not "Not Applicable" or "Not Known/Not Recorded"
2507	2	Field cannot be Not Applicable

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NTDB

3RD PARTY

## Injury TR41.1 – Report of Physical Abuse

### Definition

A report of suspected physical abuse was made to law enforcement and/or protective services.

### Field Values

1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information

This includes, but is not limited to, a report of child, elder, spouse or intimate partner physical abuse.

### Data Source Hierarchy Guide

1. Case Management/Social Service Notes
2. ED Records
3. Progress Notes
4. Discharge Summary
5. History & Physical
6. Nursing Notes/Flow Sheet
7. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9201	1	Value is not a valid menu option
9202	2	Field cannot be Not Applicable
9203	2	Filed cannot be blank

STATE

NTDB

3RD PARTY

## Injury TR41.2 – Investigation of Physical Abuse

### Definition

An investigation by law enforcement and/or protective services was initiated because of the suspected physical abuse.

### Field Values

1. Yes
2. No
3. Not Applicable
4. Not Known/Not Recorded

### Additional Information

- This includes, but is not limited to, a report of child, elder, spouse or intimate partner abuse
- Only complete when report of physical abuse is yes.
- The null value of “Not Applicable” defaults where Report of Physical Abuse is no.

### Data Source Hierarchy Guide

1. Case Management/Social Service Notes
2. ED Records
3. Progress Notes
4. Discharge Summary
5. History & Physical
6. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9301	1	Value is not a valid menu option
9302	2	Field cannot be blank
9303	3	Field should not be Not Applicable when Report of Physical Abuse = 1 (Yes)

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NTDB

3RD PARTY

## Injury TR41.3 – Caregiver at Discharge

### Definition

The patient was discharged to a caregiver different than the caregiver at admission due to suspected physical abuse.

### Field Values

1. Yes
2. No
3. Not Applicable
4. Not Known/Not Recorded

### Additional Information

- Only complete when report of Physical abuse (Injury tab) is yes
- Only complete for patients less than 18 year of age, excluding emancipated minors.
- The Null Value “Not Applicable” defaults where report of Physical abuse is “No”
- The null value “Not Applicable” should be used if the patient expires prior to discharge.

### Data Source Hierarchy Guide

1. Case Management/Social Service Notes
2. Progress Notes
3. Discharge Summary
4. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9401	1	Value is not a valid menu option
9402	2	Field cannot be blank

# **NTDS PRE-HOSPITAL INFORMATION**

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NTDB

3RD PARTY

## Pre-Hospital TR9.1 – EMS Dispatched Date

### Definition

The date the unit transporting to your hospital was notified by dispatch.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as MM-DD-YYYY.
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- Leave blank for patients not transported by EMS

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2801	1	Date is not valid
2802	1	Date out of range
2803	3	EMS Dispatch Date is earlier than Date of Birth
2804	4	EMS Dispatch Date is later than EMS Unit Arrival on Scene Date
2805	4	EMS Dispatch Date is later than EMS Unit Scene Departure Date
2806	3	EMS Dispatch Date is later than ED/Hospital Arrival Date
2807	4	EMS Dispatch Date is later than ED Discharge Date
2808	3	EMS Dispatch Date is later than Hospital Discharge Date
2809	2	Field cannot be blank

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NTDB

3RD PARTY

## Pre-Hospital TR9.10 – EMS Dispatched Time

### Definition

The time the unit transporting to your hospital was notified by dispatch.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as HH:MM
- Used to auto-generate an additional calculated field: Total EMS Time (elapsed time from EMS dispatch to hospital arrival).
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility was notified by dispatch or assigned to this transport.
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene was dispatched.
- Leave blank for patients not transported by EMS

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
2901	1	Time is not valid
2902	1	Time out of range
2903	4	EMS Dispatch Time is later than EMS Unit Arrival on Scene Time
2904	4	EMS Dispatch Time is later than EMS Unit Scene Departure Time
2905	4	EMS Dispatch Time is later than ED/Hospital Arrival Time
2906	4	EMS Dispatch Time is later than ED Discharge Time
2907	4	EMS Dispatch Time is later than Hospital Discharge Time
2908	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR9.2 – EMS Arrive Scene Time

### Definition

The time the unit transporting to your hospital arrived on the scene.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as HH:MM military time.
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).
- Leave blank for patients not transported by EMS

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3101	1	Time is not valid
3102	1	Time out of range
3103	4	EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time
3104	4	EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time
3105	4	EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time
3106	4	EMS Unit Arrival on Scene Time is later than ED Discharge Time
3107	4	EMS Unit Arrival on Scene Time is later than Hospital Discharge Time
3108	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR9.3 – EMS Leave Scene Time

### Definition

The time the unit transporting to your hospital left the scene.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as HH:MM military time.
- Used to auto-generate two additional calculated fields: Total EMS Response Time (elapsed time from EMS dispatch to scene arrival) and Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the time at which the unit transporting the patient to your facility from the transferring facility departed the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the time at which the unit transporting the patient to your facility from the scene departed the scene (arrival is defined at date/time when the vehicle stopped moving).
- Leave blank for patients not transported by EMS

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3301	1	Time is not valid
3302	1	Time out of range
3303	4	EMS Unit Scene Departure Time is earlier than EMS Dispatch Time
3304	4	EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time
3305	4	EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time
3306	4	EMS Unit Scene Departure Time is later than the ED Discharge Time
3307	4	EMS Unit Scene Departure Time is later than Hospital Discharge Time
3308	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR8.10 – Transport Mode

### Definition

The Mode of Transport delivering the patient to your hospital

### Field Values

1. Ground Ambulance
2. Helicopter Ambulance
3. Fixed-Wing ambulance
4. Private/Public vehicle/Walk-in
5. Police
6. Other
7. Not Known/Not Recorded

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3401	1	Value is not a valid menu option
3402	2	Field cannot be blank
3403	4	Transport Mode should not be 4 (Private/Public Vehicle/Walk-in) when EMS response times are not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.67 – Initial Field Systolic Blood Pressure

### Definition

First recorded systolic blood pressure measured at the scene of injury.

### Field Values

Relevant value for the data element

### Additional Information

- Leave blank if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Leave blank for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- If Not Known/Not Recorded, leave blank

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks

Rule ID	Level	Message
3601	1	Invalid value
3602	2	Field cannot be blank
3603	3	SBP exceeds the max of 300

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.69 – Initial Field Pulse Rate

### Definition

First recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

### Field Values

Relevant value for the data element

### Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- Leave blank for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- If Not Known/Not Recorded, leave blank

### Data Source Hierarchy Guide

1. EMS Run Report

#### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3701	1	Invalid value
3702	2	Field cannot be blank
3703	3	Pulse rate exceeds the max of 299

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.70 – Initial Field Respiratory Rate

### Definition

First recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

### Field Values

Relevant value for the data element

### Additional Information

- Leave blank if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Leave blank for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- Completion of this field will show Pre-hospital Respiratory Assistance (TR18.80)
- If Not Known/Not Recorded, leave blank

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3801	1	Invalid value. RR cannot be > 99 for age in years >= 6 OR RR cannot be > 120 for age in years < 6. If age and age units are not valued, RR cannot be > 120.
3802	2	Field cannot be blank
3803	3	Invalid, out of range. RR cannot be > 99 and <=120 for age in years < 6. If age and age units are not valued, RR cannot be > 99.

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.82 – Initial Field Oxygen Saturation

### Definition

First recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

### Field Values

- Relevant value for the data element
- Value should be based upon assessment before administration of supplemental oxygen.

### Additional Information

- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- Leave blank for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- If Not Known/Not Recorded, leave blank.

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
3901	1	Pulse oximetry is outside the valid range of 0 - 100
3902	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.60 – Initial Field GCS - Eye

### Definition

First recorded Glasgow Coma Score (Eye) measured at the scene of injury.

### Field Values

1. No eye movement when assessed
  2. Opens eyes in response to painful stimulation
  3. Opens eyes in response to verbal stimulation
  4. Opens eyes spontaneously
- Not Known/Not Recorded

### Additional Information

- Used to calculate Overall GCS - EMS Score.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4001	1	Value is not a valid menu option
4003	2	Field cannot be blank

STATE

NTDB

3RD PARTY

**Pre-Hospital TR18.61.2 & TR18.61.0 – Initial Field GCS - Verbal**

**Definition**

First recorded Glasgow Coma Score (Verbal) measured at the scene of injury.

**Field Values**

Pediatric ( $\leq 2$  years):

- 1. No vocal response
- 2. Inconsolable, agitated
- 3. Inconsistently consolable, moaning
- 4. Cries but is consolable, inappropriate interactions
- 5. Smiles, oriented to sounds, follows objects, interacts

Adult

- 1. No verbal response
- 2. Incomprehensible sounds
- 3. Inappropriate words
- 4. Confused
- 5. Oriented

**Additional Information**

- Used to calculate Overall GCS - EMS Score.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- Data elements automatically switched to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

- 1. EMS Run Report

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
4101	1	Value is not a valid menu option
4103	2	Field cannot be blank

STATE

NTDB

3RD PARTY

**Pre-Hospital TR18.62.2 & TR18.62.0 – Initial Field GCS - Motor**

**Definition**

First recorded Glasgow Coma Score (Motor) measured at the scene of injury.

**Field Values**

*Pediatric (≤ 2 years):*

- |                      |  |
|----------------------|--|
| 1. No motor response | 4. Withdrawal from pain                |
| 2. Extension to pain | 5. Localizing pain                     |
| 3. Flexion to pain   | 6. Appropriate response to stimulation |

*Adult*

- |                      |                         |
|----------------------|-------------------------|
| 1. No motor response | 4. Withdrawal from pain |
| 2. Extension to pain | 5. Localizing pain      |
| 3. Flexion to pain   | 6. Obeys commands       |

**Additional Information**

- Used to calculate Overall GCS - EMS Score.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- The null value "Not Applicable" is used for patients who arrive by 4. Private/Public Vehicle/Walk-in.
- Data elements automatically switched to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
4201	1	Value is not a valid menu option
4203	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR18.65 – Initial Field GCS - Total

### Definition

First recorded Glasgow Coma Score (Total) measured at the scene of injury.

### Field Values

Relevant value for data element

### Additional Information

- Utilize only if total score is available without component scores.
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Auto-calculated when GCS Eye, GCS Verbal, and GCS Motor are complete

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4301	1	GCS Total is outside the valid range of 3 - 15
4303	4	Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS - Motor
4304	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## ED/TTA TR25.54 – Inter-Facility Transfer

### Definition

Was the patient transferred to your facility from another acute care facility?

### Field Values

1. Yes
2. No

### Additional Information

- Must complete “Arrived From” (TR16.22) and “Mode of Arrival” (TR8.8) to populate this field.
- Patients transferred from a private doctor’s office, stand-alone ambulatory surgery center, or delivered to your hospital by non-EMS transport are not considered inter-facility transfers
- Outlying facilities purporting to provide emergency care services or utilized to stabilize a patient are considered acute care facilities (Stand-Alone Emergency Rooms)

### Data Source Hierarchy Guide

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4401	2	Field cannot be blank
4402	1	Value is not a valid menu option
4404	3	Field should not be Not Known/Not Recorded
4405	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Pre-Hospital TR17.22 – Trauma Center Criteria

### Definition

Physiologic and anatomic EMS trauma triage criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report

### Field Values

- |  |   |
|--|---|
| 1. Glasgow Coma Score <= 13  | 6. Two or more proximal long-bone fractures           |
| 2. Systolic blood pressure < 90 mmHg   | 7. Crushed, degloved, mangled, or pulseless extremity |
| 3. Respiratory rate < 10 or > 29 breaths per minute (< 20 in infants aged < 1 year) or need for ventilator support | 8. Amputation proximal to wrist or ankle              |
| 4. All penetrating injuries to head, neck, torso, and extremities proximal to elbow or knee                        | 9. Pelvic fracture                                    |
| 5. Chest wall instability or deformity (e.g., flail chest)   | 10. Open or depressed skull fracture                  |
|  | 11. Paralysis   |
|  | 12. Not Applicable                                    |
|  | 13. Not Known/Not Recorded                            |

### Additional Information

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Trauma Center Criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Check all that apply.
- Consistent with NEMSIS v3.

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9501	1	Value is not a valid menu option
9502	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR17.47 – Vehicular, Pedestrian, Other Risk Injury

### Definition

EMS trauma triage mechanism of injury criteria for transport to a trauma center as defined by the Centers for Disease Control and Prevention and the American College of Surgeons-Committee on Trauma. This information must be found on the scene of injury EMS Run Report.

### Field Values

- |   |  |
|---|--|
| <ol style="list-style-type: none"> <li>1. Fall adults: &gt; 20 ft. (one story is equal to 10 ft.)</li> <li>2. Fall children: &gt; 10 ft. or 2-3 times the height of the child</li> <li>3. Crash intrusion, including roof: &gt; 12 in. occupant site; &gt; 18 in. any site</li> <li>4. Crash ejection (partial or complete) from automobile</li> <li>5. Crash death in same passenger compartment</li> <li>6. Crash vehicle telemetry data (AACN) consistent with high risk injury</li> </ol> | <ol style="list-style-type: none"> <li>7. Auto v. pedestrian/bicyclist thrown, run over, or &gt;20 MPH impact Motorcycle crash &gt; 20 mph</li> <li>8. For adults &gt; 65; SBP &lt; 110</li> <li>9. Patients on anticoagulants and bleeding disorders</li> <li>10. Pregnancy &gt; 20 weeks</li> <li>11. EMS provider judgment</li> <li>12. Burns</li> <li>13. Burns with Trauma</li> </ol> |
|---|--|

### Additional Information

- The null value "Not Applicable" should be used to indicate that the patient did not arrive by EMS.
- The null value "Not Applicable" should be used if EMS Run Report indicates patient did not meet any Vehicular, Pedestrian, Other Risk Injury criteria.
- The null value "Not Known/Not Recorded" should be used if this information is not indicated, as an identical response choice, on the EMS Run Report or if the EMS Run Report is not available.
- Check all that apply.
- Consistent with NEMSIS v3.

### Data Source Hierarchy Guide

1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9601	1	Value is not a valid menu option
9602	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Pre-Hospital TR15.53 – Pre-Hospital Cardiac Arrest

### Definition

Indication of whether patient experienced cardiac arrest prior to ED/Hospital Arrival.

### Field Values

1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information

- “N/A” should not be used for this field
- A patient who experienced a sudden cessation of cardiac activity. The patient was unresponsive with no normal breathing and no signs of circulation.
- The event must have occurred outside the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-Hospital cardiac arrest could occur at a transferring/referring facility
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.

### Data Source Hierarchy Guide

1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9701	1	Value is not a valid menu option
9702	2	Field cannot be blank
9703	2	Field cannot be Not Applicable

# **Emergency Department/Trauma Team Activation Information**

STATE

NTDB

3RD PARTY

**ED/TTA TR18.55 – ED/Hospital Arrival Date****Definition**

The date the patient arrived to the ED/Hospital

**Field Values**

Relevant value for data element

**Additional Information**

- If the patient was brought to the ED, enter date patient arrived at ED. If patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Collected as DD-MM-YYYY
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

**Data Source Hierarchy Guide**

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
4501	1	Date is not valid
4502	1	Date out of range
4503	2	Field cannot be blank
4505	2	Field cannot be Not Known/Not Recorded
4506	3	ED/Hospital Arrival Date is earlier than EMS Dispatch Date
4507	3	ED/Hospital Arrival Date is earlier than EMS Unit Arrival on Scene Date
4508	3	ED/Hospital Arrival Date is earlier than EMS Unit Scene Departure Date
4509	2	ED/Hospital Arrival Date is later than ED Discharge Date
4510	2	ED/Hospital Arrival Date is later than Hospital Discharge Date
4511	3	ED/Hospital Arrival Date is earlier than Date of Birth
4512	3	ED/Hospital Arrival Date should be after 1993
4513	3	ED/Hospital Arrival Date minus Injury Incident Date should be less than 30 days
4514	3	ED/Hospital Arrival Date minus EMS Dispatch Date is greater than 7 days
4515	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## ED/TTA TR18.56 – ED/Hospital Arrival Time

### Definition

The time the patient arrived to the ED/Hospital

### Field Values

Relevant value for data element

### Additional Information

- If the patient was brought to the ED, enter time patient arrived at ED. If patient was directly admitted to the hospital, enter time patient was admitted to the hospital.
- Collected as HH:MM military time.
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4601	1	Time is not valid
4602	1	Time out of range
4603	2	Field cannot be blank
4604	4	ED/Hospital Arrival Time is earlier than EMS Dispatch Time
4605	4	ED/Hospital Arrival Time is earlier than EMS Unit Arrival on Scene Time
4606	4	ED/Hospital Arrival Time is earlier than EMS Unit Scene Departure Time
4607	4	ED/Hospital Arrival Time is later than ED Discharge Time
4608	4	ED/Hospital Arrival Time is later than Hospital Discharge Time
4609	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.11 – Initial ED/Hospital Systolic Blood Pressure

### Definition

First recorded systolic blood pressure in the ED/hospital within 30 minutes or less of ED/hospital arrival.

### Field Values

Relevant value for data element

### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If Not Known/Not Recorded, leave blank.

### Data Source Hierarchy Guide

1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4701	1	Invalid Value
4702	2	Field cannot be blank
4704	3	SBP value exceeds the max of 300
4705	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.2– Initial ED/Hospital Pulse Rate

### Definition

First recorded pulse in the ED/hospital (palpated or auscultated) within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

### Field Values

Relevant value for data element

### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If Not Known/Not Recorded, leave blank.

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
4801	1	Invalid Value
4802	2	Field cannot be blank
4804	3	Pulse rate exceeds the max of 299
4805	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment- Initial ED/Hospital Temperature

### Definition

First recorded temperature (in degrees Celsius [centigrade]) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

### Field Values

Relevant value for data element

#### Units:

- 1. C (Celsius) – TR18.30
- 2. F (Fahrenheit) – TR18.30.1

#### Route: TR18.147

- 1. Oral
- 2. Tympanic
- 3. Rectal
- 4. Axillary
- 5. Temporal
- 6. Other
- 7. Not Known/Not Recorded

### Additional Information

- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Entry in one unit will auto-populate the other.
- If not known, leave units blank and select “Not Known/Not Recorded” for Route.

### Data Source Hierarchy Guide

- 1. Triage/Trauma/Hospital Flow Sheet
- 2. Nurses Notes/Flow Sheet

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
4901	1	Invalid value
4902	2	Field cannot be blank
4903	3	Temperature exceeds the max of 45.0 Celsius
4904	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.7– Initial ED/Hospital Respiratory Rate****Definition**

First recorded respiratory rate in the ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a number per minute).

**Field Values**

Relevant value for data element

**Additional Information**

- If available, complete additional field: "Resp. Assistance."
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known/Not Recorded, leave blank and select "Not Applicable" for "Resp. Assistance".

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
5001	1	Invalid value. RR cannot be > 99 for age in years >= 6 OR RR cannot be > 120 for age in years < 6. If age and age units are not valued, RR cannot be > 120.
5002	2	Field cannot be blank
5005	3	Invalid, out of range. RR cannot be > 99 and <=120 for age in years < 6. If age and age units are not valued, RR cannot be > 99.
5006	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.10- Initial ED/Hospital Respiratory Assistance

### Definition

Determination of respiratory assistance associated with the initial ED/hospital respiratory rate within 30 minutes or less of ED/hospital arrival.

### Field Values

- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable
- Not Known/Not Recorded

### Additional Information

- Only completed if a value is provided for Initial ED/Hospital Respiratory Rate.
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- When “Initial ED/Hospital Respiratory Rate” is “Not Known/Not Recorded”, select “Not Applicable”

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
5101	1	Value is not a valid menu option
5102	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.31- Initial ED/Hospital Oxygen Saturation

### Definition

First recorded oxygen saturation in ED/hospital within 30 minutes or less of ED/hospital arrival (expressed as a percentage).

### Field Values

Relevant value for data element

### Additional Information

- If available, complete additional field: "Initial ED/Hospital Supplemental Oxygen.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known/Not Recorded, leave blank.

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
5201	1	Pulse oximetry is outside the valid range of 0 - 100
5202	2	Field cannot be blank
5205	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.109– Initial ED/Hospital Supplemental Oxygen

### Definition

Determination of the presence of supplemental oxygen during assessment of initial ED/hospital oxygen saturation level within 30 minutes or less of ED/hospital arrival.

### Field Values

- Yes
- No
- Not Applicable
- Not Known/Not Recorded

### Additional Information

- Only completed if a value is provided for "Initial ED/Hospital Oxygen Saturation."
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
5301	1	Value is not a valid menu option
5303	2	Field cannot be blank when Initial ED/Hospital Oxygen Saturation is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.14- Initial ED/Hospital GCS - Eye

### Definition

First recorded Glasgow Coma Score (Eye) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

### Field Values

1. No eye movement when assessed
2. Opens eyes in response to painful stimulation
3. Opens eyes in response to verbal stimulation
4. Opens eyes spontaneously
5. Not Applicable
6. Not Known/Not Recorded

### Additional Information

- Used to calculate Overall GCS - ED Score.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
5401	1	Value is not a valid menu option
5403	2	Field cannot be blank
5304	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.15.2 & TR18.15.0- Initial ED/Hospital GCS - Verbal**

**Definition**

First recorded Glasgow Coma Score (Verbal) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

**Field Values**

Pediatric ( $\leq 2$  years):

- |                                       |   |
|---------------------------------------|---|
| 1. No vocal response                  | 4. Cries but is consolable, inappropriate interactions    |
| 2. Inconsolable, agitated             | 5. Smiles, oriented to sounds, follows objects, interacts |
| 3. Inconsistently consolable, moaning |   |

Adult

- |                            |             |
|----------------------------|-------------|
| 1. No verbal response      | 4. Confused |
| 2. Incomprehensible sounds | 5. Oriented |
| 3. Inappropriate words     |             |

**Additional Information**

- Used to calculate Overall GCS - ED Score.
- If patient is intubated then the GCS Verbal score is equal to 1.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Elements automatically switched to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
5501	1	Value is not a valid menu option
5503	2	Field cannot be blank
5504	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.16.2 & TR18.16.0- Initial ED/Hospital GCS - Motor**

**Definition**

First recorded Glasgow Coma Score (Motor) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

**Field Values**

*Pediatric (<= 2 years):*

- |                      |  |
|----------------------|--|
| 1. No motor response | 4. Withdrawal from pain                |
| 2. Extension to pain | 5. Localizing pain                     |
| 3. Flexion to pain   | 6. Appropriate response to stimulation |

*Adult*

- |                      |                         |
|----------------------|-------------------------|
| 1. No motor response | 4. Withdrawal from pain |
| 2. Extension to pain | 5. Localizing pain      |
| 3. Flexion to pain   | 6. Obeys commands       |

**Additional Information**

- Used to calculate Overall GCS – ED Score.
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Elements automatically switched to Pediatrics for patients younger than 2 years

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
5601	1	Value is not a valid menu option
5603	2	Field cannot be blank

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.22- Initial ED/Hospital GCS - Total****Definition**

First recorded Glasgow Coma Score (Total) in the ED/hospital within 30 minutes or less of ED/hospital arrival.

**Field Values**

Relevant value for data element

**Additional Information**

- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "A&Ox4," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
5701	1	GCS Total is outside the valid range of 3 - 15
5703	4	Initial ED/Hospital GCS - Total does not equal the sum of Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, and Initial ED/Hospital GCS - Motor
5705	2	Field cannot be blank
5706	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.21– Initial ED/Hospital GCS Assessment Qualifiers**

**Definition**

Documentation of factors potentially affecting the first assessment of GCS within 30 minutes or less of ED/hospital arrival.

**Field Values**

1. Patient Chemically Sedated or Paralyzed
2. Obstruction to the Patient’s Eye
3. Patient Intubated
4. Valid GCS: Patient was not sedated, not intubated, and did not have obstruction to the eye
5. Not Known/Not Recorded

**Additional Information**

- Identifies treatments given to the patient that may affect the first assessment of GCS. This field does not apply to self-medications the patient may administer (i.e., ETOH, prescriptions, etc.).
- If an intubated patient has recently received an agent that results in neuromuscular blockade such that a motor or eye response is not possible, then the patient should be considered to have an exam that is not reflective of their neurologic status and the chemical sedation modifier should be selected.
- Neuromuscular blockade is typically induced following the administration of agent like succinylcholine, mivacurium, rocuronium, (cis)atracurium, vecuronium, or pancuronium. While these are the most common agents, please review what might be typically used in your center so it can be identified in the medical record.
- Each of these agents has a slightly different duration of action, so their effect on the GCS depends on when they were given. For example, succinylcholine's effects last for only 5-10 minutes.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- Select up to three options.

**Data Source Hierarchy Guide**

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
5801	1	Value is not a valid menu option
5802	2	Field cannot be blank
5803	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR1.6.1 & TR1.6- Initial ED/Hospital Height

### Definition

First recorded height upon ED/Hospital arrival

### Field Values

- Relevant value for the data element for height
- Units:
  - Centimeters - TR1.6
  - Inches - TR1.6.1

### Additional Information

- Can be recorded in centimeters or inches, and will be converted and reported in centimeters for NTDB submission.
- Entering a value into one unit will auto-populate the other.
- May be based on family or self-report.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known/Not Recorded, leave blank

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
8501	1	Invalid value
8502	2	Field cannot be blank
8503	3	Height exceeds the max of 244 (cm)
8504	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR1.6.5- Initial ED/Hospital Weight

### Definition

First recorded, measured or estimated baseline weight upon ED/Hospital arrival.

### Field Values

- Relevant value for the data element for weight
- Units:
  - Kilograms
  - Pounds

### Additional Information

- Can be recorded in kilograms or pounds, will be converted to kilograms for NTDB submission
- May be based on family or self-report.
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Not Known/Not Recorded, leave blank

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
8601	1	Invalid value
8602	2	Field cannot be blank
8603	3	Weight exceeds the max of 907 (kg)
8604	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

**Initial Assessment TR18.91–Drug Screen**

**Definition**

First recorded positive drug screen results within 24 hours after first hospital encounter (select all that apply).

**Field Values**

- |                           |                                    |
|---------------------------|------------------------------------|
| 1. AMP (Amphetamine)      | 9. OXY (Oxycodone)                 |
| 2. BAR (Barbiturate)      | 10. PCP (Phencyclidine)            |
| 3. BZO (Benzodiazepines)  | 11. TCA (Tricyclic Antidepressant) |
| 4. COC (Cocaine)          | 12. THC (Cannabinoid)              |
| 5. mAMP (Methamphetamine) | 13. Other                          |
| 6. MDMA (Ecstasy)         | 14. None                           |
| 7. MTD (Methadone)        | 15. Not Tested                     |
| 8. OPI (Opioid)           |                                    |

**Additional Information**

- Record positive drug screen results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- “None” is reported for patients whose only positive results are due to drugs administered at any facility (or setting) treating this patient event, or for patients who were tested and had no positive results.
- If multiple drugs are detected, only report drugs that were not administered at any facility (or setting) treating this patient event.
- Selections are made in a pick-list.

**Data Source Hierarchy Guide**

1. Lab Results
2. Transferring Facility Records

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Field cannot be blank
6013	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.46–Alcohol Screen

### Definition

A blood alcohol concentration (BAC) test was performed on the patient within 24 hours after first hospital encounter.

### Field Values

1. Yes
2. No

### Additional Information

- Alcohol screen may be administered at any facility, unit, or setting treating this patient event.
- Selecting “Yes” will show Blood Alcohol Content.

### Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
5911	1	Value is not a valid menu option
5912	2	Field cannot be blank
5913	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## Initial Assessment TR18.103 – Alcohol Screen Results

### Definition

First recorded blood alcohol concentration (BAC) results within 24 hours after first hospital encounter.

### Field Values

Relevant value for data element

### Additional Information

- Collect as X.XX standard lab value (e.g. 0.08)
- Record BAC results within 24 hours after first hospital encounter, at either your facility or the transferring facility.
- For those patients who were not tested, leave blank
- Collected as g/dl

### Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
6011	1	Value is not a valid menu option
6012	2	Field cannot be blank
6013	2	Field cannot be Not Applicable

STATE

NTDB

3RD PARTY

## ED/TTA TR17.27 – ED Discharge Disposition

### Definition

The disposition of the patient at the time of discharge from the ED

### Field Values

- |  |                                     |
|--|-------------------------------------|
| 1. Floor bed (general admission, non-specialty unit bed) | 8. Intensive Care Unit (ICU)        |
| 2. Observation Unit (unit that provides < 24 hour stays) | 9. Home without services            |
| 3. Telemetry/step-down unit (less acuity than ICU)       | 10. Left against medical advice     |
| 4. Home with services                                    | 11. Transferred to another hospital |
| 5. Deceased/Expired                                      | 12. Not Applicable                  |
| 6. Other (jail, institutional care, mental health, etc.) |                                     |
| 7. Operating Room  |                                     |

### Additional Information

- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 4, 5, 6, 9, 10, 11, then Hospital Discharge Date, Time, and Disposition will lock and not be available for data entry.

### Data Source Hierarchy Guide

1. Physician Order
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. ED Record
6. History & Physical

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
6101	1	Value is not a valid menu option
6102	2	Field cannot be blank
6104	2	Field cannot be Not Known/Not Recorded
6106	2	Field cannot be Not Applicable when Hospital Discharge Date is Not Applicable

STATE

NTDB

3RD PARTY

## ED/TTA TR27.14 – Signs of Life

### Definition

Indication of whether patient arrived at ED/Hospital with signs of life

### Field Values

1. Arrived with NO signs of life
2. Arrived with signs of life
3. Not Known/Not Recorded

### Additional Information

A patient with no signs of life is defined as having none of the following: organized EKG activity, pupillary responses, spontaneous respiratory attempts or movement, and unassisted blood pressure. This usually implies the patient was brought to the ED with CPR in progress.

### Data Source Hierarchy Guide

1. Triage/Trauma/Hospital Flow Sheet
2. Progress Notes
3. Nursing Notes/Flow Sheet
4. EMS Run Report
5. History & Physical

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
6201	1	Value is not a valid menu option
6202	2	Field cannot be blank
6206	3	Field should not be Not Known/Not Recorded
6207	2	Field cannot be Not Applicable
6208	3	Field is 1 (Arrived with NO signs of life) when Initial ED/Hospital SBP > 0, Pulse > 0,
6209	3	Field is 2 (Arrived with signs of life) when Initial ED/Hospital SBP = 0, Pulse = 0,

STATE

NTDB

3RD PARTY

**ED/TTA TR17.41 – ED Discharge Date****Definition**

The date the order was written for the patient to be discharged from the ED

**Field Values**

Relevant value for data element

**Additional Information**

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Date is the date of death as indicated on the patient's death certificate.

**Data Source Hierarchy Guide**

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
6301	1	Date is not valid
6302	1	Date out of range
6303	2	Field cannot be blank
6304	4	ED Discharge Date is earlier than EMS Dispatch Date
6305	4	ED Discharge Date is earlier than EMS Unit Arrival on Scene Date
6306	4	ED Discharge Date is earlier than EMS Unit Scene Departure Date
6307	2	ED Discharge Date is earlier than ED/Hospital Arrival Date
6308	2	ED Discharge Date is later than Hospital Discharge Date
6309	3	ED Discharge Date is earlier than Date of Birth
6310	3	ED Discharge Date minus ED/Hospital Arrival Date is greater than 365 days

STATE

NTDB

3RD PARTY

## ED/TTA TR17.42 – ED Discharge Time

### Definition

The time the order was written for the patient to be discharged from the ED

### Field Values

Relevant value for data element

### Additional Information

- Collected as HH:MM military time.
- Used to auto-generate an additional calculated field: Total ED Time: (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- If ED Discharge Disposition is 5 Deceased/Expired, then ED Discharge Time is the time of death as indicated on the patient's death certificate.

### Data Source Hierarchy Guide

1. Physician Order
2. ED Record
3. Triage/Trauma/Hospital Flow Sheet
4. Nursing Notes/Flow Sheet
5. Discharge Summary
6. Billing Sheet
7. Progress Notes

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
6401	1	Time is not valid
6402	1	Time out of range
6403	2	Field cannot be blank
6404	4	ED Discharge Time is earlier than EMS Dispatch Time
6405	4	ED Discharge Time is earlier than EMS Unit Arrival on Scene Time
6406	4	ED Discharge Time is earlier than EMS Unit Scene Departure Time
6407	4	ED Discharge Time is earlier than ED/Hospital Arrival Time
6408	4	ED Discharge Time is later than Hospital Discharge Time

# **PROCEDURE INFORMATION**

STATE

NTDB

3RD PARTY

## Procedures TR200.2 – ICD-10 Hospital Procedures

### Definition

Operative and selected non-operative procedures conducted during hospital stay. Operative and selected non-operative procedures are those that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or complications. The list of procedures below should be used as a guide to non-operative procedures that should be provided to NTDB. This list is based on procedures sent to NTDB with a high frequency. Not all hospitals capture all procedures listed below. Please transmit those procedures that you capture to NTDB.

### Field Values

- Major and minor procedure ICD-10-CM procedure codes.
- The maximum number of procedures that may be reported for a patient is 200.

### Additional Information

- The null value "Not Applicable" is used if the patient did not have procedures.
- Include only procedures performed at your institution.
- Capture all procedures performed in the operating room.
- Capture all procedures in the ED, ICU, ward, or radiology department that were essential to the diagnosis, stabilization, or treatment of the patient's specific injuries or their complications.
- Procedures with an asterisk have the potential to be performed multiple times during one episode of hospitalization. In this case, capture only the first event. If there is no asterisk, capture each event even if there is more than one.
- Note that the hospital may capture additional procedures.
- Validity is activated when Procedure Performed (TR22.30) is "Yes"

#### Diagnostic and Therapeutic Imaging

Computerized tomographic Head\*  
 Computerized tomographic Chest\*  
 Computerized tomographic Abdomen\*  
 Computerized tomographic Pelvis\*  
 Diagnostic ultrasound (includes FAST)\*  
 Doppler ultrasound of extremities \*  
 Angiography  
 Angioembolization  
 REBOA (ICD10: 04L03DZ)  
 IVC filter

#### Cardiovascular

Open cardiac massage  
 CPR

#### CNS

#### Musculoskeletal

Soft tissue/bony debridements\*  
 Closed reduction of fractures  
 Skeletal and halo traction  
 Fasciotomy

#### Transfusion

Transfusion of red cells\* (only capture first 24 hours after hospital arrival)

Transfusion of platelets\* (only capture first 24 hours after hospital arrival)

Transfusion of plasma\* (only capture first 24 hours after hospital arrival)

Insertion of ICP monitor \*  
 Ventriculostomy \*  
 Cerebral oxygen monitoring \*

**Genitourinary**

Ureteric catheterization (i.e. Ureteric stent)  
 Suprapubic cystostomy

**Respiratory**

Insertion of endotracheal tube\*  
 Continuous mechanical ventilation\*  
 Chest tube\*  
 Bronchoscopy\*  
 Tracheostomy

**Gastrointestinal**

Endoscopy (includes gastroscopy, sigmoidoscopy, colonoscopy)

Gastrostomy/jejunostomy (percutaneous or endoscopic)

Percutaneous (endoscopic) gastrojejunoscopy

**Data Source Hierarchy Guide**

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
8801	1	Invalid value
8802	1	Procedures with the same code cannot have the same Hospital Procedure Start Date and Time
8803	2	Field cannot be blank, must either (1) contain a valid ICD-10 code (2) be Not Known/Not Recorded if not coding ICD-10 or (3) be Not Applicable if no procedures were performed
8804	4	Field should not be Not Applicable unless patient had no procedures performed
8805	1	Invalid value (ICD-10 CA only)

STATE

NTDB

3RD PARTY

## Procedures TR200.8 – Hospital Procedure Start Date

### Definition

The date operative and selected non-operative procedures were performed.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as MM/DD/YYYY
- Validity is activated when Procedure Performed (TR22.30) is “Yes”

### Data Source Hierarchy Guide

1. Operative Reports
2. Procedure Notes
3. Trauma Flow Sheet
4. ED Record
5. Nursing Notes/Flow Sheet
6. Radiology Reports
7. Discharge Summary

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
6601	1	Date is not valid
6602	1	Date out of range
6603	4	Hospital Procedure Start Date is earlier than EMS Dispatch Date
6604	4	Hospital Procedure Start Date is earlier than EMS Unit Arrival on Scene Date
6605	4	Hospital Procedure Start Date is earlier than EMS Unit Scene Departure Date
6606	4	Hospital Procedure Start Date is earlier than ED/Hospital Arrival Date
6607	4	Hospital Procedure Start Date is later than Hospital Discharge Date
6608	4	Hospital Procedure Start Date is earlier than Date of Birth
6609	2	Field cannot be blank

STATE

NTDB

3RD PARTY

## Procedures TR200.9 – Hospital Procedure Start Time

### Definition

The time operative and selected non-operative procedures were performed.

### Field Values

Relevant value for the data element

### Additional Information

- Collected as HH:MM military time.
- Procedure start time is defined as the time the incision was made (or the procedure started).
- If distinct procedures with the same procedure code are performed, their start times must be different.
- Validity is activated when Procedure Performed (TR22.30) is “Yes”

### Data Source Hierarchy Guide

1. Operative Reports
2. Anesthesia Reports
3. Procedure Notes
4. Trauma Flow Sheet
5. ED Record
6. Nursing Notes/Flow Sheet
7. Radiology Reports
8. Discharge Summary

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
6701	1	Time is not valid
6702	1	Time out of range
6703	4	Hospital Procedure Start Time is earlier than EMS Dispatch Time
6704	4	Hospital Procedure Start Time is earlier than EMS Unit Arrival on Scene Time
6705	4	Hospital Procedure Start Time is earlier than EMS Unit Scene Departure Time
6706	4	Hospital Procedure Start Time is earlier than ED/Hospital Arrival Time
6707	4	Hospital Procedure Start Time is later than Hospital Discharge Time
6708	2	Field cannot be blank

## **DIAGNOSIS INFORMATION**

STATE

NTDB

3RD PARTY

## Diagnosis TR21.21- Co-Morbid Conditions

### Definition

Pre-existing co-morbid factors

### Field Values

- |  |   |
|--|---|
| 1. Other                                       | 21. Prematurity                           |
| 2. Alcohol Use Disorder                        | 23. Chronic Obstructive Pulmonary Disease |
| 4. Bleeding Disorder                           | 24. Steroid Use                           |
| 5. Currently Receiving Chemotherapy for Cancer | 25. Cirrhosis                             |
| 6. Congenital Anomalies                        | 26. Dementia                              |
| 7. Congestive Heart Failure                    | 30. Attention Deficit Disorder/ADHD       |
| 8. Current Smoker                              | 31. Anticoagulant Therapy                 |
| 9. Chronic Renal Failure                       | 32. Angina Pectoris                       |
| 10. Cerebrovascular Accident (CVA)             | 33. Mental/Personality Disorder           |
| 11. Diabetes Mellitus                          | 34. Myocardial Infarction (MI)            |
| 12. Disseminated Cancer                        | 35. Peripheral Arterial Disease (PAD)     |
| 13. Advanced Directive Limiting Care           | 36. Substance Abuse Disorder              |
| 15. Functionally Dependent Health Status       | 37. Not Applicable                        |
| 19. Hypertension                               | 38. Not Known/Not Recorded                |

### Additional Information

- The Null Value “Not Applicable” is used for patients with no known co-morbid conditions. If the patient has no comorbidities, this null value will be associated automatically by leaving the field blank.
- For any Co-Morbid condition to be valid, there must be a diagnosis noted in the patient medical record that meets the definition that is included in this data dictionary.
- Fields must be added individually
- Select all that apply

### Data Source Hierarchy Guide

1. History & Physical
2. Physician’s Notes
3. Progress Notes
4. Case Management/Social Services
5. Nursing Notes/Flow Sheet
6. Triage/Trauma Flow Sheet
7. Discharge Summary

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
6801	1	Value is not a valid menu option
6802	2	Field cannot be blank

**CO-MORBID CONDITIONS**

**Advanced directive limiting care:** The patient had a written request limiting life sustaining therapy, or similar advanced directive, present prior to arrival at your center.

**Alcohol use disorder:** *(Consistent with the American Psychiatric Association (APA) DMS 5, 2013. Always use the most recent definition provided by the APA.)* Diagnosis of alcohol use disorder documented in the patient’s medical record, present prior to injury.

**Angina Pectoris:** *(Consistent with the American Heart Association (AHA), May 2015. Always use the most recent definition provided by the AHA.)* Chest pain or discomfort due to Coronary Heart Disease, present prior to injury. Usually causes uncomfortable pressure, fullness, squeezing or pain in the center of the chest. Patient may also feel the discomfort in the neck, jaw, shoulder, back or arm. Symptoms may be different in women than men. A diagnosis of Angina or Chest Pain must be documented in the patient’s medical record.

**Anticoagulant Therapy:** Documentation in the medical record of the administration of medication (anticoagulants, antiplatelet agents, thrombin inhibitors, thrombolytic agents) that interferes with blood clotting, present prior to injury. Exclude patients who are on chronic Aspirin therapy. Some examples are:

ANTICOAGULANTS	ANTIPLATELET AGENTS	THROMBIN INHIBITORS	THROMBOLYTIC AGENTS
Fondaparinux	Tirofiban	Bevalirudin	Alteplase
Warfarin	Dipyridamole	Argatroban	Retepase
Dalteparin	Anagrelide	Lepirudin, Hirudin	Tenecteplase
Lovenox	Eptifibatide	Drotrecogin alpha	kabikinase
Pentasaccaride	Dipyridamole	Dabigatran	tPA
APC	Clopidogrel		
Ximelagatran	Cilostazol		
Pentoxifylline	Abciximab		
Rivaroxaban	Ticlopidine		
Apixaban	Prasugrel		
Heparin	Ticagrelor		

**Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD):** History of a disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.

**Bleeding disorder:** *(Consistent with the American Society of Hematology, 2015. Always use the most recent definition provided by the American Society of Hematology.)* A group of conditions that result

when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient's medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

**Cerebrovascular accident (CVA):** A history prior to injury of a cerebrovascular accident (embolic, thrombotic, or hemorrhagic) with persistent residual motor sensory or cognitive dysfunction (e.g., hemiplegia, hemiparesis, aphasia, sensory deficit, impaired memory). A diagnosis of CVA must be documented in the patient's medical record.

**Chronic Obstructive Pulmonary Disease (COPD):** (*Consistent with World Health Organization (WHO), 2015. Always use the most recent definition provided by the WHO.*) Lung ailment that is characterized by a persistent blockage of airflow from the lungs, present prior to injury. It is not one single disease but an umbrella term used to describe chronic lung diseases that cause limitations in lung airflow. The more familiar terms "chronic bronchitis" and "emphysema" are no longer used, but are now included within the COPD diagnosis and result in any one or more of the following:

- Functional disability from COPD (e.g., dyspnea, inability to perform activities of daily living [ADLs].)
- Hospitalization in the past for treatment of COPD.
- Requires chronic bronchodilator therapy with oral or inhaled agents.
- A Forced Expiratory Volume in 1 second (FEV1) of <75% of predicted on pulmonary function testing.

A diagnosis of COPD must be documented in the patient's medical record. Do not include patients whose only pulmonary disease is acute asthma, and/or diffuse interstitial fibrosis or sarcoidosis.

**Chronic renal failure:** Chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration, present prior to injury. A diagnosis of Chronic Renal Failure must be documented in the patient's medical record.

**Cirrhosis:** Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease, present prior to injury. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. A diagnosis of Cirrhosis, or documentation of Cirrhosis by diagnostic imaging studies or a laparotomy/laparoscopy, must be in the patient's medical record.

**Congenital Anomalies:** Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic anomaly, present prior to injury. A diagnosis of a Congenital Anomaly must be documented in the patient's medical record.

**Congestive Heart Failure:** The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure, present prior to injury. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury. Common manifestations are:

- Abnormal limitation in exercise tolerance due to dyspnea or fatigue

- Orthopnea (dyspnea on lying supine)
- Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
- Increased jugular venous pressure
- Pulmonary rales on physical examination
- Cardiomegaly
- Pulmonary vascular engorgement

**Currently receiving chemotherapy for cancer:** A patient who is currently receiving any chemotherapy treatment for cancer, prior to injury. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma.

**Current Smoker:** A patient who reports smoking cigarettes every day or some days within the last 12 months, prior to injury. Exclude patients who smoke cigars or pipes or smokeless tobacco (chewing tobacco or snuff).

**Dementia:** Documentation in the patient's medical record of dementia including senile or vascular dementia (e.g., Alzheimer's) present prior to injury.

**Diabetes mellitus:** Diabetes mellitus that requires exogenous parenteral insulin or an oral hypoglycemic agent, present prior to injury. A diagnosis of Diabetes Mellitus must be documented in the patient's medical record.

**Disseminated cancer:** Patients who have cancer that has spread to one or more sites in addition to the primary site AND in whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal, present prior to injury. Other terms describing disseminated cancer include: "diffuse", "widely metastatic", "widespread", or "carcinomatosis". Common sites of metastases include major organs, (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and/or bone). A diagnosis of Cancer that has spread to one or more sites must be documented in the patient's medical record.

**Functionally Dependent health status:** Pre-injury functional status may be represented by the ability of the patient to complete age appropriate activities of daily living (ADL). Activities of Daily Living include: bathing, feeding, dressing, toileting, and walking. Include patients whom prior to injury, and as a result of cognitive or physical limitations relating to a pre-existing medical condition, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.

**Hypertension:** History of persistent elevated blood pressure requiring medical therapy, present prior to injury. A diagnosis of Hypertension must be documented in the patient's medical record.

**Mental/Personality Disorder:** (*Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.*) Documentation of the presence of pre-injury depressive disorder, bipolar disorder, schizophrenia, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder. A diagnosis of Mental/Personality Disorder must be documented in the patient's medical record.

**Myocardial Infarction:** History of a MI in the six months prior to injury. A diagnosis of MI must be documented in the patient's medical record.

**Peripheral Arterial Disease (PAD):** *(Consistent with Centers for Disease Control, 2014 Fact Sheet. Always use the most recent definition provided by the CDC.)* The narrowing or blockage of the vessels that carry blood from the heart to the legs, present prior to injury. It is primarily caused by the buildup of fatty plaque in the arteries, which is called atherosclerosis. PAD can occur in any blood vessel, but it is more common in the legs than the arms. A diagnosis of PAD must be documented in the patient's medical record.

**Prematurity:** Infants delivered before 37 weeks from the first day of the last menstrual period, and a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. A diagnosis of Prematurity, or delivery before 37 weeks gestation, must be documented in the patient's medical record.

**Steroid Use:** Patients that require the regular administration of oral or parenteral corticosteroid medications within 30 days prior to injury for a chronic medical condition. Examples of oral or parenteral corticosteroid medications are: prednisone and dexamethasone. Examples of chronic medical conditions are: COPD, asthma, rheumatologic disease, rheumatoid arthritis, and inflammatory bowel disease. Exclude topical corticosteroids applied to the skin, and corticosteroids administered by inhalation or rectally.

**Substance Abuse Disorder:** *(Consistent with American Psychiatric Association (APA) DSM 5, 2013. Always use the most recent definition provided by the APA.)* Documentation of Substance Abuse Disorder documented in the patient medical record, present prior to injury. A diagnosis of Substance Abuse Disorder must be documented in the patient's medical record.

STATE

NTDB

3RD PARTY

## Diagnosis TR200.1– ICD-10 Injury Diagnoses

### Definition

Diagnoses related to all identified injuries

### Field Values

- Injury diagnoses as defined by ICD-10-CM code range S00-S99, T07, T14, T20-T28 and T30-32.
- The maximum number of diagnoses that may be reported for an individual patient is 50.

### Additional Information

- ICD-10 codes pertaining to other medical conditions (e.g., CVA, MI, Co-morbidities, etc (may also be included in this field)
- Used to auto-generate additional calculated fields: Abbreviated Injury Scale (Six body Regions) and Injury Severity Score.

### Data Source Hierarchy Guide

1. Autopsy/Medical Examiner Report
2. Operative Reports
3. Radiology Reports
4. Physician’s Notes
5. Trauma Flow Sheet
6. History & Physical
7. Nursing Notes/Flow Sheet
8. Progress Notes
9. Discharge Summary

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
8701	1	Invalid value (ICD-10 CM only)
8702	2	Field cannot be blank
8703	2	At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CM only)
8704	4	Field should not be Not Known/Not Recorded
8705	1	Invalid value (ICD-10 CA only)
8706	2	At least one diagnosis must be provided and meet inclusion criteria (ICD-10 CA only)

# **INJURY SEVERITY INFORMATION**

STATE

NTDB

3RD PARTY

## Injury Severity Information TR200.14.1- AIS Predot Code

### Definition

The Abbreviated Injury Scale (AIS) PreDot codes that reflect the patient's injuries.

### Field Values

- The predot code is the 6 digits preceding the decimal point in an associated AIS code
- In ImageTrend, this field includes both the AIS PreDot (IS\_01) and AIS Severity (IS\_02) Codes:
  1. Minor Injury
  2. Moderate Injury
  3. Serious Injury
  4. Severe Injury
  5. Critical Injury
  6. Maximum Injury, Virtually Unsurvivable
  9. Not Possible to Assign

### Additional Information

- Smart search and categorical search features available for users

### Data Source Hierarchy Guide

1. AIS coding manual

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
7001	1	Invalid Value
7004	3	AIS codes submitted are not valid AIS 05, Update 08 codes
7007	2	Field cannot be blank
7008	2	Field cannot be Not Applicable

# **OUTCOME INFORMATION**

STATE

NTDB

3RD PARTY

**Outcome TR26.9– Total ICU Length of Stay****Definition**

The cumulative amount of time spent in the ICU. Each partial or full day should be measured as one calendar day

**Field Values**

Relevant value for data element (auto-calculated by the registry software)

**Additional Information**

- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping an ICU episode are recorded in the patient's chart.
- If any dates are missing then a LOS cannot be calculated.
- If patient has multiple ICU episodes on the same calendar day, count as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- This field is auto-calculated, but can be manually edited/entered.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was in ICU on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was in ICU on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
J.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

## Data Source Hierarchy Guide

1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
7501	1	Total ICU Length of Stay is outside the valid range of 1 - 575
7502	2	Field cannot be blank
7503	3	Total ICU Length of Stay is greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7504	3	Value is greater than 365, please verify this is correct

STATE

NTDB

3RD PARTY

## Outcome TR26.58- Total Ventilator Days

### Definition

The cumulative amount of time spent on the ventilator. Each partial or full day should be measured as one calendar day

### Field Values

Relevant value for data element

### Additional Information

- Excludes mechanical ventilation time associated with OR procedures.
- Non-invasive means of ventilatory support (CPAP or BIPAP) should not be considered in the calculation of ventilator days.
- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- The calculation assumes that the date and time of starting and stopping Ventilator episode are recorded in the patient's chart.
- If any dates are missing then a Total Vent Days cannot be calculated.
- At no time should the Total Vent Days exceed the Hospital LOS.
- The null value "Not Applicable" is used if the patient was not on the ventilator according to the above definition.
- This field is auto-calculated with completion in the "Ventilator" tab of the registry, but can be manually edited/entered.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
A.	01/01/11	01:00	01/01/11	04:00	1 day (one calendar day)
B.	01/01/11	01:00	01/01/11	04:00	
	01/01/11	16:00	01/01/11	18:00	1 day (2 episodes within one calendar day)
C.	01/01/11	01:00	01/01/11	04:00	
	01/02/11	16:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
D.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	18:00	2 days (episodes on 2 separate calendar days)
E.	01/01/11	01:00	01/01/11	16:00	
	01/02/11	09:00	01/02/11	21:00	2 days (episodes on 2 separate calendar days)
F.	01/01/11	Unknown	01/01/11	16:00	1 day
G.	01/01/11	Unknown	01/02/11	16:00	2 days (patient was on Vent on 2 separate calendar days)
H.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	Unknown	2 days (patient was on Vent on 2 separate calendar days)
I.	01/01/11	Unknown	01/02/11	16:00	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)

#### Associated Edit Checks (NTDB)

Rule ID	Level	Message
7601	1	Total Ventilator Days is outside the valid range of 1 - 575
7602	2	Field cannot be blank
7603	4	Total Ventilator Days should not be greater than the difference between ED/Hospital Arrival Date and Hospital Discharge Date
7604	4	Value is greater than 365, please verify this is correct

STATE

NTDB

3RD PARTY

**Outcome TR25.93– Hospital Discharge Date****Definition**

The date the order was written for the patient to be discharged from the hospital

**Field Values**

Relevant value for data element

**Additional Information**

- Collected as MM-DD-YYYY
- Used to auto-generate an additional calculated field: Total length of hospital Stay (elapsed time from ED/hospital arrival to hospital discharge)
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If Hospital Discharge Disposition is Deceased/Expired, then the hospital discharge date is the date of death as indicated on the patient’s death certificate.
- If the patient is an organ donor, the date of death is the date that the patient was pronounced dead as indicated on the death certificate (NOT the date that the patient was taken to the OR)
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

**Data Source Hierarchy Guide**

1. Physician Order
2. Discharge instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
7701	1	Date is not valid
7702	1	Date out of range
7703	2	Field cannot be blank
7704	3	Hospital Discharge Date is earlier than EMS Dispatch Date
7705	3	Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date
7706	3	Hospital Discharge Date is earlier than EMS Unit Scene Departure Date
7707	2	Hospital Discharge Date is earlier than ED/Hospital Arrival Date
7708	2	Hospital Discharge Date is earlier than ED Discharge Date
7709	3	Hospital Discharge Date is earlier than Date of Birth
7710	3	Hospital Discharge Date minus Injury Incident Date is greater than 365 days, please verify this is correct

- 7711 3 Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days, please verify this is correct
- 7712 2 Field must be Not Applicable when ED Discharge Disposition = 4, 6, 9, 10, or 11
- 7713 2 Field must be Not Applicable when ED Discharge Disposition = 5 (Died)

STATE

NTDB

3RD PARTY

## Outcome TR25.94- Hospital Discharge Time

### Definition

The time the order was written for the patient to be discharged from the hospital

### Field Values

Relevant value for data element

### Additional Information

- Collected as HH:MM Military time
- Used to auto-generate an additional calculated field: Total Length of Hospital Stay (elapsed time from ED/hospital Arrival to hospital discharge).
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- If hospital discharge disposition is deceased/expired then hospital discharge time is the time of death as indicated on the patient’s death certificate.
- If a patient is an organ donor, the time the patient was pronounced deceased is the time that is recorded in this field.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

### Data Source Hierarchy Guide

1. Physician Order
2. Discharge instructions
3. Nursing Notes/Flow Sheet
4. Case Management/Social Services Notes
5. Discharge Summary

### Associated Edit Checks (NTDB):

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Field cannot be blank
7804	3	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	3	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	3	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	2	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	2	Hospital Discharge Time is earlier than ED Discharge Time
7809	2	Field must be Not Applicable when ED Discharge Disposition = 4, 6, 9, 10, or 11
7810	2	Field must be Not Applicable when ED Discharge Disposition = 5 (Died)

STATE

NTDB

3RD PARTY

## Outcome TR25.27- Hospital Discharge Disposition

### Definition

The disposition of the patient when discharged from the hospital

### Field Values

- |   |  |
|---|--|
| 1. Discharged/Transferred to a short-term general hospital for inpatient care | 10. Discharged/Transferred to court/law enforcement  |
| 2. Discharged/Transferred to an Intermediate Care Facility (ICF)              | 11. Discharged/Transferred to inpatient rehab or designated unit                                     |
| 3. Discharged/Transferred to home under care of organized home health service | 12. Discharged/Transferred to Long Term Care Hospital (LTCH)   |
| 4. Left against medical advice or discontinued care (AMA)                     | 13. Discharged/Transferred to a psychiatric hospital or psychiatric distinct part unit of a hospital |
| 5. Deceased/Expired   | 14. Discharged/Transferred to another type of institution not defined elsewhere                      |
| 6. Discharged to home or self-care (routine discharge)                        | 15. Not Known/Not Recorded   |
| 7. Discharged/Transferred to Skilled Nursing Facility (SNF)                   |  |
| 8. Discharged/Transferred to hospice care                                     |  |

### Additional Information

- Home refers to the patient’s current place of residence (immediately prior to injury) e.g. prison, child protective services etc
- Field values based on UB-04 disposition coding
- Disposition to any other non-medical facility should be coded as discharged to home or self-care (routine discharge)
- The null value “Not Applicable” is used if ED Discharge Disposition = 5 Deceased/Expired
- The null value “Not Applicable” is used if ED Discharge Disposition = 4, 6, 9, 10, or 11.
- Disposition to any other medical facility should be coded as discharged to another type of inpatient facility not defined elsewhere
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

### Data Source Hierarchy Guide

1. Physician Order
2. Discharge instructions
3. Case Management/Social Services Notes
4. Nursing Notes/Flow Sheet
5. Discharge Summary

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
7901	1	Value is not a valid menu option
7902	2	Field cannot be blank
7903	2	Filed must be Not Applicable when ED Discharge Disposition = 5 (Died)
7907	2	Field must be Not Applicable when ED Discharge Disposition = 4, 6, 9, 10, or 11
7908	2	Field cannot be Not Applicable
7909	2	Field cannot be "Not Known/Not Recorded" when Hospital Arrival Date and Hospital

# **FINANCIAL INFORMATION**

STATE

NTDB

3RD PARTY

## Outcome TR2.5 – Primary Method of Payment

### Definition

Primary source of payment for hospital care

### Field Values

1. Medicaid
2. Not Billed (for any reason)
3. Self-Pay
4. Private/Commercial Insurance
6. Medicare
7. Other Government
10. Other

### Additional Information

No Fault Automobile, Workers compensation, and Blue Cross/Blue Shield should be captured as Private/Commercial Insurance.

### Data Source Hierarchy Guide

1. Billing Sheet
2. Admission Form
3. Face Sheet

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
8001	1	Value is not a valid menu option
8002	2	Field cannot be blank
8003	2	Field cannot be Not Applicable

# **HOSPITAL COMPLICATIONS**

STATE

NTDB

3RD PARTY

**Complications/PI TR23.1 – Complications****Definition**

Any medical complication that occurred during the patient's stay at your hospital

**Field Values**

- |   |  |
|---|--|
| 1. Other                                      | 29. Osteomyelitis  |
| 4. Acute Kidney Injury                        | 30. Unplanned return to OR                                 |
| 5. Adult Respiratory Distress Syndrome (ARDS) | 31. Unplanned admission to the ICU                         |
| 8. Cardiac Arrest with CPR                    | 32. Severe Sepsis  |
| 12. Deep Surgical site infection              | 33. Catheter-Associated urinary tract infection (CAUTI)    |
| 14. Deep vein thrombosis (DVT)                | 34. Central Line Associated bloodstream infection (CLABSI) |
| 15. Extremity compartment syndrome            | 35. Ventilator-Associated Pneumonia (VAP)                  |
| 18. Myocardial infarction                     | 36. Alcohol Withdrawal Syndrome                            |
| 19. Organ/Space surgical site infection       | 37. Pressure Ulcer   |
| 21. Pulmonary Embolism                        | 38. Superficial Incisional Surgical Site Infection         |
| 22. Stroke/CVA                                |  |
| 25. Unplanned intubation                      |  |

**Additional Information**

- The Null value “Not Applicable” should be used for patients with no complications. This is done by leaving the element blank.
- For any Hospital complication to be valid, there must be a diagnosis noted in the patient medical recorded that meets the definition in this data dictionary.
- Check all that apply
- Hospital Complications which were retired greater than 2 years before the current NTDS version are no longer listed under Field Values above, which is why there are numbering gaps. Refer to the NTDS Change Log for a full list of retired Hospital Complications.

**Data Source Hierarchy Guide**

1. Physician Notes
2. Operative Report
3. Progress Notes
4. Radiology Report
5. Respiratory Notes
6. Lab Reports
7. Nursing Notes/Flow Sheet
8. Discharge Summary

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
---------	-------	---------

8101	1	Value is not a valid menu option
8102	2	Field cannot be blank
8103	2	Hospital Complications include Ventilator-associated pneumonia although Total Ventilator Days is Not Applicable. Please verify

## **HOSPITAL COMPLICATIONS**

**Acute Kidney Injury:** (Consistent with the March 2012 Kidney Disease Improving Global Outcome (KDIGO) Guideline. Always use the most recent definition provided by the KDIGO.) Acute Kidney Injury, AKI (stage 3), is an abrupt decrease in kidney function that occurred during the patient's initial stay at your hospital.

### ***KDIGO (State 3) Table:***

(SCr) 3 times baseline

**OR;**

Increase in SCr to  $\geq 4\text{mg/dl}$  ( $\geq 353.3\mu\text{mol/l}$ )

**OR;**

Initiation of renal replacement therapy OR, In patients  $< 18$  years, decrease in eGFR to  $<35$  ml/min per  $1.73\text{ m}^2$

**OR;**

Urine output  $<0.3$  ml/kg/h for  $> 24$  hours

**OR;**

Anuria for  $\geq 12$  hrs.

A diagnosis of AKI must be documented in the patient's medical record. If the patient or family refuses treatment (e.g., dialysis,) the condition is still considered to be present if a combination of oliguria and creatinine are present.

EXCLUDE patients with renal failure that were requiring chronic renal replacement therapy such as periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration prior to injury.

**Adult respiratory distress syndrome (ARDS):** (*Consistent with the 2012 New Berlin Definition. Always use the most recent New Berlin definition provided.*)

Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.

Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules

Origin of edema: Respiratory failure not fully explained by cardiac failure or fluid overload. Need objective assessment (e.g., echocardiography) to exclude hydrostatic edema if no risk factor present.

Oxygenation:  $200 < PaO_2 / FiO_2 \leq 300$  (at a minimum) With PEEP or CPAP  $\geq 5$  cmH<sub>2</sub>O

**Alcohol Withdrawal Syndrome:** *(Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.)* Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient's initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record.

**Cardiac arrest with CPR:** Cardiac arrest is the sudden cessation of cardiac activity after hospital arrival. The patient becomes unresponsive with no normal breathing and no signs of circulation. If corrective measures are not taken rapidly, this condition progresses to sudden death. Cardiac Arrest must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

EXCLUDE patients who are receiving CPR on arrival to your hospital.

INCLUDE patients who have had an episode of cardiac arrest evaluated by hospital personnel, and received compressions or defibrillation or cardioversion or cardiac pacing to restore circulation.

**Catheter-associated Urinary Tract Infection** *(Consistent with the January 2015 CDC defined CAUTI):* A UTI where an indwelling urinary catheter was in place for  $>2$  calendar days on the date of event, with day of device placement being Day 1,

**AND**

An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for  $>2$  calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated.

**January 2016 CDC CAUTI Criterion SUTI 1a:**

Patient must meet 1, 2, **and** 3 below:

1. Patient has an indwelling urinary catheter in place for the entire day on the date of event and such catheter had been in place for  $>2$  calendar days, on that date (day of device placement = Day 1)
2. Patient has at least **one** of the following signs or symptoms:
  - Fever ( $>38^{\circ}\text{C}$ )
  - Suprapubic tenderness with no other recognized cause
  - Costovertebral angle pain or tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria  $>10^5$  CFU/ml.

**OR**

Patient must meet 1, 2, **and** 3 below:

1. Patient had an indwelling urinary catheter in place for >2 calendar days which was removed on the day of, or day before the date of event.
2. Patient has at least **one** of the following signs or symptoms:
  - fever (>38<sup>0</sup>C)
  - suprapubic tenderness with no other recognized cause
  - costovertebral angle pain or tenderness with no other recognized cause
  - urinary urgency with no other recognized cause
  - urinary frequency with no other recognized cause
  - dysuria with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is a bacteria >10<sup>5</sup> CFU/ml.

***January 2016 CDC CAUTI Criterion SUTI 2:***

Patient must meet 1, 2 **and** 3 below:

1. Patient is ≤1 year of age
2. Patient has at least **one** of the following signs or symptoms:
  - fever (>38.0<sup>0</sup>C)
  - hypothermia (<36.0<sup>0</sup>C)
  - apnea with no other recognized cause
  - bradycardia with no other recognized cause
  - lethargy with no other recognized cause
  - vomiting with no other recognized cause
  - suprapubic tenderness with no other recognized cause
3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10<sup>5</sup> CFU/ml.

Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of ≥10<sup>5</sup> CFU/ml.

A diagnosis of UTI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Central line-associated bloodstream infection** (*Consistent with the January 2016 CDC defined CLABSI. Always use the most recent definition provided by the CDC.*) A laboratory-confirmed bloodstream infection (LCBI) where central line (CL) or umbilical catheter (UC) was in place for > 2 calendar days on the date of event, with day of device placement being Day 1,

**AND**

The line was also in place on the date of event or the day before. If a CL or UC was in place for > 2 calendar days and then removed, the date of event of the LCBI must be the day of discontinuation or the next day to be a CLABSI. If the patient is admitted or transferred into a facility with an implanted central line (port) in place, and that is the patient's only central line, day of first access in an inpatient location is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line. Such lines continue to be eligible for CLABSI once they are accessed until they are either discontinued or the day after patient discharge (as per the Transfer Rule.) Note that the "de-access" of a port does not result in the patient's removal from CLABSI surveillance.

**January 2016 CDC Criterion LCBI 1:**

Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.)

**AND**

Organism(s) identified in blood is not related to an infection at another site.

**OR**

**January 2016 CDC Criterion LCBI 2:**

Patient has at least one of the following signs or symptoms: fever ( $>38^{\circ}\text{C}$ ), chills, or hypotension

**AND**

Organism(s) identified from blood is not related to an infection at another site.

**AND**

the same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., and *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the 7-day time period which includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

**OR**

**January 2016 CDC Criterion LCBI 3:**

Patient  $\leq 1$  year of age has at least one of the following signs or symptoms: fever ( $>38^{\circ}\text{C}$ ), hypothermia ( $<36^{\circ}\text{C}$ ), apnea, or bradycardia

**AND**

Organism(s) identified from blood is not related to an infection at another site

**AND**

the same common commensal (i.e., diphtheroids [*Corynebacterium* spp. not *C. diphtheriae*], *Bacillus* spp. [not *B. anthracis*], *Propionibacterium* spp., coagulase-negative staphylococci [including *S. epidermidis*], viridans group streptococci, *Aerococcus* spp., *Micrococcus* spp.) is identified from two or more blood specimens drawn on separate occasions, by a culture or nonculture base microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.) Criterion elements must occur within the Infection Window Period, the 7-day time period which

includes the collection date of the positive blood, the 3 calendar days before and the 3 calendar days after.

A diagnosis of LCBSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Deep surgical site infection:** *(Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.)* Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) According to list in Table 2

**AND**

involves deep soft tissues of the incision (e.g., fascial and muscle layers)

**AND**

patient has at least **one** of the following:

- a. purulent drainage from the deep incision.
- b. a deep incision that spontaneously dehisces, or is deliberately opened or aspirated by a surgeon, attending physician\*\* or other designee and organism is identified by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) or culture or non-culture based microbiologic testing method is not performed

**AND**

patient has at least **one** of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.

c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

COMMENTS: There are two specific types of deep incisional SSIs:

1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

**Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative**

**Procedure Categories. Day 1 = the date of the procedure.**

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Deep Vein Thrombosis (DVT):** The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava. A diagnosis of DVT must be documented in the patient's medical record. This diagnosis may be confirmed by a venogram, ultrasound, or CT, and must have occurred during the patient's initial stay at your hospital.

**Extremity compartment syndrome:** A condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. A diagnosis of Extremity Compartment Syndrome must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital. Only record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.

**Myocardial infarction:** An acute myocardial infarction must be noted with documentation of any of the following:

Documentation of ECG changes indicative of acute MI (one or more of the following three):

1. ST elevation >1 mm in two or more contiguous leads
2. New left bundle branch block
3. New q-wave in two or more contiguous leads

**OR**

New elevation in troponin greater than three times upper level of the reference range in the setting of suspected myocardial ischemia

**OR**

Physician diagnosis of myocardial infarction

Must have occurred during the patient's initial stay at your hospital.

**Organ/space surgical site infection:** *(Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.)* Must meet the following criteria:

Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

**AND**

infection involves any part of the body deeper than the fascial/muscle layers, that is opened or manipulated during the operative procedure

**AND**

patient has at least **one** of the following:

- a. purulent drainage from a drain that is placed into the organ/space (e.g., closed suction drainage system, open drain, T-tube drain, CT guided drainage)
- b. organisms are identified from an aseptically-obtained fluid or tissue in the organ/space by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
- c. an abscess or other evidence of infection involving the organ/space that is detected on gross anatomical or histopathologic exam, or imaging test

**AND**

meets at least **one** criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.

**Table 2. Surveillance Period for Deep Incisional or Organ/Space SSI Following Selected NHSN Operative Procedure Categories. Day 1 = the date of the procedure.**

30-day Surveillance			
Code	Operative Procedure	Code	Operative Procedure
AAA	Abdominal aortic aneurysm repair	LAM	Laminectomy
AMP	Limb amputation	LTP	Liver transplant
APPY	Appendix surgery	NECK	Neck surgery
AVSD	Shunt for dialysis	NEPH	Kidney surgery
BILI	Bile duct, liver or pancreatic surgery	OVRY	Ovarian surgery
CEA	Carotid endarterectomy	PRST	Prostate surgery
CHOL	Gallbladder surgery	REC	Rectal surgery
COLO	Colon surgery	SB	Small bowel surgery
CSEC	Cesarean section	SPLE	Spleen surgery
GAST	Gastric surgery	THOR	Thoracic surgery
HTP	Heart transplant	THUR	Thyroid and/or parathyroid surgery
HYST	Abdominal hysterectomy	VHYS	Vaginal hysterectomy
KTP	Kidney transplant	XLAP	Exploratory Laparotomy
90-day Surveillance			
Code	Operative Procedure		
BRST	Breast surgery		
CARD	Cardiac surgery		
CBGB	Coronary artery bypass graft with both chest and donor site incisions		
CBGC	Coronary artery bypass graft with chest incision only		
CRAN	Craniotomy		
FUSN	Spinal fusion		
FX	Open reduction of fracture		
HER	Herniorrhaphy		
HPRO	Hip prosthesis		
KPRO	Knee prosthesis		
PACE	Pacemaker surgery		
PVBY	Peripheral vascular bypass surgery		
VSHN	Ventricular shunt		

**Table 3. Specific Sites of an Organ/Space SSI.**

Code	Site	Code	Site
BONE	Osteomyelitis	LUNG	Other infections of the respiratory tract
BRST	Breast abscess mastitis	MED	Mediastinitis
CARD	Myocarditis or pericarditis	MEN	Meningitis or ventriculitis
DISC	Disc space	ORAL	Oral cavity (mouth, tongue, or gums)
EAR	Ear, mastoid	OREP	Other infections of the male or female reproductive tract
EMET	Endometritis	PJI	Periprosthetic Joint Infection
ENDO	Endocarditis	SA	Spinal abscess without meningitis
EYE	Eye, other than conjunctivitis	SINU	Sinusitis
GIT	GI tract	UR	Upper respiratory tract
HEP	Hepatitis	USI	Urinary System Infection
IAB	Intraabdominal, not specified	VASC	Arterial or venous infection
IC	Intracranial, brain abscess or dura	VCUF	Vaginal cuff
JNT	Joint or bursa		

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Osteomyelitis** (*Consistent with the January 2016 CDC definition of Bone and Joint infection. Always use the most recent definition provided by the CDC.*) Osteomyelitis must meet at least **one** of the following criteria:

1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least **two** of the following localized signs or symptoms: fever (>38.0°C), swelling\*, pain or tenderness\*, heat\*, or drainage\*

AND at least **one** of the following:

- a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
- b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

\* With no other recognized cause

A diagnosis of Osteomyelitis must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Pulmonary embolism:** A lodging of a blood clot in a pulmonary artery with subsequent obstruction of blood supply to the lung parenchyma. The blood clots usually originate from the deep leg veins or the pelvic venous system. Consider the condition present if the patient has a V-Q scan interpreted as high probability of pulmonary embolism or a positive pulmonary arteriogram or positive CT angiogram and/or a diagnosis of PE is documented in the patient's medical record. Must have occurred during the patient's initial stay at your hospital.

**Pressure Ulcer:** (*Consistent with the National Pressure Ulcer Advisory Panel (NPUAP) 2014. Always use the most recent definition provided by the NPUAP.*) A localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear. A number of contributing or confounding factors are also associated with pressure ulcers; the significance of these factors is yet to be elucidated. Equivalent to NPUAP Stages II-IV, Unstageable/Unclassified, and Suspected Deep Tissue Injury. Documentation of Pressure Ulcer must be in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Severe Sepsis:** (*Consistent with the American College of Chest Physicians and the Society of Critical Care Medicine October 2010. Always use the most recent definition provided by the American College of Chest Physicians and the Society of Critical Care Medicine.*)

Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.

Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

A diagnosis of Sepsis must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Stroke/CVA:** A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms:

- Change in level of consciousness
- Hemiplegia
- Hemiparesis
- Numbness or sensory loss affecting on side of the body
- Dysphasia or aphasia
- Hemianopia
- Amaurosis fugax
- Other neurological signs or symptoms consistent with stroke

**AND:**

- Duration of neurological deficit  $\geq 24$  h

**OR:**

- Duration of deficit  $< 24$  h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death

**AND:**

- No other readily identifiable non-stroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified

**AND:**

- Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, angiography,) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission.)

Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission. A diagnosis of Stroke/CVA must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital

**Superficial Incisional Surgical Site Infection:** (*Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.*) Must meet the following criteria:

Infection occurs within 30 days after any NHSN operative procedure (where day 1 = the procedure date)

**AND**

involves only skin and subcutaneous tissue of the incision

**AND**

patient has at least **one** of the following:

- a. purulent drainage from the superficial incision.
- b. organisms identified from an aseptically-obtained specimen from the superficial incision or subcutaneous tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).
- c. superficial incision that is deliberately opened by a surgeon, attending physician\*\* or other designee and culture or non-culture based testing is not performed.

**AND**

patient has at least **one** of the following signs or symptoms: pain or tenderness; localized swelling; erythema; or heat. A culture or non-culture based test that has a negative finding does not meet this criterion.

- d. diagnosis of a superficial incisional SSI by the surgeon or attending physician\*\* or other designee.

COMMENTS: There are two specific types of superficial incisional SSIs:

1. Superficial Incisional Primary (SIP) – a superficial incisional SSI that is identified in the primary incision in a patient that has had an operation with one or more incisions (e.g., Csection incision or chest incision for CBGB)
2. Superficial Incisional Secondary (SIS) – a superficial incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)

A diagnosis of SSI must be documented in the patient's medical record, and must have occurred during

- a. the patient's initial stay at your hospital.

**Unplanned admission to ICU:** Patients admitted to the ICU after initial transfer to the floor, and/or patients with an unplanned return to the ICU after initial ICU discharge. Must have occurred during the patient's initial stay at your hospital. EXCLUDE: Patients in which ICU care was required for postoperative care of a planned surgical procedure.

**Unplanned Intubation:** Patient requires placement of an endotracheal tube and mechanical or assisted ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress, hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency

Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24 hours after extubation. Must have occurred during the patient's initial stay at your hospital.

**Unplanned Return to the Operating Room:** Unplanned return to the operating room after initial operation management for a similar or related previous procedure. Must have occurred during the patient's initial stay at your hospital.

**Ventilator-Associated Pneumonia (VAP):** *(Consistent with the January 2016 CDC defined VAP. Always use the most recent definition provided by the CDC.)* A pneumonia where the patient is on mechanical ventilation for > 2 calendar days on the date of event, with day of ventilator placement being Day 1,

**AND**

The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.

**VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):**

IMAGING TEST EVIDENCE	SIGNS/SYMPOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38°C or &gt;100.4°F)</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) or leukocytosis (≥12,000 WBC/mm<sup>3</sup>)</li> <li>• For adults ≥70 years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least two of the following:</p> <ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations (e.g., PaO<sub>2</sub>/FIO<sub>2</sub> ≤240), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Organism identified from blood</li> <li>• Organism identified from pleural fluid</li> <li>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.)</li> <li>• ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain)</li> <li>• Positive quantitative culture of lung tissue</li> <li>• Histopathologic exam shows at least one of the following evidences of pneumonia: <ul style="list-style-type: none"> <li>○ Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</li> <li>○ Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae</li> </ul> </li> </ul>

**VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li>   <li>• Consolidation</li>   <li>• Cavitation</li>   <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li>   <li>• Leukopenia (<math>\leq 4000</math> WBC/<math>\text{mm}^3</math>) or leukocytosis (<math>\geq 12,000</math> WBC/<math>\text{mm}^3</math>)</li>   <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> </ul> <p>AND at least one of the following:</p>	<p>At least one of the following:</p> <ul style="list-style-type: none"> <li>• Virus, <i>Bordetella</i>, <i>Legionella</i>, <i>Chlamydia</i> or <i>Mycoplasma</i> identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST).</li>   <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, <i>Chlamydia</i>)</li>   <li>• Fourfold rise in <i>Legionella pneumophila</i> serogroup 1 antibody titer to <math>\geq 1:128</math> in paired acute and convalescent sera by indirect IFA.</li> </ul>
<p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</p>	<ul style="list-style-type: none"> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., <math>\text{O}_2</math> desaturations (e.g., <math>\text{PaO}_2/\text{FiO}_2 \leq 240</math>), increased oxygen requirements, or increased ventilator demand)</li> </ul>	<ul style="list-style-type: none"> <li>• Detection of <i>L. pneumophila</i> serogroup 1 antigens in urine by RIA or EIA</li> </ul>

**VAP Algorithm (PNU3 Immunocompromised Patients):**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest imaging test results with at least <i>one</i> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants <math>\leq 1</math> year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive chest imaging test result is acceptable.</b></p>	<p>Patient who is immunocompromised has at least <i>one</i> of the following:</p> <ul style="list-style-type: none"> <li>• Fever (<math>&gt;38^{\circ}\text{C}</math> or <math>&gt;100.4^{\circ}\text{F}</math>)</li> <li>• For adults <math>\geq 70</math> years old, altered mental status with no other recognized cause</li> <li>• New onset of purulent sputum<sup>3</sup>, or change in character of sputum<sup>4</sup>, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, or tachypnea<sup>5</sup></li> <li>• Rales<sup>6</sup> or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., PaO<sub>2</sub>/FIO<sub>2</sub> <math>&lt;240</math>]<sup>7</sup>, increased oxygen requirements, or increased ventilator demand)</li> <li>• Hemoptysis</li> <li>• Pleuritic chest pain</li> </ul>	<p>At least <i>one</i> of the following:</p> <ul style="list-style-type: none"> <li>• Identification of matching <i>Candida</i> spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.<sup>11,12,13</sup></li> <li>• Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following: <ul style="list-style-type: none"> <li>- Direct microscopic exam</li> <li>- Positive culture of fungi</li> <li>- Non-culture diagnostic laboratory test</li> </ul> </li> </ul> <p>Any of the following from:  <b>LABORATORY CRITERIA DEFINED UNDER PNU2</b></p>

**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.</p>	<p>Worsening gas exchange (e.g., O<sub>2</sub> desaturation [e.g. pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</p> <p>AND at least three of the following:</p> <ul style="list-style-type: none"> <li>• Temperature instability</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (≥15,000 WBC/mm<sup>3</sup>) and left shift (≥10% band forms)</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting</li> <li>• Wheezing, rales, or rhonchi</li> <li>• Cough</li> <li>• Bradycardia (&lt;100 beats/min) or tachycardia (&gt;170 beats/min)</li> </ul>

**VAP Algorithm ALTERNATE CRITERIA (PNU1), for children >1 year old or ≤12 years old:**

IMAGING TEST EVIDENCE	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest imaging test results with at least one of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive and persistent infiltrate</li> <li>• Consolidation</li> <li>• Cavitation</li> <li>• Pneumatoceles, in infants ≤1 year old</li> </ul> <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.</p>	<p>At least three of the following:</p> <ul style="list-style-type: none"> <li>• Fever (&gt;38.0°C or &gt;100.4°F) or hypothermia (&lt;36.0°C or &lt;96.8°F)</li> <li>• Leukopenia (≤4000 WBC/mm<sup>3</sup>) or leukocytosis (≥15,000 WBC/mm<sup>3</sup>)</li> <li>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</li> <li>• New onset or worsening cough, or dyspnea, apnea, or tachypnea</li> <li>• Rales or bronchial breath sounds</li> <li>• Worsening gas exchange (e.g., O<sub>2</sub> desaturations [e.g., pulse oximetry &lt;94%], increased oxygen requirements, or increased ventilator demand)</li> </ul>

A diagnosis of Pneumonia must be documented in the patient's medical record, and must have occurred during the patient's initial stay at your hospital.

**Multiple Cause Coding Hierarchy:** If two or more events cause separate injuries, an external cause code should be assigned for each cause. The first-listed external cause code will be selected in the following order:

1. External cause codes for child and adult abuse take priority over all other external cause codes
2. External cause codes for terrorism events take priority over all other external cause codes except child and adult abuse.
3. External cause codes for cataclysmic events take priority over all other external cause codes except child and adult abuse, and terrorism.
4. External cause codes for transport accidents take priority over all other external cause codes except cataclysmic events, and child and adult abuse, and terrorism.
5. The first listed external cause code should correspond to the cause of the most serious diagnosis due to an assault, accident or self-harm, following the order of hierarchy listed above.

# **SECTION B:**

Wisconsin Core Data Elements

STATE

3RD PARTY

## Demographics TR1.2 – Medical Record #

### Definition

The facility medical record number that represents the patient

### Field Values

Relevant value for data element

### Additional Information

This number will not change for the person regardless of changes to the account number of facility trauma registry number. If the patient is identified as an existing patient late in their care use the final medical record number to complete this field rather than the initially assigned medical record that was used prior to discover of the existing MRN.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Discharge Summary
4. Admission Form

STATE

3RD PARTY

## Demographics TR1.9 – Patient’s Last Name

### Definition

The last name of the patient.

### Field Values

Relevant value for data element

### Additional Information

- If Alias is used it will be documented in the alias sections, this field should be the patients actual legal name
- If the patient’s legal name is not known, leave blank.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

STATE

3RD PARTY

## Demographics TR1.8 – Patient’s First Name

### Definition

The first name of the patient.

### Field Values

Relevant value for data element

### Additional Information

- If Alias is used it will be documented in the alias sections, this field should be the patients actual legal name
- If the patient’s legal name is not known, leave blank.

### Data Source Hierarchy Guide

1. Face Sheet
2. Billing Sheet
3. Admission Form

STATE

## Injury 5.13 – Injury Type

### Definition

This is the initial type of injury. The force that caused the most severe injury based on a matrix.

### Field Values

1. Blunt
2. Burn
3. Penetrating
4. Other
5. Not Known/Not Recorded

### Additional Information

- This field is often auto-populated based on the ICD 10 matrix, however it may need to be manually entered.
- ICD-10 Matrix:  
[https://www.facs.org/~media/files/quality%20programs/trauma/icd10cm\\_nonpoisoning\\_cause\\_matrix.ashx](https://www.facs.org/~media/files/quality%20programs/trauma/icd10cm_nonpoisoning_cause_matrix.ashx)

### Data Source Hierarchy Guide

- NTDB External Cause of Injury Matrix.

STATE

## Pre-Hospital TR5.33 – Was patient extricated?

### Definition

Was the patient extricated?

### Field Values

1. Yes
2. No
3. Not Known/Not Recorded

### Additional Information

This can be from a MVC but can also refer to other times patient requires extrication.

### Data Source Hierarchy Guide

1. EMS Run Report

STATE

## Pre-Hospital TR7.3- Scene/Transport Agency Name

### Definition

The Service name of the first ambulance/flight service attending to the patient at the scene, if applicable. This field applies only if patient arrived to your facility by EMS.

### Field Values

Relevant value for the data element

### Additional Information

- Picked from a drop-down menu after selecting agency state.
- If agency cannot be found, select "Out of State Agency" and inform trauma program by emailing [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov)

### Data Source Hierarchy Guide

1. EMS Run Report

STATE

## Pre-Hospital TR15.38- EMS ePCR Available?

### Definition

This field applies only if an ambulance/flight selection was made from previous “Mode” field. Select “Complete” if a full EMS report was available, through the Elite database, or the agency’s electronic medical record system at the time of abstraction. Select “Missing” if no EMS report was available at the time of abstraction or if greater than 10 days have passed since the date of service and the ePCR is not available in Elite.

### Field Values

1. Complete
2. Missing
3. Not applicable

### Data Source Hierarchy Guide

1. EMS Run Report

STATE

## Pre-Hospital TR18.80- Pre-Hospital Respiratory Assistance

### Definition

Was the patient being assisted with breathing during the time the vitals were taken with mechanical ventilation or bag mask ventilation?

### Field Values

1. Unassisted Respiratory Rate
2. Assisted Respiratory Rate
3. Not Applicable
4. Not Known/Not Recorded

### Additional Information

- Only completed if a value is provided for Pre-Hospital Respiratory Rate (TR18.70).
- Respiratory Assistance is defined as mechanical and/or external support of respiration.
- Please note that first recorded hospital vitals do not need to be from the same assessment.
- When “Pre-Hospital Respiratory Rate” is “Not Known/Not Recorded”, select “Not Applicable”

### Data Source Hierarchy Guide

1. EMS Run Report

STATE

## Referring Facility TR33.64- Transfer In

### Definition

Was the facility transferred to your facility from another acute care facility?

### Field Values

1. Yes
2. No

### Additional Information

If "No" is selected then submit the tab and continue data entry

### Data Source Hierarchy Guide

1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork

STATE

## Referring Facility TR33.1– Referring Facility

### Definition

The name of the facility that cared for the patient immediately before the patient arrived at your facility

### Field Values

1. Wisconsin Facilities with DHS identification Name
2. Other (used for out of state facilities)

### Additional Information

If “other” is selected then must fill out additional field “if other”

### Data Source Hierarchy Guide

1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork

STATE

## Referring Facility TR33.1.1- Other Facility

### Definition

Free text field to identify the name of the out-of-state facility that transferred the patient to your facility

### Field Values

Free text description of the facility that transferred the patient to your facility

### Additional Information

- Only used when the referring facility is not listed.
- Will show when Referring Hospital is set to Other

### Data Source Hierarchy Guide

1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet

STATE

## Referring Facility TR33.2– Referring Facility Arrival Date

### Definition

The date the patient arrived at the referring facility

### Field Values

Relevant data values in MM/DD/YYYY

### Additional Information

If date of arrival is not documented, leave blank

### Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet
3. EMS Run Sheet

STATE

## Referring Facility TR33.3– Referring Facility Arrival Time

### Definition

The time the patient arrived at the referring facility

### Field Values

Time in 24 hour format HH:MM

### Additional Information

If time of arrival is not documented, leave blank

### Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

STATE

## Referring Facility TR33.30- Referring Facility Discharge Date

### Definition

The date the patient was discharged from the referring facility

### Field Values

Relevant data values in MM/DD/YYYY

### Additional Information

If date of discharge is not documented, leave blank

### Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

STATE

## Referring Facility TR33.31- Referring Facility Discharge Time

### Definition

The time the patient was discharged from the referring facility

### Field Values

Time in 24 hour format HH:MM

### Additional Information

If time of discharge is not documented, leave blank

### Data Source Hierarchy Guide

1. Referring facility documentation
2. Trauma/Transfer/Hospital Flow Sheet

STATE

## ED/TTA TR17.65- Facility Access

### Definition

How did the patient come into your facility?

### Field Values

1. Emergency Department
2. Direct Admit - not ED or Trauma Department
3. Trauma Department - Independent from ED
4. Not Applicable
5. Not Known/Not Recorded

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet

STATE

## ED/TTA TR16.22- Arrived From

### Definition

Location the patient arrived from

### Field Values

- Scene
- Referring Hospital
- Clinic/MD Office
- Jail
- Home
- Nursing Home
- Supervised Living
- Urgent Care
- Not Known/Not Recorded

### Additional Information

Patients injured at home should be coded as "Scene"

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet

## ED/TTA TR8.8- Mode of Arrival

### Definition

The modality that brought the patient to your facility, if multiple modes indicate the last mode that brought the patient to your facility.

### Field Values

- Ground Ambulance
- Helicopter Ambulance
- Fixed-wing Ambulance
- Private Vehicle/Walk-in
- Police
- Other
- Not Applicable
- Not Known/Not Recorded

### Additional Information

The last mode that brought the patient to your facility

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. EMS Run Sheet

STATE

## ED/TTA TR17.45- Transfer Delay

### Definition

Was there a delay in transferring this patient to another facility?

### Field Values

1. Yes
2. No
3. Not Applicable
4. Not Known/Not Recorded

### Additional Information

Marking this element as “Yes” will generate TR17.44, Reason for Transfer Delay

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet

STATE

## ED/TTA TR17.44 – Reason for Transfer Delay

### Definition

The cause of the delay in patient transfer out of the ED.

### Field Values

1. Delayed identification that the patient needed trauma center resources
2. Equipment issue
3. High ED census at receiving hospital/busy
4. High ED census at transferring hospital/busy
5. In-house imaging delay
6. Late requesting transporting EMS unit
7. Low patient acuity
8. Other
9. Patient status change/complication
10. Referring hospital Issue – Radiology
11. Referring Physician Decision Making
12. Weather or Natural Factors
13. Waiting for transporting EMS unit
14. Not Applicable
15. Not Known/Not Recorded

### Additional Information

This element is required when TR17.45 is marked as “Yes”

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Access Center Record/Communication Center
4. EMS Run Sheet

STATE

3RD PARTY

## ED/TTA TR17.21- Trauma Team Activation Level

### Definition

Was the facility-specific trauma activation/alert activated?

### Field Values

- Level 1
- Level 2
- Level 3
- Not Activated
- Not Known/Not Recorded

### Additional Information

- This should be the initial level/alert that was sent out. If the level was upgraded put the first activation that went out
- If no activation/alert was sent out but trauma/surgeon saw the patient in the ED select “Level 3”
- If the patient was a direct admit, Select “Not Activated”
- Not applicable should not be used for this field.
- If your facility has only one level of activation, select Level 1.
- If your facility has two levels of activation, Level 1 is associated with the highest level.

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Physician Notes

STATE

3RD PARTY

## ED/TTA TR17.78.3-Activation Level Upgrade/Downgrade

### Definition

If the trauma team activation level was upgraded or downgraded, select the new activation level.

### Field Values

- Level 1
- Level 2
- Level 3
- Not Activated
- Not Known/Not Recorded
- Not Applicable

### Additional Information

- If the activation was cancelled, select “Not Activated”
- If your facility has only one level of activation, select Level 1.
- If your facility has two levels of activation, Level 1 is associated with the highest level.
- If the activation level was not updated, select “Not Applicable”.

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
5. Physician Notes

STATE

## ED/TTA TR17.31- Date Trauma Team Activated

### Definition

The date the facility specific trauma alert/activation was paged out

### Field Values

Relevant data values in MM/DD/YYYY

### Additional Information

- Required if a leveled trauma activation is entered (Level 1, Level 2, Level 3)
- If the patient was not an activation/alert, leave blank

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet

STATE

## ED/TTA TR17.34- Time Trauma Team Activated

### Definition

The time the facility specific trauma alert/activation was paged out

### Field Values

Time in 24 hour format HH:MM

### Additional Information

- Required if a leveled trauma activation is entered (Level 1, Level 2, Level 3)
- If the patient was not an activation/alert, leave blank

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet

STATE

**ED/TTA TR18.99- Admitting Service**

**Definition**

The service the patient was admitted to at your facility

**Field Values**

- |                                |                            |
|--------------------------------|----------------------------|
| 1. Anesthesia/CRNA             | 19. Not Known/Not Recorded |
| 2. Burn                        | 20. OB                     |
| 3. Cardiology                  | 21. Ophtha                 |
| 4. Cardiovascular (CV) Surgery | 22. Or Surg                |
| 5. CCM                         | 23. OralMax                |
| 6. Emergency Medicine          | 24. Orthopedics            |
| 7. ENT                         | 25. Other                  |
| 8. Gastrointestinal            | 26. Pedi Surgery           |
| 9. Gen Surgery                 | 27. Pediatrics             |
| 10. GYN                        | 28. Plastic Surgery        |
| 11. Hospitalist                | 29. Pulmonary Medicine     |
| 12. Infection Control          | 30. Radiology              |
| 13. Int. Med.                  | 31. Respiratory Therapy    |
| 14. Nephrology                 | 32. Thoracic Surg          |
| 15. Neurology                  | 33. Trauma                 |
| 16. Neurosurgery               | 34. Trauma Nurse           |
| 17. Non-Surgical               | 35. Urology                |
| 18. Not Applicable             | 36. Vascular               |

**Additional Information**

- The admitting attending will determine what service the patient was admitted to
- If the patient was discharged from the ED, Select “Not Applicable”

**Data Source Hierarchy Guide**

1. Trauma/Triage/Hospital Flow Sheet
2. History & Physical

STATE

## ED/TTA TR17.25 – ED Physical Discharge Date

### Definition

The date the patient was physically discharged from the ED or transferred to inpatient unit/OR.

### Field Values

Relevant value for data element

### Additional Information

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Length of Stay (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes

STATE

## ED/TTA TR17.26 – ED Physical Discharge Time

### Definition

The time the patient was physically discharged from the ED or transferred to inpatient unit/OR.

### Field Values

Relevant value for data element

### Additional Information

- Collected as HH:MM.
- Used to auto-generate an additional calculated field: Length of Stay: (elapsed time from ED admit to ED discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.  
TR

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes

STATE

## Procedures TR22.30- Procedure Performed?

### Definition

Indicate if the patient had a procedure performed upon them while in your facility

### Field Values

- Yes
- No
- Not Known/Not Recorded

### Additional Information

If the answer is “No”, leave ICD-10 Procedures, Date Performed, and Time blank.

### Data Source Hierarchy Guide

1. Trauma/Triage/Hospital Flow Sheet

STATE

## Diagnosis – Injury Severity Score

### Definition

Injury Severity Score (ISS) that reflects the patient’s injuries

### Field Values

Relevant value for the constellation of injuries

### Additional Information

The Injury Severity Score (ISS) is an anatomical scoring system that provides an overall score for patients with multiple injuries. Each injury is assigned an Abbreviated Injury Scale (AIS) score and is allocated to one of six body regions (Head, Face, Chest, Abdomen, Extremities (including Pelvis), External). Only the highest AIS score in each body region is used. The 3 most severely injured body regions have their score squared and added together to produce the ISS score.

The ISS score takes values from 0 to 75. If an injury is assigned an AIS of 6 (unsurvivable injury), the ISS score is automatically assigned to 75. The ISS score is virtually the only anatomical scoring system in use and correlates linearly with mortality, morbidity, hospital stay and other measures of severity.

This value is auto-populated by the ImageTrend system



Must complete ICD-10 Diagnosis and AIS code to populate

STATE

## Outcome TR25.34 – Hospital Physical Discharge Date

### Definition

The date the patient expired or was physically discharged from the hospital (separate from the order for discharge)

### Field Values

Relevant value for data element

### Additional Information

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Hospital Length of Stay – Calendar Days: (elapsed time from hospital admit to hospital discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes

STATE

## Outcome TR25.48 – Hospital Physical Discharge Time

### Definition

The time the patient expired or was physically discharged from the hospital (separate from the order for discharge)

### Field Values

Relevant value for data element

### Additional Information

- Collected as HH:MM.
- Used to auto-generate an additional calculated field: Hospital Length of Stay – Calendar Days: (elapsed time from hospital admit to hospital discharge).
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.
- This field will lock when the ED disposition is 4, 5, 6, 9, 10, or 11.

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes

## Diagnosis – ISS Region

### Definition

The Injury Severity Score (ISS) body region codes that reflect the patient’s injuries

### Field Values

1. Head – TR21.2
2. Face – TR21.5
3. Chest – TR21.3
4. Abdomen – TR21.6
5. Extremity – TR21.4
6. External – TR21.7

### Additional Information

- Auto-populated by entering ICD 10 Diagnosis and AIS Code
- Head or Neck Injuries include injury to the brain or cervical spine, skull or cervical spine fractures.
- Facial injuries include those involving the mouth, ears, nose and facial bones.
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine.
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region.
- Injuries to the extremities or to the pelvic or shoulder girdle including sprains, fractures, dislocations, and amputations, except for the spinal column, skull and rib cage.
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface.

### Data Source Hierarchy Guide

1. Physician Order
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. Discharge Summary
5. Billing Sheet
6. Progress Notes

# **SECTION C:**

Report Writer Dataset Elements

The ImageTrend Report Writer utilizes two separate datasets, Transactional and Analytical. Elements can typically be found by using the ImageTrend Data Element Number (TR#.##). "N/A" indicates a field which is either unavailable in Report Writer or is currently under development for future use. The following tables identify the level of requirement (NTDB or WI CORE), the associated ImageTrend Data Element Number, the element title as displayed on the data entry form, the element as it appears within the Report Writer for transactional reports, and the element as it appears within the Report Writer for analytical reports respectively. These tables are ordered as the data items appear within this data dictionary.

<b>DEMOGRAPHICS</b>				
<b>Required</b>	<b>Data Element</b>	<b>Element Name</b>	<b>Transactional Report Name</b>	<b>Analytical Report Name</b>
NTDB	TR1.20	ZIP	Patient Home Zip (TR1.20)	Patient Home Zip (TR1.20)
NTDB	TR1.19	Country	Patient Home Country (TR1.19)	Patient Home Country (TR1.19)
NTDB	TR1.23	State	Patient Home State (TR1.23)	Patient Home State (TR1.23)
NTDB	TR1.22	County	Patient Home County (TR1.22)	Patient Home County (TR1.22)
NTDB	TR1.21	City	Patient Home City (TR1.21)	Patient Home City (TR1.21)
NTDB	TR1.13	Alternate Residence	Patient Alternate Home Residence (TR1.13)	Patient Alternate Home Residence (TR1.13)
NTDB	TR1.7	Date of Birth	Patient Date of Birth (TR1.7)	Patient Date of Birth (TR1.7)
NTDB	TR1.12	Age	Patient Age (TR1.12)	Patient Age (TR1.12)
NTDB	TR1.14	Age Units	Patient Age Units (TR1.14)	Patient Age Units (TR1.14)
NTDB	TR1.16	Race	Patient Race (TR1.16)	Patient Race (TR1.16)
NTDB	TR1.17	Ethnicity	Patient Ethnicity (TR1.17)	Patient Ethnicity (TR1.17)
NTDB	TR1.15	Sex	Patient Gender (TR1.15)	Patient Gender (TR1.15)
CORE	TR5.12	Registry Number	Incident Number (TR5.12)	Incident Number (TR5.12)
CORE	TR1.2	Medical Record Number	Patient Medical Record Number (TR1.2)	Patient Medical Record Number (TR1.2)
CORE	TR1.9	Last Name	Patient Last Name (TR1.9)	Patient Last Name (TR1.9)
CORE	TR1.8	First Name	Patient First Name (TR1.8)	Patient First Name (TR1.8)
CORE	TR1.10	Middle Initial	Patient Middle Initial (TR1.10)	Patient Middle Initial (TR1.10)

<b>INJURY</b>				
<b>Required</b>	<b>Data Element</b>	<b>Element Name</b>	<b>Transactional Report Name</b>	<b>Analytical Report Name</b>
NTDB	TR5.1	Injury Date	Incident Date (TR5.1)	Incident Date (TR5.1)
NTDB	TR5.18	Injury Time	Incident Time (TR5.18)	Incident Time (TR5.18)
NTDB	TR2.10	Work Related	Incident Work Related (TR2.10)	Incident Work Related (TR2.10)
NTDB	TR2.6	Occupational Industry	Patient Occupational Industry (TR2.6)	Patient Occupational Industry (TR2.6)
NTDB	TR2.11	Occupation	Patient Occupation (TR2.11)	Patient Occupation (TR2.11)
NTDB	TR200.3	ICD10 External Cause Code	ICD-10 Injury Code (TR200.3)	ICD-10 Injury Code (TR200.3)
NTDB	TR200.5	ICD10 Location	ICD-10 Location Code (TR200.5)	ICD-10 Location Code (TR200.5)
NTDB	TR5.6	Incident ZIP	Incident Location Zip Code (TR5.6)	Incident Location Zip Code (TR5.6)
NTDB	TR5.11	Incident Country	Incident Country (TR5.11)	Incident Country (TR5.11)
NTDB	TR5.7	Incident State	Injury State (TR5.7)	Incident State (TR5.7)
NTDB	TR5.9	Incident County	Incident County (TR5.9)	Incident County (TR5.9)
NTDB	TR5.10	Incident City	Incident City (TR5.10)	Incident City (TR5.10)
NTDB	TR41.1	Report of Physical Abuse	Report of Physical Abuse (TR41.1)	Report of Physical Abuse (TR41.1)
NTDB	TR41.2	Investigation of Physical Abuse	Investigation of physical abuse (TR41.2)	Investigation of physical abuse (TR41.2)
NTDB	TR41.3	Discharge to Alternate Caregiver	Caregiver At Discharge (TR41.3)	Caregiver At Discharge (TR41.3)
CORE	TR5.13	Injury Type	Trauma Type with ICD-10 COI codes (TR5.13)	Trauma Type with ICD-10 COI codes (TR5.13)
NTDB	TR29.24	Protective Devices	Safety Device Used (TR29.24)	Protective Device – Safety Device Used (TR29.24)
	TR29.32	Airbag Deployed	Airbag Deployment (TR29.32)	N/A
	TR29.31	Child Specific Restraint	Child Specific Restraint (TR29.31)	N/A

## PRE-HOSPITAL

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR9.1	EMS Dispatched Date	EMS Unit Notified Date (TR9.1)	EMS Unit Notified Date (TR9.1)
NTDB	TR9.10	EMS Dispatch Time	EMS Unit Notified Time (TR9.10)	EMS Unit Notified Time (TR9.10)
NTDB	TR9.2	EMS Arrive Scene	EMS Unit Arrived On Scene (TR9.2)	EMS Unit Arrived on Scene (TR9.2)
NTDB	TR9.3	EMS Leave Scene	EMS Unit Left Scene (TR9.3)	EMS Unit Left Scene (TR9.3)
NTDB	TR8.10	Transport Mode	EMS Transport Mode From Scene (TR8.10)	EMS Transport Mode From Scene (TR8.10)
NTDB	TR18.67	SBP	Prehospital Systolic Blood Pressure (TR18.67)	Prehospital Systolic Blood Pressure (TR18.67)
NTDB	TR18.69	Pulse Rate	Prehospital Pulse Rate (TR18.69)	Prehospital Pulse Rate (TR18.69)
NTDB	TR18.70	Respiratory Rate	Prehospital Respiratory Rate (TR18.70)	Prehospital Respiratory Rate (TR18.70)
NTDB	TR18.82	02Sat	Prehospital Pulse Oximetry (TR18.82)	Prehospital Pulse Oximetry (TR18.82)
NTDB	TR18.60	GCS Eye	Prehospital GCS Eye (TR18.60)	Prehospital GCS Eye (TR18.60)
NTDB	TR18.61.2/ TR18.61.0	GCS Verbal	Prehospital GCS Verbal (TR18.61.2)	<b>Adult:</b> Prehospital GCS Verbal (TR18.61.2) <b>Pediatric:</b> Prehospital GCS Verbal - Pediatric (TR18.61.0)
NTDB	TR18.62.2/ TR18.62.0	GCS Motor	Prehospital GCS Motor (TR18.62.2)	<b>Adult:</b> Prehospital GCS Motor (TR18.62.2) <b>Pediatric:</b> Prehospital GCS Motor – Pediatric (TR18.62.2)
NTDB	TR18.65	GCS Total	Prehospital GCS Calculated (TR18.65)	Prehospital GCS Calculated (TR18.65)
NTDB	TR25.54	Inter-Facility Transfer	InterFacility Transfer (TR25.54)	InterFacility Transfer (TR25.54)
NTDB	TR17.22	Trauma Center Criteria	Trauma Alert Type (TR17.22)	Trauma Alert Type (TR17.22)

NTDB	TR17.47	Vehicular, Pedestrian, Other Risk Injury	Vehicular, Pedestrian, Other Risk Injury (TR17.47)	N/A
NTDB	TR15.53	Cardiac Arrest	Pre-Hospital Cardiac Arrest (TR15.53)	Pre-Hospital Cardiac Arrest (TR15.53)
CORE	TR8.14	Extrication?	Pre-Hospital Extrication (TR5.33)	N/A
CORE	TR7.3	Agency Name	EMS Service Name (TR7.3)	EMS Service Name (TR7.3)
CORE	TR15.38	EMS Run Sheet Present	EMS Report Status (TR15.38)	EMS Report Status (TR15.38)
CORE	TR18.136	RTS	Prehospital Calculated RTS (TR18.136)	Prehospital Calculated RTS (TR18.136)
CORE	TR18.80	Respiratory Assistance	Prehospital Respiratory Assistance (TR18.80)	Prehospital Respiratory Assistance (TR18.80)

## REFERRING FACILITY

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
CORE	TR33.1	Referring Hospital	Referring Hospital Name (TR33.1)	Referring Hospital Name (TR33.1)
CORE	TR33.1.1	Other Facility	Other Facility Transferred From (TR33.1.1)	N/A
CORE	TR33.2	Arrival Date	Referring Hospital Arrival Date (TR33.2)	Referring Hospital Arrival Date (TR33.2)
CORE	TR33.3	Arrival Time	Referring Hospital Arrival Time (TR33.41)	Referring Hospital Arrival Time (TR33.41)
CORE	TR33.30	Discharge Date	Referring Discharge Date (TR33.30)	Referring Hospital Discharge Date (TR33.30)
CORE	TR33.31	Discharge Time	Referring Hospital Discharge Time (TR33.31)	Referring Hospital Discharge Time (TR33.31)
CORE	TR33.78	Length of Stay	<ul style="list-style-type: none"> <li>Referring Hospital Length Of Stay Days</li> <li>Referring Hospital Length Of Stay Hours</li> <li>Referring Hospital Length Of Stay Minutes</li> <li>Referring Hospital Length Of Stay Total Minutes</li> </ul>	Referring Hospital Length Of Stay In Minutes/Referring Hospital Length Of Stay In Hours/Referring Hospital Length Of Stay In Days

<b>ED/TTA &amp; INITIAL ASSESSMENT</b>				
<b>Required</b>	<b>Data Element</b>	<b>Element Name</b>	<b>Transactional Report Name</b>	<b>Analytical Report Name</b>
NTDB	TR18.55	Arrival Date	ED Admission Date (TR18.55)	ED Admission Date (TR18.55)
NTDB	TR18.56	Arrival Time	ED Admission Time (TR18.56)	ED Admission Time (TR18.56)
NTDB	TR18.11	SBP	Initial Assessment Systolic Blood Pressure (TR18.11)	Initial Assessment Systolic Blood Pressure (TR18.11)
NTDB	TR18.2	Pulse Rate	Initial Assessment Pulse Rate (TR18.2)	Initial Assessment Pulse Rate (TR18.2)
NTDB	TR18.30/TR18.30.1	Temperature	<b>Celsius:</b> Initial Assessment Body Temperature Celsius (TR18.30) <b>Fahrenheit:</b> Initial Assessment Body Temperature Fahrenheit (TR18.30.1)	<b>Celsius:</b> Initial Assessment Body Temperature Celsius (TR18.30) <b>Fahrenheit:</b> Initial Assessment Body Temperature Fahrenheit (TR18.30.1)
NTDB	TR18.7	Respiratory Rate	Initial Assessment Respiratory Rate (TR18.7)	Initial Assessment Respiratory Rate (TR18.7)
NTDB	TR18.10	Respiratory Assistance	Initial Assessment Respiratory Assistance (TR18.10)	Initial Assessment Respiratory Assistance (TR18.10)
NTDB	TR18.31	02Sat	Initial Assessment Pulse Oximetry (TR18.31)	Initial Assessment Pulse Oximetry (TR18.31)
NTDB	TR18.109	Supplemental 02	Initial Assessment Supplemental Oxygen (TR18.109)	Initial Assessment Supplemental Oxygen (TR18.109)
NTDB	TR18.14	GCS Eye	Initial Assessment GCS Eye (TR18.14)	Initial Assessment GCS Eye (TR18.14)
NTDB	TR18.15.2/TR18.15.0	GCS Verbal	Initial Assessment GCS Verbal (TR18.15.2)	<b>Adult:</b> Initial Assessment GCS Verbal (TR18.15.2) <b>Pediatric:</b> Initial Assessment GCS Verbal - Pediatric (TR18.15.2)
NTDB	TR18.16.2/TR18.16.0	GCS Motor	Initial Assessment GCS Motor (TR18.16.2)	<b>Adult:</b> Initial Assessment GCS Motor (TR18.16.2) <b>Pediatric:</b> Initial Assessment

				GCS Motor - Pediatric (TR18.16.2)
NTDB	TR18.22	GCS Total	Initial Assessment GCS Total (TR18.22)	ED-Hospital Initial GCS Total - Calculated (TR18.22)
NTDB	TR18.21	GCS Qualifier	Initial Assessment GCS Qualifier (TR18.21)	ED-Hospital Initial GCS Qualifier List (TR18.21)
NTDB	TR1.6.1/ TR1.6	Height	<b>Inches:</b> Patient Height In Centimeters (TR1.6) <b>Centimeters:</b> Patient Height In Inches (TR1.6.1)	<b>Inches:</b> Patient Height In Inches (TR1.6.1) <b>Centimeters:</b> Patient Height In Centimeters (TR1.6)
NTDB	TR1.6.5	Weight	<b>Kilograms:</b> Patient Weight In Kilograms (TR6.5) <b>Pounds:</b> Patient Weight In Pounds (TR6.6)	<b>Kilograms:</b> Patient Weight In Kilograms (TR6.5) <b>Pounds:</b> Patient Weight In Pounds (TR6.6)
NTDB	TR18.91	Drug Screen	Drug Screen (TR18.91)	Drug Screen (TR18.91)
NTDB	TR18.46	Alcohol Use Indicator	Alcohol Screen (TR18.46)	Alcohol Screen (TR18.46)
NTDB	TR18.103	Alcohol Screen Results	ED/Acute Care Blood Alcohol Description (TR18.103)	ED/Acute Care Blood Alcohol Description (TR18.103)
NTDB	TR17.27	Discharge Disposition	ED Discharge Disposition (TR17.27)	ED Discharge Disposition (TR17.27)
NTDB	TR27.14	Signs of Life	Signs of Life (TR27.14)	Signs Of Life (TR27.14)
NTDB	TR17.41	Discharge Order Date	ED Decision to Discharge/Transfer Date (TR17.41)	ED Decision to Discharge/Transfer Date (TR17.41)
NTDB	TR17.42	Discharge Order Time	ED Decision to Discharge/Transfer Time (TR17.42)	ED Decision to Discharge/Transfer Time (TR17.42)
CORE	TR17.65	Facility Access	Facility Access (TR17.65)	N/A
CORE	TR16.22	Arrived From	Arrived From (TR16.22)	Arrived From (TR16.22)
CORE	TR17.21	Trauma Team Activation	Trauma Team Activation Level (TR17.21)	Trauma Team Activation Level (TR17.21)
CORE	TR17.31	Activation Date	Trauma Team Activated Date (TR17.31)	Trauma Team Activated Date (TR17.31)
CORE	TR17.34	Activation Time	Trauma Team Activated Time (TR17.34)	Trauma Team Activated Time

				(TR17.34)
CORE	TR17.79	Response Time	Trauma Team Member Response Time In Minutes (TR17.79)	Trauma Team Member Response Time In Minutes (TR17.10 - TR17.15)
CORE	TR18.99	Admitting Service	Admitting Service (TR18.99)	Admitting Service (TR18.99)
CORE	TR18.135	RTS	Initial Assessment Calculated RTS (TR18.135)	N/A
CORE	TR17.25	Discharge Date	ED Discharge Date (TR17.25)	ED Discharge Date (TR17.25)
CORE	TR17.26	Discharge Time	ED Discharge Time (TR17.26)	ED Discharge Time (TR17.26)
CORE	TR17.45	Transfer Delay	Transfer Delay (TR17.45)	Transfer Delay (TR17.45)
CORE	TR17.44	Transfer Delay Reason	Transfer Delay Reason (TR17.44)	Transfer Delay Reason (TR17.44)

## PROCEDURES

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR200.2	ICD10 Procedure	ICD-10 Procedure Code (TR200.2.1)	ICD-10 Procedure Code (TR200.2.1)
NTDB	TR200.8	Date Performed	ICD-10 Procedure Performed Date (TR200.8)	ICD-10 Procedure Performed Date (TR200.8)
NTDB	TR200.9	Time Performed	ICD-10 Procedure Performed Time (TR200.9)	ICD-10 Procedure Performed Time (TR200.9)

## DIAGNOSIS

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR21.21	Co-Morbid Conditions	Co-morbidity Condition (TR21.21)	Co-morbidity Condition (TR21.21)
NTDB	TR200.1	ICD 10 Diagnosis	ICD-10 Diagnosis Code (TR200.1)	ICD-10 Diagnosis Code (TR200.1)/ ED-Hospital ICD-10 Diagnosis Description (TR200.1)

CORE	NA	ISS	ISS Calculated (TR21.8)	ISS Calculated (TR21.8)
CORE	NA	TRISS	<ul style="list-style-type: none"> <li>• TRISS Blunt</li> <li>• TRISS Penetrating</li> </ul>	ED-Hospital Probability Of Survival TRISS - Calculated (TR21.9)
CORE	7. Head - TR21.2 8. Face - TR21.5 9. Chest - TR21.3 10. Abdomen - TR21.6 11. Extremity - TR21.4 12. External - TR21.7	ISS Region	1. AIS Head Calculated (TR21.2.1) 2. AIS Face Calculated (TR21.5.1) 3. AIS Chest Calculated (TR21.3.1) 4. AIS Abdomen Calculated (TR21.6.1) 5. AIS Extremity Calculated (TR21.4.1) 6. AIS External Calculated (TR21.7.1)	1. ED-Hospital AIS Head Region Score - Calculated (TR21.2.1) 2. ED-Hospital AIS Face Region Score - Calculated (TR21.5.1) 3. ED-Hospital AIS Chest Region Score - Calculated (TR21.3.1) 4. ED-Hospital AIS Abdomen Region Score - Calculated (TR21.6.1) 5. ED-Hospital AIS Extremities Region Score - Calculated (TR21.4.1) 6. ED-Hospital AIS External Region Score - Calculated (TR21.7.1)

## INJURY SEVERITY INFORMATION

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR200.14.1	ICD10 AIS Codes	ICD-10 AIS 05 Code	ICD-10 AIS 05 Code

## OUTCOME

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR26.9	Total ICU Days	Total ICU Length Of Stay - Days (TR26.9)	Total ICU Length Of Stay - Days (TR26.9)

NTDB	TR26.58	Total Ventilator Days	Total Ventilator Days (TR26.58)	Total Ventilator Days (TR26.58)
NTDB	TR25.93	Discharge Order Date	Hospital Discharge Orders Written Date (TR25.93)	N/A
NTDB	TR25.94	Discharge Order Time	Hospital Discharge Orders Written Time (TR25.94)	N/A
NTDB	TR25.27	Discharge Disposition	Hospital Discharge Disposition (TR25.27)	Hospital Discharge Disposition (TR25.27)
CORE	TR25.44	Length of Stay	Hospital Length Of Stay - Calendar Days (Physical D/C) (TR25.44)	Hospital Length Of Stay (TR25.44)
CORE	TR25.34	Discharge Date	Hospital Discharge Date (TR25.34)	Hospital Discharge Date (TR25.34)
CORE	TR25.48	Discharge Time	Hospital Discharge Time (TR25.48)	Hospital Discharge Time (TR25.48)
CORE	TR25.92	Discharge Status	Discharge Status (Dead/Alive) (TR25.92)	N/A

## FINANCIAL INFORMATION

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR2.5	Primary Method of Payment	Primary Method Of Payment (TR2.5)	Primary Method Of Payment (TR2.5)

## HOSPITAL COMPLICATIONS

Required	Data Element	Element Name	Transactional Report Name	Analytical Report Name
NTDB	TR23.1	Complications	Injury Complication Type (TR23.1)	Injury Complication Type (TR23.1)

In addition to the required elements above, the following options are commonly used within reports.

<b>OTHER COMMON ELEMENTS</b>		
<b>Element Name</b>	<b>Transactional Report Name</b>	<b>Analytical Report Name</b>
Facility Name	Facility Name	Facility Name
Region Name	Region Name	Region Name
Facility Trauma Level (I, II, III, IV)	Hospital Trauma Level	Hospital Trauma Level
ED Length of Stay	ED/Acute Care Length Of Stay Total Minutes	N/A
Incident Status	Incident Status	Incident Status
Incident Form Title	Incident Form Title	Incident Form Title
EMS Scene Time	EMS Scene Time in Minutes (TR9.8)	Pre-Hospital EMS Scene Arrival to EMS Scene Departure in Minutes
EMS Transport Time	EMS Transport Time (Minutes)	Pre-Hospital EMS Scene Departure to ED-Hospital Patient Arrival in Minutes
ICD-10 Diagnosis Code	ED-Hospital ICD-10 Diagnosis Category (TR200.1)	ED-Hospital ICD-10 Diagnosis Category (TR200.1)
ICD-10 Injury Code	Incident ICD-10 Injury Category (TR200.3)	Incident ICD-10 Injury Category (TR200.3)
ICD-10 Procedure Code	ED-Hospital ICD-10 Procedure Category (TR200.2)	ED-Hospital ICD-10 Procedure Category (TR200.2)

# **SECTION D:**

Wisconsin NTDB Extension Import Mappings

## Demographics TR1.8 – Patient’s First Name

### Definition

The first name of the patient.

### Schema Data Type

String

### XSD Type

- xs:string

## Demographics TR1.9 – Patient’s Last Name

### Definition

The last name of the patient.

### Schema Data Type

String

### XSD Type

- xs:string

## Demographics TR1.10 – Patient’s Middle Initial

### Definition

The patient’s middle initial

### Schema Data Type

String

### XSD Type

- xs:string

## Demographics TR1.2 – Medical Record #

### Definition

The facility medical record number that represents the patient

### Schema Data Type

String

### XSD Type

- xs:string

## ED/TTA TR17.21- Trauma Team Activation Level

### Definition

Was the facility-specific trauma activation/alert activated?

### Schema Data Type

String

### XSD Type

- xs:string

### Field Values

Activation Level	3 <sup>rd</sup> party upload code
Level 1	1
Level 2	2
Level 3	3
Not Activated	0
Not Known/Not Recorded	-45