



Wisconsin  
Department of Health Services

# **Wisconsin State Trauma Registry**

## **Data Dictionary**

### **Version 3.1**

**Release Date: 5/16/2016**

**Applicable to admissions starting**

**January 1, 2016**

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# Wisconsin State Trauma Registry

## Inclusion Criteria

**January 1, 2016 to December 31, 2016**

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

**At least one of the following injury diagnostic codes defined as follows:**

### **ICD-9-CM: 800–959.9**

Excluding the following isolated injuries:

905–909.9 (late effects of injury)

910–924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites)

930–939.9 (foreign bodies)

Excluding drowning, unless consequences of MVC

Excluding strangulation/asphyxiation

Excluding poisoning or drug overdose

**OR**

### **ICD-10-CM:**

S00-S99 with 7th 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 7th character modifier of A ONLY (burns by specific body parts – initial encounter)**

**T30-T32 (burn by TBSA percentages)**

**T79.A1-T79.A9 with 7th character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)**

**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 IN ADDITION TO THE DIAGNOSIS ABOVE, ONE OF THE FOLLOWING MUST ALSO BE TRUE:**

- **Hospital admission as defined by your facility specific trauma registry inclusion criteria; OR**
- **Patient transfer via EMS transport (including air ambulance) from one hospital to another hospital; OR**
- **Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)OR**

**Facility-Specified trauma response (leveled/activated traumas**

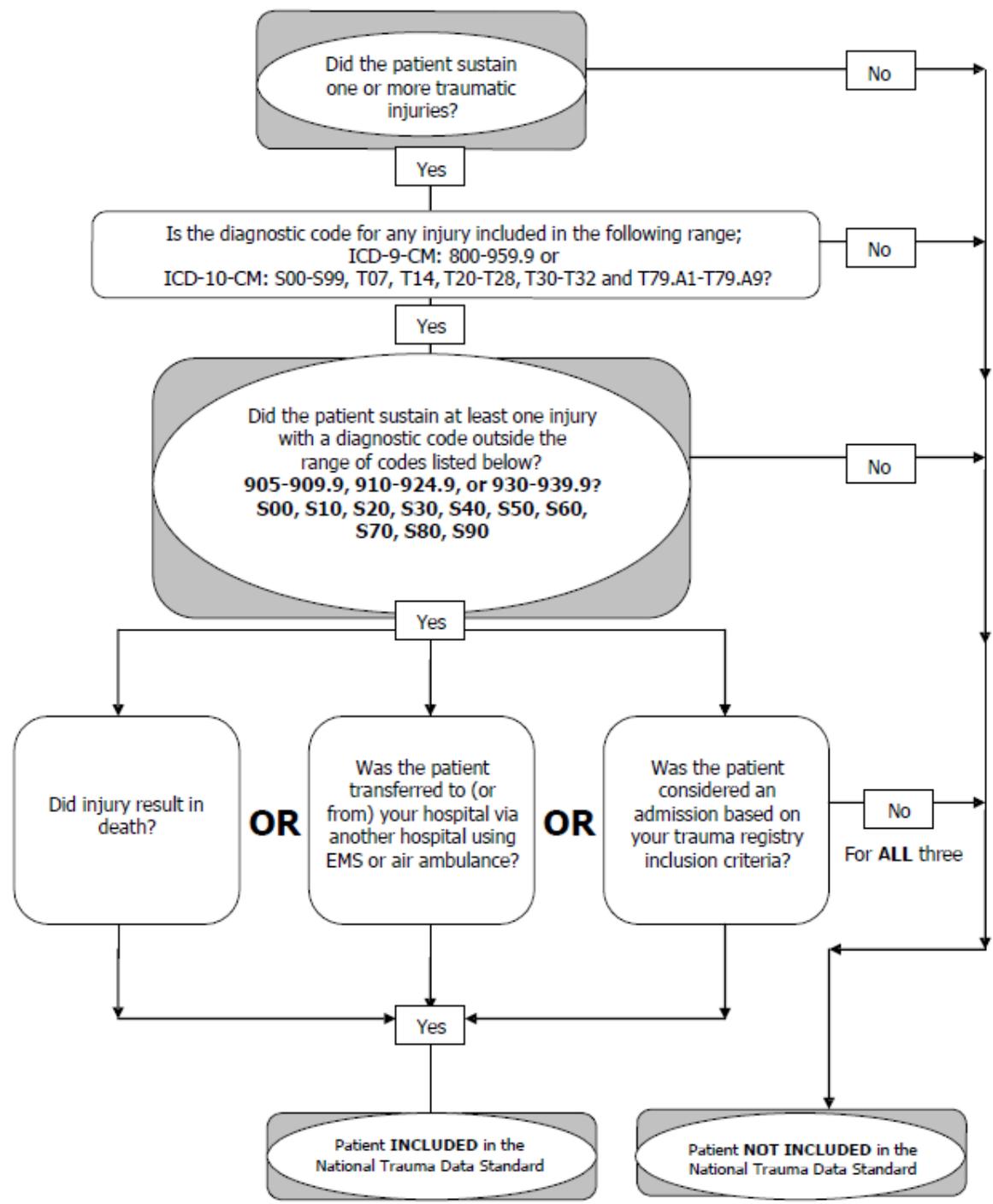
**Falls from same level resulting in an isolated closed distal extremity fracture or isolated hip fractures are included at the discretion of individual facilities. While**

**these injuries may meet the NTDB inclusion criteria, Wisconsin is not mandating their inclusion at this time.**

**Additional Information: Facilities may determine to include patients in their registry that meet their facility inclusion criteria:**

- 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.**

### National Trauma Data Standard Inclusion Criteria



## Common Null Values

### Definition:

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, the hospitalization for the patient care event. For example, variables documenting EMS care would be “Not Applicable” if a patient self- transports 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” this can be 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.

### Special Characters in WI Version 5 DI portal:

“N/A” or not applicable is indicated by typing /  
“Unknown” is indicated by typing in ?

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

# Demographic

**Section: Demographic**

**Sub-Section: Record Information**

**WI Variable: Initial Location**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Initial Location**

**Definition: The initial location in your facility where the patient arrived at your facility.**

**Field Values:**

- 1. Resuscitation Room**
- 2. Emergency Department**
- 3. Operating Room**
- 4. Intensive Care Unit**
- 5. Step-Down Unit**
- 6. Floor**
- 7. Telemetry Unit**
- 8. Observation Unit**
- 9. Burn Unit**
- 11 Post Anesthesia Care Unit**
- 12 Special Procedure Unit**
- 13 Labor and Delivery**
- 14 Neonatal/Pediatric Care Unit**

**Additional Information: For this field if a patient is admitted to a pediatric intensive care unit, neonatal intensive care unit or any intensive care unit at your facility select option 4. Intensive Care Unit.**

**Data Source Hierarchy:**

- 1. Triage/Trauma Flow Sheet**
- 2. ED Record**
- 3. INPT Nursing Progress Notes**
- 4. History and Physical**
- 5. Face Sheet**
- 6. Billing Sheet**
- 7. Discharge Summary**

**Associated Edit Checks (NTDB): None**

**Section: Demographic**  
**Sub-Section: Record Information**  
**WI Variable: Data Set**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Data Set**

**Definition:** This indicates if the record will be abstracted using the Core (required) list of data fields or a more comprehensive list of data fields that can be tailored to the needs of the facility.

**Field Values:**

1. Core
2. Comprehensive

**Additional Information:** NTDB fields will be required in both data sets and will be indicated by the name of the field appearing in red font and are required for both the core and comprehensive data sets. The additional fields that Wisconsin requires will be included in both the comprehensive and core sets and will be in blue font. If individual facilities would like to abstract some of the elements beyond the Wisconsin Core elements you should select “comprehensive” even if you do not intend to abstract each field, you are able to abstract only the fields of use to your facility in the comprehensive data set.

**Data Source Hierarchy Guide:**

1. This is specific to your facility if you are collecting the core or the comprehensive data sets.

**Associated Edit Checks (NTDB): None**

**Note:** If you choose to enter more than just the core fields, you should be able to speak to which patients you collect more than the core data elements (such as highest level of activation, all patients in the registry, certain mechanism etc)

**Section: Demographics**

**Sub-Section: Record Information**

**WI Variable: Submitting Facility**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Facility**

**Definition: The Wisconsin Department of Health Services number assigned to each facility**

**Field Values: applicable data**

**Additional Information: May be pre-filled in the web portal**

**Data Source Hierarchy Guide:**

- 1. WDHS provided number**

**Associated Edit Checks (NTDB): None**

**Section: Demographic**

**Sub-Section: Record Information**

**WI Variable: Facility Trauma Registry Number**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Trauma #**

**Definition: This is a unique ID number assigned to individual patients. It is necessary to have both the submitting facility number and the facility trauma registry number to identify a specific individual patient.**

**Note: This might be auto- populated**

**Field Values: Applicable Data**

**Additional Information: if you enter into the web portal this number is assigned for you. If you use a third party vendor you need to have a unique ID assigned to each patient.**

**Data Source Hierarchy Guide:**

- 1. Auto-populated for web portal**
- 2. Facility specific numbering system.**

**Associated Edit Checks (NTDB): None**

**Section: Demographic**

**Sub-Section: Record Information**

**WI Variable: Medical Record Number**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Medical Record #**

**Definition: The facility medical record number that represents the patient.**

**Field Values: Applicable data**

**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**

**Associated Edit Checks (NTDB): None.**

**Section: Demographics**

**Sub-Section: Record information**

**WI Variable: Arrival Date**

**WI CORE: Yes**

**NTDB Variable: ED/Hospital Arrival Date (ED\_01)**

**DI V5 field: Patient 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 the patient arrived at the ED. If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital.
- Collected as YYYY-MM-DD
- 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**

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

**Section: Demographic**

**Sub-Section: Record Information**

**WI Variable: Arrival Time**

**WI CORE: Yes**

**NTDB Variable: ED/Hospital Arrival Time (ED\_02)**

**DI V5 field: Patient 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 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. INPT Nursing Progress Notes
4. Face Sheet
5. Billing Sheet
6. Discharge Summary

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Section: Demographics**

**Sub-Section: Record Information**

**WI Variable: Last Name**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Patient Name: Last**

**Definition: The last name of the patient.**

**Field Values:**

**Relevant value for the data element**

- N/A should not be used for this field
- Unknown/Not Documented/Not Known should be used if the patient's legal name is not known.
- If Unknown/Not Documented /Not Known is used, field *ALIAS: Last Name* must be filled out

**Additional Information:**

- If Alias is used it will be documented in the alias sections, this field should be the patients actual legal name

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Demographics**

**Sub-Section: Record Information**

**WI Variable: First Name**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Patient Name: First**

**Definition: The first Name of the patient**

**Field Values:**

**Relevant value for the data element**

- N/A should not be used for this field
- Unknown/Not Documented/Not Known should be used if the patient's legal name is not known.
- If Unknown/Not Documented /Not Known is used, field *ALIAS: First Name* must be filled out

**Additional Information:**

- If Alias is used it will be documented in the alias sections, this field should be the patients actual legal name

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Demographic**

**Sub-Section: Record information**

**WI Variable: NTDB inclusion**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: NTDB**

**Definition:**

- **Does the patient meet the inclusion criteria for the NTDB.**

**Field Values:**

1. **Yes**
2. **No**

**Additional Information:**

- **Unknown, Not Applicable should not be used for this field**

**Data Source Hierarchy Guide:**

1. **Triage/Trauma/Hospital flow sheet**
2. **EMS Run sheet**
3. **ED Record**
4. **Admission paperwork**

**Associated Edit Checks (NTDB): None**

## National Trauma Data Standard Patient Inclusion Criteria

### Definition:

To ensure consistent data collection across States into the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the following criteria:

At least one of the following injury diagnostic codes defined as follows:

*International Classification of Diseases, Ninth Revision, Clinical Modification (ICD-9-CM):*  
800–959.9

*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)*

*T79.A1-T79.A9 with 7<sup>th</sup> character modifier of A ONLY (Traumatic Compartment Syndrome – initial encounter)*

Excluding the following isolated injuries:

*ICD-9-CM:*

905–909.9 (late effects of injury)

910–924.9 (superficial injuries, including blisters, contusions, abrasions, and insect bites)

930–939.9 (foreign bodies)

*ICD-10-CM:*

*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)*

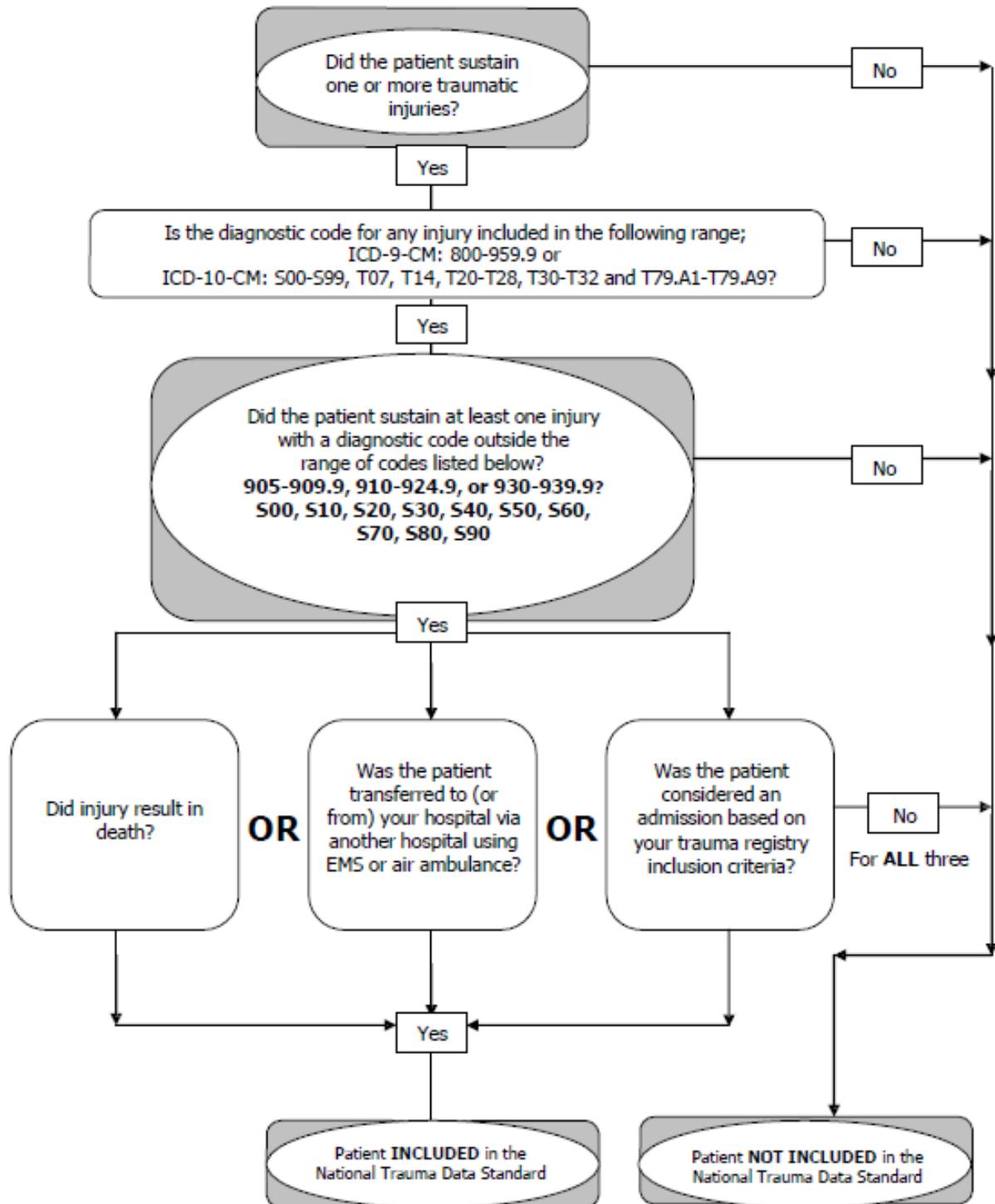
Late effect codes, which are represented using the same range of injury diagnosis codes but with the 7<sup>th</sup> digit modifier code of D through S, are also excluded.

**AND MUST INCLUDE ONE OF THE FOLLOWING IN ADDITION TO**

**(ICD-9-CM 800–959.9 OR ICD-10-CM S00-S99, T07, T14, T20-T28, T30-T32 and T79.A1-T79.A9):**

- Hospital admission as defined by your trauma registry inclusion criteria; OR
- Patient transfer via EMS transport (including air ambulance) from one hospital to another hospital; OR
- Death resulting from the traumatic injury (independent of hospital admission or hospital transfer status)

### National Trauma Data Standard Inclusion Criteria



**Section: Demographic**

**Sub-Section: Patient**

**WI Variable: Date of Birth**

**WI CORE: Yes**

**NTDB Variable: Date of Birth (D\_07)**

**DI V5 field: Date of Birth**

**Definition:**

**The patient's date of birth**

**Field Values:**

- **Relevant value for data element**

**Additional Information:**

- **Collected as YYYY-MM-DD**
- **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.**
- **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 mgmt./Social service notes**

**Associated Edit Checks**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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 ED/Hospital Arrival 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 ED/Hospital Arrival Date
0613	2	Field cannot be Not Applicable

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: Age**

**WI CORE: Yes**

**NTDB Variable: Age (D\_08)**

**DI V5 field: Age**

**Definition:**

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

**Field Values:**

- Relevant value for data element

**Additional Information:**

- Will auto-calculate unless date of birth is unknown or is the same as date of ED Arrival.
- 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):**

[Associated Edit Checks](#)

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

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: In**

**WI CORE: Yes**

**NTDB Variable: Age Units (D\_09)**

**DI V5 field: Age: In**

**Definition: This is the unit of measure associated with age.**

**Field Values:**

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

**Additional Information:**

- Age Units is either auto-populated using the date of birth and the hospital arrival 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):**

**Associated Edit Checks**

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

**Section: Demographics**  
**Sub-Section: Patient**  
**WI Variable: Gender**  
**WI CORE: Yes**  
**NTDB Variable: Sex (D\_12)**  
**DI V5 field: Sex**

**Definition:**  
**The patient's sex**

**Field Values:**

- 1. Male**
- 2. Female**

**Additional Information:**

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

**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):**

**Associated Edit Checks**

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

**Section: Demographics**  
**Sub-Section: Patient**  
**WI Variable: Race**  
**WI CORE: Yes**  
**NTDB Variable: Race (D\_10)**  
**DI V5 field: Race**

**Definition:**

- The patient's race

**Field Values:**

1. American Indian
2. Asian
3. Black or African American
4. Native Hawaiian or Other Pacific Islander
5. White
6. Other Race
7. Unknown

**Additional Information:**

- Patient race should be based on self-report or identified by a family member
- The Maximum number of races that may be reported for an individual patient is 2.
- Hispanic is not a race. If the Race is not documented or unknown, you should report 7.

**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):**

**Associated Edit Checks**

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

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: Ethnicity**

**WI CORE: Yes**

**NTDB Variable: Ethnicity (D\_11)**

**DI V5 field: Ethnicity**

**Definition:**

- The patient's ethnicity.

**Field Values:**

1. Hispanic or Latino
2. Not Hispanic or Latino

**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.

**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):**

**Associated Edit Checks**

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

**Section: Demographic**

**Sub-Section: Patient**

**WI Variable: Zip Code, Patient Information**

**WI CORE: Yes**

**NTDB Variable: Patient's Home Zip Code (D\_01)**

**DI V5 field: 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

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

[Associated Edit Checks](#)

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

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: City**

**WI CORE: Yes**

**NTDB Variable: Patient's Home City (D\_05)**

**DI V5 field: 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.

**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):**

#### Associated Edit Checks

Rule ID	Level	Message
0401	1	Invalid value
0402	4	Blank, required to complete when Patient's Home Zip Code is Not Known/Not Recorded
0403	5	Blank, required to complete variables: Patients Home Zip Code or Alternate Home Residence

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: State**

**WI CORE: Yes**

**NTDB Variable: Patient's Home State (D\_03)**

**DI V5 field: 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.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
0201	1	Invalid value (US only)
0202	2	Field cannot be blank (US only)
0204	2	Field must be Not Applicable (Non-US)

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: County**

**WI CORE: Yes**

**NTDB Variable: Patient's Home County (D\_04)**

**DI V5 field: 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.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
0301	1	Invalid value (US only)
0302	2	Field cannot be blank (US only)
0304	2	Field must be Not Applicable (Non-US)

**Section: Demographics**

**Sub-Section: Patient**

**WI Variable: Country**

**WI CORE: Yes**

**NTDB Variable: Patient's Home Country (D\_02)**

**DI V5 field: Country**

**Definition:**

The country where the patient resides.

**Field Values:**

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

**Additional Information:**

- Values are two character FIPS codes representing the country (e.g., US)
- If a patient's home country is not US, 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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Section: Demographic**

**Sub-Section: Patient**

**WI Variable: Alternate Home Residence**

**WI CORE: Yes**

**NTDB Variable: Alternate Home Residence (D\_06)**

**DI V5 field: Alternate Residence**

**Definition:**

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

**Field Values:**

- 1. Undocumented Citizen**
- 2. Migrant worker**
- 3. Homeless**

**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**

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

# **Injury**

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Injury Date**

**WI CORE: Yes**

**NTDB Variable: Injury Incident Date (I\_01)**

**DI V5 field: Injury (Date)**

**Definition:**

The Date the injury occurred.

**Field Values:**

- Relevant value for data element

**Additional Information:**

- Collected as YYYY-MM-DD
- 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.
- “Unknown” is indicated by typing in ?

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks**

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

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Injury Time**

**WI CORE: Yes**

**NTDB Variable: Injury Incident Time (I\_02)**

**DI V5 field: 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.
- “Unknown” is indicated by typing in ?

**Data Source Hierarchy Guide:**

1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet.
5. Case Management/Social Services notes

**Associated Edit Checks**

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

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Injury Site E849**

**WI CORE: Yes**

**NTDB Variable: ICD-9 place of Occurrence External Cause Code (I\_08)**

**DI V5 field: Place of Injury/E849**

**Definition:**

Place of occurrence external cause code used to describe the place/site/location of the injury event (E 849.X).

**Field Values:**

0. Home
1. Farm
2. Mine
3. Industry
4. Recreation
5. Street
6. Public Building
7. Residential Institution
8. Other
9. Unspecified

**Additional Information:**

- Only ICD-9-CM Codes will be accepted for ICD-9 Place of Occurrence External Cause Code

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
1801	1	Invalid value
1802	4	Blank, required field (at least one ICD-9-CM or ICD-10 trauma code must be entered)

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Place of Injury/ICD 10**

**WI CORE: Yes**

**NTDB Variable: ICD-10 Place of Occurrence External Cause Code**

**DI V5 field: ICD10 Location 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 the injury event

**Additional Information:**

- Only ICD-10-CM codes will be accepted for ICD-10 Place of Occurrence External Cause Code.

**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):**

**Associated Edit Checks**

Rule ID	Level	Message
9001	1	Invalid value (ICD-10 CM only)
9002	2	Field cannot be blank (at least one ICD-9-CM or ICD-10 trauma code must be entered)
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)

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: ZIP code**

**WI CORE: Yes**

**NTDB Variable: Incident Location Zip Code (I\_12)**

**DI V5 field: ZIP**

**Definition:**

**The ZIP 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.**
- **“Unknown” is indicated by typing in ?**

**Data Source Hierarchy Guide:**

- 1. EMS Run Sheet**
- 2. Triage Form/Trauma Flow Sheet**
- 3. ED Nurses’ Notes**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
2001	1	Invalid value
2002	4	Blank, required field
2004	5	Not Known/Not Recorded, complete variables: Incident State, Incident County and Incident City
2005	5	Not Applicable, complete variables: Incident State, Incident County and Incident City

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: City**

**WI CORE: Yes**

**NTDB Variable: Incident City (I\_16)**

**DI V5 field: 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.
- “Unknown” is indicated by typing in ?

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
2401	1	Invalid value (US only)
2403	2	Field cannot be blank (US only)
2404	2	Field must be Not Applicable (Non-US)

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: State**

**WI CORE: Yes**

**NTDB Variable: Incident State (I\_14)**

**DI V5 field: 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
- FIPS codes are automatically calculated by the Version 5 web portal.
- "Unknown" is indicated by typing in ?
- 

**Data Source Hierarchy Guide:**

1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses' Notes

**Associated Edit Checks**

Rule ID	Level	Message
2201	1	Invalid value
2202	5	Blank, required to complete variable: Incident Location Zip Code
2203	4	Blank, required to complete when Incident Location Zip Code is Not Applicable or Not Known/Not Recorded

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: County**

**WI CORE: Yes**

**NTDB Variable: Incident County (I\_15)**

**DI V5 field: 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.
- Version 5 web portal will automatically calculate the FIPS code.
- “Unknown” is indicated by typing in ?
- 

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
2301	1	Invalid value
2302	5	Blank, required to complete variable: Incident Location Zip Code
2303	4	Blank, required to complete when Incident Location Zip Code is Not Applicable or Not Known/Not Recorded

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Country**

**WI CORE: Yes**

**NTDB Variable: Incident Country (I\_13)**

**DI V5 field: 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)
- “Unknown” is indicated by typing in ?
- 

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
2101	1	Invalid value
2102	4	Blank, required to complete when Incident Location Zip Code is Not Applicable or Not Known/Not Recorded
2103	5	Blank, required to complete variable: Incident Location Zip Code

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Protective/Safety Devices**

**WI CORE: Yes**

**NTDB Variable: Protective Devices (I\_17), Child Specific Restraint (I\_18), Airbag Deployment (I\_19)**

**DI V5 field: Protective Devices**

**Definition:**

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

**Field Values:**

**Restraints (Choose 1)**

- **None (Select if mechanism is not related to a vehicle)**
- **Seatbelt-Lap and Shoulder**
- **Seatbelt-Lap only**
- **Seatbelt-Shoulder Only**
- **Seatbelt-NFS (not further specified)**
- **Child Booster Seat**
- **Child Car Seat**
- **Infant Car Seat**
- **Truck bed restraint**
- **Not Applicable**
- **Unknown**

**Airbag (Choose up to 4)**

- **No airbags in vehicle**
- **Airbags did not deploy**
- **Front (deployed)**
- **Side (deployed)**
- **Airbag deployed other (knee, airbelt, curtain, etc)**
- **Airbag type unknown (deployed)**
- **Not Applicable**
- **Unknown**

### Equipment (Choose up to 4)

- None
- Helmet
- Eye Protection
- Protective Clothing
- Protective non-clothing gear (I.E., shin guards, padding)
- Hard hat
- Personal flotation device
- Other
- Not applicable
- Unknown

### Additional Information:

- Check all that apply.
- 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.
- “Unknown” is indicated by typing in ?
- Work related equipment may be 1 None, 2 Helmet, 3 Eye Protection, etc.

### Data Source Hierarchy Guide:

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

#### Associated Edit Checks

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: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded
2506	3	Protective Device should be 8 (Airbag Present) when Airbag Deployment is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded
2507	2	Field cannot be Not Applicable

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Work Related**

**WI CORE: Yes**

**NTDB Variable: Work-Related (I\_03)**

**DI V5 field: Work Related**

**Definition:**

- Indication of whether the injury occurred during paid employment

**Field Values:**

1. Yes
2. No

**Additional Information:**

- If work related, two additional data fields must be completed: Patient's Occupational Industry and Patient's Occupation.
- Equipment may be associated with work-related injuries.

**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):**

**Associated Edit Checks**

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: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded
1406	4	Work-Related should be 1 (Yes) when Patient's Occupational Industry is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Patient's Occupational Industry**

**WI CORE: Yes**

**NTDB Variable: Patient's Occupational Industry (I\_04)**

**DI V5 field: Occupation**

**Definition:**

- **The occupational industry associated with the patient's work environment.**

**Field Values:**

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

**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.
- “Unknown” is indicated by typing in ?

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
1501	1	Invalid value
1502	4	If completed, then Work-Related must be 1 Yes
1503	5	If completed, then Patient Occupation must be completed
1504	4	Blank, required to complete when Work-Related is 1 (Yes)

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Patient's Occupational Industry**

**WI CORE: Yes**

**NTDB Variable: Patient's Occupational Industry (I\_04)**

**DI V5 field: Occupational Industry**

**Definition:**

- The occupational industry associated with the patient's work environment.

**Field Values:**

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

**Additional Information:**

- If work related, also must complete Patient's Occupation
- Based upon US Bureau of Labor Statistics Industry Classification.
- "Unknown" is indicated by typing in ?

**Data Source Hierarchy Guide:**

1. Triage Form/Trauma Flow Sheet
2. EMS Run Sheet
3. ED Nurses' Notes

## Associated Edit Checks (NTDB):

### Associated Edit Checks

Rule ID	Level	Message
1501	1	Invalid value
1502	4	If completed, then Work-Related must be 1 Yes
1503	5	If completed, then Patient Occupation must be completed
1504	4	Blank, required to complete when Work-Related is 1 (Yes)

**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.

**Real Estate** -Industries in the Real Estate subsector group establishments that are primarily engaged in renting or leasing real estate to others; managing real estate for others; selling, buying, or renting real estate for others; and providing other real estate related services, such as appraisal services.

**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.

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Report of Physical Abuse**

**WI CORE: Yes**

**NTDB Variable: Report of Physical Abuse (I\_20)**

**DI V5 field: 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

**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):**

**Associated Edit Checks**

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

**Section: Injury**

**Sub-Section: Injury Information**

**WI Variable: Investigation of Physical Abuse**

**WI CORE: Yes**

**NTDB Variable: Investigation of Physical Abuse (I\_21)**

**DI V5 field: 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

**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" should be used for patients where Report of Physical Abuse is no.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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)

**Section: Injury**

**Sub-Section: Mechanism of Injury**

**WI Variable: Primary E-Code**

**WI CORE: Yes**

**NTDB Variable: ICD-9 Primary External Cause Code (I\_06)**

**DI V5 field: Primary E-Code**

**Definition:**

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

**Field Values:**

- Relevant ICD-9-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 on the CDC matrix)
- ICD-9-CM codes will be accepted for this data element. Activity codes should not be reported in 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**

Rule ID	Level	Message
1701	1	E-Code is not a valid ICD-9-CM code
1702	2	Field cannot be blank (at least one ICD-9 or ICD-10 trauma code must be entered)
1703	4	External Cause Code should not be = (810.0, 811.0, 812.0, 813.0, 814.0, 815.0, 816.0, 817.0, 818.0, 819.0) and Age < 15
1704	2	Should not be 849.x (where x is 0-9)
1705	3	External Cause Code should not be an activity code. Primary External Cause Code should be within the range of E800-999.9

**Section: Injury**

**Sub-Section: Mechanism of Injury**

**WI Variable: Secondary E-Code**

**WI CORE: Yes**

**NTDB Variable: ICD-9 Additional External Cause Code (I\_10)**

**DI V5 field: Secondary E Code**

**Definition:**

- **Additional External Cause Code used in conjunction with the Primary External Cause Code if multiple external cause codes are required to describe the injury event.**

**Field Values:**

- **Relevant ICD-9-CM code value for injury event**

**Additional Information:**

- **External Cause codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, Penetrating, Burn) and Intentionality (based upon CDC matrix)**
- **Only ICD-9-CM codes will be accepted for ICD-9 Additional External cause code.**
- **Activity codes should not be reported in this field**
- **Refer to appendix 3: Glossary of Terms for multiple cause coding hierarchy.**

**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):**

**Associated Edit Checks**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
1901	1	E-Code is not a valid ICD-9-CM code
1902	4	Additional External Cause Code should not be equal to Primary External Cause Code.
1903	2	Field cannot be blank (at least one ICD-9-CM or ICD-10 trauma code must be entered)

**Section: Injury**

**Sub-Section: Mechanism of Injury**

**WI Variable: Primary ICD 10 E CODE**

**WI CORE: Yes**

**NTDB Variable: ICD-10 Primary External Cause Code (I\_07)**

**DI V5 field: Primary ICD10 Mechanism**

**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.

**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):**

**Associated Edit Checks**

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 (at least one ICD-9 or ICD-10 trauma code must be entered)
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)

**Section: Injury**

**Sub-Section: Mechanism of Injury**

**WI Variable:**

**WI Core: Yes**

**NTDB Variable: ICD-10 Additional External Cause Code (I\_11)**

**DI V5 Field: Secondary ICD 10 Mechanism**

**Definition: Additional External Cause Code used in conjunction with the primary external cause code if multiple external cause codes are required to describe the injury event.**

**Field Values:**

1. Relevant ICD-10-CM code value for injury event.

**Additional Information:**

- External cause codes are used to auto-generate two calculated fields: Trauma Type: (Blunt, penetrating, Burn) and intentionality (based on CDC matrix)
- Only ICD-10-CM codes will be accepted for ICD-10 Additional External Cause Code
- Activity codes should not be reported in this field.
- Refer to appendix. 3: Glossary of Terms for multiple cause coding hierarchy

**Data Source Hierarchy:**

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

**Associated Edit Checks**

**Associated Edit Checks**

Rule ID	Level	Message
9101	1	E-Code is not a valid ICD-10-CM code (ICD-10 CM only)
9102	4	Additional External Cause Code ICD-10 should not be equal to Primary External Cause Code ICD-10
9103	2	Field cannot be blank (at least one ICD-9-CM or ICD-10 trauma code must be entered)
9104	1	E-Code is not a valid ICD-10-CA code (ICD-10 CA only)

**Section: Injury**

**Sub-Section: Mechanism of Injury**

**WI Variable: Injury Type**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Injury Type**

**Definition: This is the initial type of injury. The force that caused the most severe injury based on a matrix. This is an auto-populated field.**

**Field Values:**

- 1. Blunt**
- 2. Burn**
- 3. Penetrating**
- 4. Other**
- 5. Unknown**

**Additional Information:**

**In the version 5 software this will be auto-populated based on the ICD 9/ICD 10 matrix and will not be something that will be manually entered.**

**Third party users should NOT export this field into their submissions.**

**Data Source Hierarchy Guide:**

**ICD 9/ICD 10 cause matrix.**

**Associated Edit Checks (NTDB): None**

## **Pre-hospital Information**

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Extrication required**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Was patient extricated?**

**Definition: Was the patient extricated.**

**Field Values:**

**Yes**

**No**

**Unk**

**N/A**

**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**

**Associated Edit Checks (NTDB): None**

**Section: Pre-hospital**  
**Sub-Section: Scene/Transport**  
**Sub-Section: Scene/Transport**  
**WI Variable: Mode**  
**WI CORE: Yes**  
**NTDB Variable: Transport mode (p\_07)**  
**DI V5 field: Mode**

**Definition: The mode of transport delivering the patient to your hospital.**

**Field Values:**

- |                            |                           |
|----------------------------|---------------------------|
| 1. Ground Ambulance        |                           |
| 2. Helicopter Ambulance    | 6. Other                  |
| 3. Fixed-wing Ambulance    | 7. Not applicable         |
| 4. Private Vehicle/Walk-in | 8. Unknown/Not documented |
| 5. Police                  |                           |

**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

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**Sub-Section: Scene/Transport**

**WI Variable: Mode, if other**

**WI CORE: Yes**

**NTDB Variable: Other Transport Mode (p\_08)**

**DI V5 field: Mode If Other**

**Definition: All other modes of transport used during patient care event (prior to arrival at your hospital), except the mode delivering the patient to the hospital. (Private Vehicles should be included)**

**Field Values:**

- |                            |                     |
|----------------------------|---------------------|
| 1. Ground Ambulance        | 5. Police           |
| 2. Helicopter Ambulance    | 6. Other            |
| 3. Fixed-wing Ambulance    | 7. / Not applicable |
| 4. Private Vehicle/Walk-in | 8. ? Unknown        |

**Data Source Hierarchy Guide:**

1. EMS Run Report
2. Nurses Notes

#### **Associated Edit Checks (NTDB)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3501	1	Value is not a valid menu option
3502	2	Field cannot be blank

**Section: Pre-hospital**  
**Sub-Section: Scene/Transport**  
**WI Variable: Scene/Transport Agency ID**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Agency (ID)**

**Definition: The Service number of the first ambulance/flight service attending to the patient at the scene, if applicable. (This field applies only if an ambulance/flight selection was made from previous "Mode" field).**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Click the search button to choose agency
- If agency is not listed, please inform trauma program by emailing [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov)

**Data Source Hierarchy Guide:**

1. EMS Run Report

**Associated Edit Checks (NTDB): None**

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Scene/Transport Agency Name**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: 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 an ambulance/flight selection was made from previous "Mode" field).**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- This auto-fills after agency ID is selected
- If agency is not listed, please inform trauma program by emailing [DHSTrauma@dhs.wisconsin.gov](mailto:DHSTrauma@dhs.wisconsin.gov)

**Data Source Hierarchy Guide:**

1. EMS Run Report

**Associated Edit Checks (NTDB): None**

**Section: Pre-hospital**  
**Sub-Section: Scene/Transport**  
**WI Variable: Run Sheet Present**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Scene EMS Report**

**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 Wisconsin Ambulance Run Data System (WARDS), or the agency’s electronic medical record system at the time of abstraction. Select “Complete” if the EMS report was completed and available, “Incomplete” if a partial EMS report was available, “Missing” if no EMS report was available, and “Unreadable” if only a written EMS report was available but it was not readable at the time of abstraction.

**Field Values:**

- |               |                  |
|---------------|------------------|
| 1. Complete   | 4. Unreadable    |
| 2. Incomplete | / Not applicable |
| 3. Missing    | ? Unknown        |

**Additional information**

- If greater than 10 days has past since the date of service the record is not available in WARDS select option “Missing”

**Data Source Hierarchy Guide:**

1. EMS Run Report

**Associated Edit Checks (NTDB): None**

**Section: Pre-hospital**  
**Sub-Section: Scene/Transport**  
**WI Variable: Call Dispatched Date**  
**WI CORE: Yes**  
**NTDB Variable: EMS Dispatch Date (p\_01)**  
**DI V5 field: Call 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 YYYY-MM-DD.
- 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.

**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

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Call Dispatched Time**

**WI CORE: Yes**

**NTDB Variable: EMS Dispatch Time (p\_02)**

**DI V5 field: Call Dispatched (Time)**

**Definition: The Date the EMS was dispatched.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as HH:MM military time.
- 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 time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- 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 was dispatched.

**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

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Arrived at Scene Date**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY (p\_03)**

**DI V5 field: Arrived at Location (Date)**

**Definition: The date the unit transporting to your hospital arrived on the scene/transferring facility.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as DD-MM-YYYY.
- 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 date on 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 date on 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).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	EMS Unit Arrival on Scene Date is earlier than Date of Birth
3004	4	EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date
3005	4	EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date
3006	3	EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date
3007	4	EMS Unit Arrival on Scene Date is later than ED Discharge Date
3008	3	EMS Unit Arrival on Scene Date is later than Hospital Discharge Date
3009	3	EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days
3010	2	Field cannot be blank

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Arrived at Scene Time**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY (p\_04)**

**DI V5 field: Arrived at Location (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).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Left Scene Date**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY (p\_05)**

**DI V5 field: Departed Location (Date)**

**Definition: The date the unit transporting to your hospital left the scene.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as DD-MM-YYYY.
- Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- 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 departed from the scene (departure is defined at date/time when the vehicle started moving).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
3201	1	Date is not valid
3202	1	Date out of range
3203	3	EMS Unit Scene Departure Date is earlier than Date of Birth
3204	4	EMS Unit Scene Departure Date is earlier than EMS Dispatch Date
3205	4	EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date
3206	3	EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date
3207	4	EMS Unit Scene Departure Date is later than ED Discharge Date
3208	3	EMS Unit Scene Departure Date is later than Hospital Discharge Date
3209	3	EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days
3210	2	Field cannot be blank

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Left Scene Time**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY (p\_06)**

**DI V5 field: Departed Location (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 an additional calculated field: 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 from the transferring facility (departure is defined at date/time when the vehicle started 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 from the scene (departure is defined at date/time when the vehicle started moving).

**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

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Time on scene**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Scene Time Elapsed**

**Definition: The time the service and patient arrived at the facility or at the intercept location.**

**Field Values:**

- Relevant value for the data element

**Additional information**

- The total time the service was on the scene. (Note: This will be automatically calculated from the Arrived at Scene and Left Scene.)
- Third party vendors should not export this data

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB): None**

**Section: Pre-hospital**

**Sub-Section: Scene/Transport**

**WI Variable: Trauma center criteria**

**WI CORE: Yes**

**NTDB Variable: TRAUMA CENTER CRITERIA (p\_18) and VEHICULAR, PEDESTRIAN, OTHER RISK INJURY (p\_19) combined**

**DI V5 field: Prehospital Triage Rationale**

**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                                | 14. Auto crash ejection (partial or complete)                      |
| 2. Systolic blood pressure < 90 mmHg                       | 15. Auto crash death in same passenger compartment                 |
| 3. Resp Rate <10 (<20 for infant) or >29 or vent support   | 16. Auto crash telemetry data indication                           |
| 4. Penetrating injuries excluding distal extremities       | 17. Auto vs pedestrian thrown                                      |
| 5. Chest wall instability or deformity (e.g., flail chest) | 18. Auto vs cyclist thrown                                         |
| 6. Two or more proximal long-bone fractures                | 19. Motorcycle crash >20mph                                        |
| 7. Crushed, degloved, mangled, or pulseless extremity      | 20. Trauma with older adult                                        |
| 8. Amputation proximal to wrist or ankle                   | 21. Trauma with child                                              |
| 9. Pelvic fracture                                         | 22. Anticoagulation or bleeding disorder                           |
| 10. Open or depressed skull fracture                       | 23. Trauma with burns                                              |
| 11. Paralysis                                              | 24. Pregnancy term >20 weeks                                       |
| 26. Fall Adults > 20 ft (One story = 10 ft)                | 25. EMS provider judgment                                          |
| 27. Fall Children > 10 ft or 2-3 times height of child     | 28. For adults >65 SBP < 110                                       |
| 13. Auto crash intrusion >18 in (>12 in for occupant site) | 29. Burns                                                          |
|                                                            | 12. Fall >20 ft (>10 ft or 2-3 times height for ped)(Retired 2014) |
|                                                            | / Not Applicable                                                   |
|                                                            | ? Unknown                                                          |

**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.**

## TRAUMA CENTER CRITERIA CONTINUED –

- 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.

### Data Source Hierarchy

#### 1. EMS Run Report

### Associated Edit Checks (NTDB)

Rule ID	Level	Message
9501	1	Value is not a valid menu option

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: Systolic Blood Pressure**

**WI CORE: Yes**

**NTDB Variable: INITIAL FIELD SYSTOLIC BLOOD PRESSURE (p\_09)**

**DI V5 field: SBP (of SBP/DBP fields)**

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

**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.

**Data Source Hierarchy Guide:**

1. EMS Report

#### **Associated Edit Checks**

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

**Section: Pre-hospital**  
**Sub-Section: Treatment**  
**WI Variable: Heart Rate**  
**WI CORE: Yes**  
**NTDB Variable: INITIAL FIELD PULSE RATE (p\_10)**  
**DI V5 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.

**Data Source Hierarchy Guide:**

1. EMS Report

**Associated Edit Checks (NTDB)**

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

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: Respiratory Rate**

**WI CORE: Yes**

**NTDB Variable: INITIAL FIELD RESPIRATORY RATE (p\_11)**

**DI V5 field: Unassisted Resp 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**

- 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.

**Data Source Hierarchy Guide:**

**1. EMS 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.

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: Oxygen Saturation**

**WI CORE: Yes**

**NTDB Variable: INITIAL FIELD OXYGEN SATURATION (p\_12)**

**DI V5 field: O2 Saturation**

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

**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.
- Value should be based upon assessment before administration of supplemental oxygen.

**Data Source Hierarchy Guide:**

1. EMS Report

#### **Associated Edit Checks (NTDB)**

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

**Section: Pre-hospital**  
**Sub-Section: Treatment**  
**WI Variable: GCS Eye**  
**WI CORE: Yes**  
**NTDB Variable: INITIAL FIELD GCS – EYE (p\_13)**  
**DI V5 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 Applicable**
- ? Unknown**

**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.**

**Data Source Hierarchy Guide:**

- 1. EMS Report**

**Associated Edit Checks (NTDB)**

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

Section: Pre-hospital

Sub-Section: Treatment

WI Variable: GCS Verbal

WI CORE: Yes

NTDB Variable: INITIAL FIELD GCS – VERBAL (p\_14)

DI V5 field: Verbal

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

Field Values

**Pediatric (≤ 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 - 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

Data Source Hierarchy

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

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: GCS Motor**

**WI CORE: Yes**

**NTDB Variable: INITIAL FIELD GCS – MOTOR (p\_15)**

**DI V5 field: 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.**

**Data Source Hierarchy**

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

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: GCS Total**

**WI CORE: Yes**

**NTDB Variable: INITIAL FIELD GCS – TOTAL (p\_16)**

**DI V5 field: 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.

**Data Source Hierarchy**

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

**Section: Pre-hospital**

**Sub-Section: Treatment**

**WI Variable: Revised Trauma Score (RTS, calculated)**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: RTS**

**Definition: The ambulance service Revised Trauma Score is the sum of the coded values assigned to three physiological parameters: Glasgow Coma Scale, systolic blood pressure, and respiratory rate, taken from the initial readings at the scene.**

**Field Values**

- Relevant value for data element

**Additional Information**

- Automatically calculated from GCS, blood pressure and respiratory rate if there are numeric values.
- Third party vendors should not export.

**Data Source Hierarchy**

1. EMS Run Report

**Associated NTDB Edit Checks: None**

# Referring Facility

**Section: Referring Facility**

**Sub-Section: Referral History**

**WI Variable: Facility Transfer**

**WI CORE: Yes**

**NTDB Variable: Inter-Facility Transfer (P\_17)**

**DI V5 field: Transfer in**

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

**Field Values:**

1. Yes
2. No
3. Unknown

**Additional Information:**

- 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)
- If Yes then additional fields will be required on the referring facility tab of the web portal

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Section: Referring Facility**

**Sub-Section: Referral History**

**WI Variable: Referring Facility**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Referring Facility**

**Definition: The name and DHS number assigned to the facility that cared for the patient immediately before the patient arrived at your facility**

**Field Values:**

1. Wisconsin Facilities with DHS identification Numbers/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

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**

**Sub-Section: Referral History**

**WI Variable: If Other/Out of State**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: If Other**

**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 out of state.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**  
**Sub-Section: Referral History**  
**WI Variable: Arrival Date**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: 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 enter ? (unknown) in the web portal

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**  
**Sub-Section: Referral History**  
**WI Variable: Arrival Time**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: 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 enter ? (unknown) in the web portal

**Data Source Hierarchy Guide:**

1. Referring facility documentation
2. Trauma/Triage/Hospital Flowsheet

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**  
**Sub-Section: Referral History**  
**WI Variable: Discharge Date**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Departure (Date)**

**Definition: The date the patient was discharged from the referring facility.**

**Field Values:**

- Date in MM/DD/YYYY format
- If date of discharge is not documented enter ? (unknown) in the web portal

**Additional Information:**

None

**Data Source Hierarchy Guide:**

1. Referring Facility documentation
2. EMS run sheet

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**  
**Sub-Section: Referral History**  
**WI Variable: Discharge Time**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Departure (Time)**

**Definition: The time the patient was discharged from the referring facility.**

**Field Values:**

- **Format is 24 hour time : HH:MM**

**Additional Information:**

- **If time of discharge is not documented enter ? (unknown) in the web portal**

**Data Source Hierarchy Guide:**

- 1. Referring Facility Documentation**
- 2. EMS Run Sheet**

**Associated Edit Checks (NTDB): None**

**Section: Referring Facility**  
**Sub-Section: Referral History**  
**WI Variable: Referring LOS**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Length of Stay**

**Definition: The length of time in HH:MM spent at the referring facility**

**Field Values:**

- Time in HH:MM format

**Additional Information:**

- Auto-calculated by web portal using the Referring hospital Arrival Date and Time and the Referring Hospital Departure Date and Time
- Third party vendors should not export this field

**Data Source Hierarchy Guide:**

**Auto-Calculated**

**Associated Edit Checks (NTDB):None**

**Section: Referring Facility**  
**Sub-Section: Inter-Facility Transport**  
**WI Variable: Transport from Referring Facility**  
**WI CORE: Yes**  
**NTDB Variable: Transport Mode (P\_07)**  
**DI V5 field: 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

**Additional Information:**

**Data Source Hierarchy Guide:**

1. EMS Run Report

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Section: Referring Facility**  
**Sub-Section: Inter-Facility Transport**  
**WI Variable: If other**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: If other**

**Definition: If “other” is selected for “transport from referring facility”**

**Field Values:**

- Free text field to describe the mode of transport from the referring facility

**Additional Information:**

**Data Source Hierarchy Guide:**

- EMS Run Sheet

**Associated Edit Checks (NTDB): None.**

**Section: Referring Facility**

**Sub-Section: Inter-Facility Transport**

**WI Variable: Call Dispatched Date**

**WI CORE: Yes**

**NTDB Variable: EMS Dispatch Date (p\_01)**

**DI V5 field: Call Dispatched (Date)**

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

**Field Values:**

- Relevant value for the data elements
- Additional information
  
- Collected as YYYY-MM-DD.
- 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.

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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

**Section: Referring Facility**  
**Sub-Section: Inter-Facility Transport**  
**WI Variable: Call Dispatched Time**  
**WI CORE: Yes**  
**NTDB Variable: EMS Dispatch Time (p\_02)**  
**DI V5 field: Call Dispatched (Time)**  
**Definition: The Date the EMS was dispatched.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as HH:MM military time.
- 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 time at which the unit transporting the patient to your facility from the transferring facility was notified by dispatch.
- 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 was dispatched.

**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

**Section: Referring Facility**

**Sub-Section: Inter-Facility Transport**

**WI Variable: Arrived at Scene Date**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY (p\_03)**

**DI V5 field: Arrived at Location (Date)**

**Definition: The date the unit transporting to your hospital arrived on the scene/transferring facility.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as YYYY-MM-DD.
- 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 date on 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 date on 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).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
3001	1	Date is not valid
3002	1	Date out of range
3003	3	EMS Unit Arrival on Scene Date is earlier than Date of Birth
3004	4	EMS Unit Arrival on Scene Date is earlier than EMS Dispatch Date
3005	4	EMS Unit Arrival on Scene Date is later than EMS Unit Scene Departure Date
3006	3	EMS Unit Arrival on Scene Date is later than ED/Hospital Arrival Date
3007	4	EMS Unit Arrival on Scene Date is later than ED Discharge Date
3008	3	EMS Unit Arrival on Scene Date is later than Hospital Discharge Date
3009	3	EMS Unit Arrival on Scene Date minus EMS Dispatch Date is greater than 7 days
3010	2	Field cannot be blank

**Section: Referring Facility**

**Sub-Section: Inter-Facility Transport**

**WI Variable: Arrived at Scene Time**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY (p\_04)**

**DI V5 field: Arrived at Location (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).

**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

**Section: Referring Facility**

**Sub-Section: Inter-Facility Transport**

**WI Variable: Left Scene Date**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY (p\_05)**

**DI V5 field: Departed Location (Date)**

**Definition: The date the unit transporting to your hospital left the Referring Facility.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as YYYY-MM-DD.
- Used to auto-generate an additional calculated field: Total EMS Scene Time (elapsed time from EMS scene arrival to scene departure).
- For inter-facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- 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 departed from the scene (departure is defined at date/time when the vehicle started moving).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

Rule ID	Level	Message
3201	1	Date is not valid
3202	1	Date out of range
3203	3	EMS Unit Scene Departure Date is earlier than Date of Birth
3204	4	EMS Unit Scene Departure Date is earlier than EMS Dispatch Date
3205	4	EMS Unit Scene Departure Date is earlier than EMS Unit Arrival on Scene Date
3206	3	EMS Unit Scene Departure Date is later than ED/Hospital Arrival Date
3207	4	EMS Unit Scene Departure Date is later than ED Discharge Date
3208	3	EMS Unit Scene Departure Date is later than Hospital Discharge Date
3209	3	EMS Unit Scene Departure Date minus EMS Unit Arrival on Scene Date is greater than 7 days
3210	2	Field cannot be blank

**Section: Referring Facility**

**Sub-Section: Inter-Facility Transport**

**WI Variable: Left Scene Time**

**WI CORE: Yes**

**NTDB Variable: EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY (p\_06)**

**DI V5 field: Departed Location (Time)**

**Definition: The time the unit transporting to your hospital left the referring facility.**

**Field Values:**

- Relevant value for the data element.

**Additional information**

- Collected as HH:MM military time.
- Used to auto-generate an additional calculated field: 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 from the transferring facility (departure is defined at date/time when the vehicle started 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 from the scene (departure is defined at date/time when the vehicle started moving).

**Data Source Hierarchy Guide:**

**1. EMS Run Report**

**Associated Edit Checks (NTDB)**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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

## **Emergency Department Information**

**Section: Emergency Department (Arrival/Admission)**

**Sub-Section: Arrival/Admission**

**WI Variable: Facility Access ( fac\_access)**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Facility Access**

**Definition: How did the patient come into your facility?**

**Field Values**

- |                                       |                  |
|---------------------------------------|------------------|
| 1. Emergency Department (ED) or Resus | 4. Other         |
| 2. Direct Admit                       | / Not applicable |
| 3. Dead on Arrival (DOA)              | ? Unknown        |

**Data Source Hierarchy**

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

**Associated NTDB Edit Checks: None**

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Arrival Date (eda\_date)**

**WI CORE: Yes**

**NTDB Variable: ED/HOSPITAL ARRIVAL DATE (ED\_01)**

**DI V5 field: ED 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**

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

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Arrival Time ( edd\_time)**

**WI CORE: Yes**

**NTDB Variable: ED/HOSPITAL ARRIVAL TIME (ED\_02)**

**DI V5 field: ED 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**

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

**Section: Emergency Department**  
**Subsection: Arrival/Admission**  
**WI Variable: ED discharge order**  
**WI Core: Yes**  
**NTDB Variable: ED Discharge Date (ED\_21)**  
**DI V5 Field: ED Discharge Order**

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

**Associated Edit Checks**

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 earlier than Hospital Discharge Time

**Section: Emergency Department**  
**Subsection: Arrival/Admission**  
**WI Variable: ED discharge order time**  
**WI Core: Yes**  
**NTDB Variable: ED Discharge Time (ED\_22)**  
**DI V5 Field: ED Discharge Order (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

7. ED Record
8. Triage/Trauma/Hospital Flow Sheet
9. Nursing Notes/Flow Sheet
10. Discharge Summary
11. Billing Sheet
12. Progress Notes

## Associated Edit Checks

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	pital Discharge Time

**Section: Emergency Department**

**Sub Section: Arrival/Admission**

**WI Variable: ED Discharge Date (edd\_date)**

**WI CORE: Yes**

**NTDB Variable: ED DISCHARGE DATE**

**DI V5 field: ED Departure/Admitted (Date)**

**Definition: The date the patient was physically discharged from the ED or was transferred to inpatient floor/OR.**

**Field Values**

- Relevant value for data element

**Additional Information**

- Collected as YYYY-MM-DD.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

**Data Source Hierarchy**

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

**Associated Edit Checks (NTDB)**

**None**

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: ED Discharge Time (edd\_time)**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: ED Departure/Admitted (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 military time.
- The null value "Not Applicable" is used if the patient is directly admitted to the hospital.

**Data Source Hierarchy**

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

**Associated Edit Checks (NTDB)**

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

None

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: ED LOS**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Time in ED**

**Definition: The time the patient spent in the emergency department (auto-calculated)**

**Field Values**

- Relevant value for data element

**Additional Information**

- Auto-calculated

**Associated edit checks (NTDB): None**

**Section: Emergency Department**  
**Sub-Section: Arrival/Admission**  
**WI Variable: Signs of life**  
**WI CORE: Yes**  
**NTDB Variable: SIGNS OF LIFE (ED\_20)**  
**DI V5 field: 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 / Not applicable ??
- 2. Arrived with signs of life ? Unknown

**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**

- 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

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Mode of arrival**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: 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
- Public safety
- Water ambulance
- 8. Other
- / Not applicable
- ? Unknown

#### **Additional Information**

- The last mode that brought the patient to your facility

#### **Data Source Hierarchy**

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

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Trauma Response**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Response Level**

**Definition: Was the Facility Specific trauma activation/Alert activated?**

**Field Values:**

- |            |                         |
|------------|-------------------------|
| 1. Full    | 4. No trauma activation |
| 2. Partial | ? Unknown               |
| 3. Consult |                         |

**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 "Consult"
- If the patient was a direct admit, Select "No Trauma Activation"
- Not applicable should not be used for this field.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-section: Arrival/Admission**

**WI Variable: Trauma Response Date**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Response Activation (Date)**

**Definition: The date that the trauma alert/activation was activated.**

**Field Values:**

- **Date in MM/DD/YYYY**

**Additional information**

- **If the patient was not activated then select "N/A"**
- **If the patient was a direct admit then select "N/A"**

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Response Activation Time**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Response Activation (Time)**

**Definition: The time that the facility specific trauma alert/activation was paged out**

**Field Values:**

- **Time (HH:MM) the page/alert was sent out**

**Additional information**

- **If the patient was not an activation/alert, select "N/A"**

**Data Source Hierarchy Guide:**

**1. Trauma/Triage/Hospital Flow Sheet**

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**  
**Sub-Section: Arrival/Admission**  
**WI Variable: Elapsed Time Activation**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Elapsed**

**Definition: Auto-calculated time that compares the arrival time and the time that the alert/activation was sent out.**

**Field Values:**

- **Auto-calculated**

**Additional information**

- **Auto-Calculated.**

**Data Source Hierarchy Guide:**

- **Auto-Calculated.**

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**  
**Sub-Section: Arrival/Admission**  
**WI Variable: Revised Response Level**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Revised Response Level**

**Definition: This is the final alert/activation level.**

**Field Values:**

- |            |                         |
|------------|-------------------------|
| 1. Full    | 4. No trauma activation |
| 2. Partial | / Not applicable        |
| 3. Consult | ? Unknown               |

**Additional information**

- This applies if the activation level/Alert was upgraded or downgraded after the initial page was sent out
- If the level was not changed then select "Not Applicable"

**Data Source Hierarchy Guide:**

1. Trauma/Triage/Hospital Flow Sheet
- Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Post- ED or Direct Admission Disposition (ed\_dsp)**

**WI CORE: Yes**

**NTDB Variable: ED DISCHARGE DISPOSITION (E\_19)**

**DI V5 field: Post ED disposition**

**Definition: The disposition of the patient at the time of discharge from the ED.**

**Field Values:**

- |                                                  |                                               |
|--------------------------------------------------|-----------------------------------------------|
| <b>3. Operating Room</b>                         | <b>44. Morgue</b>                             |
| <b>4. Intensive Care Unit</b>                    | <b>45. Child Protective Agency</b>            |
| <b>5. Step-down Unit</b>                         | <b>70. Acute Care Facility</b>                |
| <b>6. Floor</b>                                  | <b>71. Intermediate Care Facility</b>         |
| <b>7. Telemetry Unit</b>                         | <b>72. Skilled Nursing Facility</b>           |
| <b>8. Observation Unit</b>                       | <b>73. Rehab (Inpatient)</b>                  |
| <b>9. Burn Unit</b>                              | <b>74. Long-Term Care</b>                     |
| <b>13. Labor and Delivery</b>                    | <b>75. Hospice</b>                            |
| <b>14. Neonatal/Pediatric Care Unit</b>          | <b>76. Mental Health/Psychiatric Hospital</b> |
| <b>40. Home or Self Care (Routine Discharge)</b> | <b>77. Nursing home</b>                       |
| <b>41. Home with Services</b>                    | <b>79. Another Type of Inpatient Facility</b> |
| <b>42. Left AMA</b>                              | <b>/ Not Applicable</b>                       |
| <b>43. Correctional Facility/Court/Law</b>       | <b>? Unknown</b>                              |

#### **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 should be "Not Applicable".**

#### **Data Source Hierarchy**

- 1. Discharge Summary**
- 2. Nursing Notes/Flow Sheet**
- 3. Case Management/Social Services Notes**
- 4. ED Record**
- 5. 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
6105	3	Field should not be Not Applicable unless patient was directly admitted to hospital

**Section: Emergency Department**

**Sub-Section: Arrival/Admission**

**WI Variable: Admitting service**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Admitting service**

**Definition: The service that the patient was admitted to**

**Field Values:**

- |                            |                                |
|----------------------------|--------------------------------|
| 1. Trauma                  | 29. Nurse Practitioner         |
| 2. Neurosurgery            | 30. Nursing                    |
| 3. Orthopedics             | 32. Ob-Gyn                     |
| 4. General Surgery         | 34. Oncology                   |
| 5. Pediatric Surgery       | 35. Ophthalmology              |
| 6. Cardiothoracic Surgery  | 36. Oral Surgery               |
| 7. Burn Services           | 37. Oromaxillo Facial Service  |
| 8. Emergency Medicine      | 38. Ortho-spine                |
| 9. Pediatrics              | 43. Plastic Surgery            |
| 10. Anesthesiology         | 45. Pulmonary                  |
| 11. Cardiology             | 46. Radiology                  |
| 14. Critical Care          | 48. Respiratory Therapist      |
| 16. Documentation Recorder | 52. Thoracic Surgery           |
| 19. ENT                    | 53. Trauma Resuscitation Nurse |
| 20. Family Medicine        | 54. Triage Nurse               |
| 21. GI                     | 55. Urology                    |
| 23. Hospitalist            | 56. Vascular Surgery           |
| 24. Infectious Disease     | 98. Other Surgical             |
| 25. Internal Medicine      | 99. Other Non-Surgical         |
| 27. Nephrology             | ? Unknown                      |
| 28. Neurology              |                                |

**Additional information**

- The admitting attending will determine what service the patient was admitted to
- If the patient was discharged from the ED, Select "Emergency Medicine"

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Weight**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL WEIGHT (ED\_16)**

**DI V5 field: Weight/Units**

**Definition: Measured or estimated baseline weight.**

**Field Values:**

- **Relevant value for the data element for weight**
- **Units:**
  1. **Kg**
  2. **lbs**

**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.**

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
8601	1	Invalid value
8602	2	Field cannot be blank
8603	3	Weight exceeds the max of 907 (kg)

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Height**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL HEIGHT (ED\_15)**

**DI V5 field: Height/Units**

**Definition: First recorded height upon ED/hospital arrival.**

**Field Values:**

- Relevant value for the data element for height
- Units:
  1. Cm
  2. in

**Additional information:**

- Can be recorded in centimeters or inches, and will be converted and reported in centimeters 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.

**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)

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Temperature**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL TEMPERATURE (ED\_05)**

**DI V5 field: Temperature/Unit/Route**

**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 the data element for temperature**

**Units:**

**1. C (Celsius)**

**2. F (Fahrenheit)**

**Route:**

**1. Oral**

**2. Tympanic**

**3. Rectal**

**4. Axillary**

**5. Core (esophageal, bladder)**

**6. Other**

**7. Temporal**

**? Unknown**

**Additional information:**

- **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):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
4901	1	Invalid value
4902	2	Field cannot be blank
4903	3	Temperature exceeds the max of 45.0 Celsius

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Were paralytic agents in effect at the time the vitals were taken?**

**WI CORE: Yes**

**NTDB Variable: Initial ED/Hospital GCS Assessment Qualifiers (ED\_14)**

**DI V5 field: Paralytic Agents?**

**Definition: Whether paralytic agents were in effect when vitals were obtained.**

**Field Values:**

**Yes**

**No**

**N/A**

**UKN**

**Additional Information:**

- **If paralytics were administered within 30 min prior to the vital signs for Atracurium, Cis-Atracurium, Pancuronium, Rocuronium, vecuronium**
- **If paralytics were administered within 10 min prior to the vital signs for Succinylcholine**
- **Common pharmacological agents**
  - **Succinylcholine (Anectine<sup>®</sup>, Quelicin<sup>®</sup>)**
  - **Atracurium**
  - **Cis-atracurium (Nimbex<sup>®</sup>)**
  - **Pancuronium**
  - **Rocuronium (Zemuron<sup>®</sup>)**
  - **Vecuronium (Norcuron)**
- **If patient is under effects of pharmacological paralytic medication they will require mechanical ventilation (intubation)**

**Data Source Hierarchy Guide:**

**1. Trauma/Triage/Hospital Flow Sheet**

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Sedated**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Sedated?**

**Definition: Did the patient receive sedating medications within 30 min prior to the time the vitals were taken in the emergency department**

**Field Values:**

**Yes**

**No**

**N/A**

**UKN**

**Additional Information:**

- **Common sedating medication**
  - **Benzodiazepines:**
    - **Diazepam (Valium ®)**
    - **Midazolam (Versed ®)**
    - **Lorazepam (Ativan ®)**
    - **Alprazolam (Xanax ®)**
    - **Clonazepam (Klonopin ®)**
  - **Opioid Analgesic**
    - **Fentanyl (Actiq ®)**
    - **Hydromorphone (Dilaudid ®)**
    - **Meperidine (Demerol ®)**
    - **Morphine**
    - **Oxycodone (Oxycontin ®)**
  - **General Anesthetic**
    - **Propofol (Diprivan ®)**
    - **Ketamine**

**Data Source Hierarchy Guide:**

**Trauma/triage/hospital flowsheet.**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5801	1	Value is not a valid menu option
5802	2	Field cannot be blank

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Eye obstruction**

**WI CORE: yes**

**NTDB Variable: Initial ED/Hospital GCS Assessment qualifiers (ED\_14)**

**DI V5 field: Eye Obstruction?**

**Definition: At the time of the vitals being taken by the emergency department providers, were the patients eyes obstructed by injury or edema such that it precluded assessment of GCS eye component?**

**Field Values:**

1. Yes
2. No
3. Unknown

**Additional Information:**

- If the documentation indicates that the patients eyes were unable to be assessed secondary to swelling/edema or injury to eye or surrounding structures this should be answered yes.

**Data Source Hierarchy Guide:**

1. Trauma/Triage/Hospital Flow Sheet

**Associated Edit Checks (NTDB): None**

**Associated Edit Checks**

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

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Was the patient intubated at the time the vitals were taken?**

**WI CORE: Yes**

**NTDB Variable: Initial ED/Hospital GCS Assessment qualifiers (ED\_14)**

**DI V5 field: Intubated?**

**Definition: Whether the patient was intubated at the time vitals were taken.**

**Field Values:**

1. Yes
2. No
3. Unknown

**Additional Information:**

- Was the patient intubated at the time the vitals were taken
- either with an endotracheal tube or a tracheostomy

**Data Source Hierarchy Guide:**

**1. Trauma/Triage/Hospital Flow Sheet**

**Associated Edit Checks (NTDB): None**

**Associated Edit Checks**

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

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: If yes, method? (if Intubated)**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: If yes, method? (If intubated)**

**Definition: The method of intubation of the patient was intubated.**

**Field Values:**

- |                                  |                                                             |
|----------------------------------|-------------------------------------------------------------|
| 1. Combitube                     | 7. Esophageal Obturator Airway                              |
| 2. Cricothyrotomy                | 8. Laryngeal Mask Airway                                    |
| 3. Cricothyrotomy – Needle       | 9. LT Blind Insertion Airway Device<br>(King <sup>®</sup> ) |
| 4. Endotracheal Tube – Nasal     | 10. Tracheostomy                                            |
| 5. Endotracheal Tube – Oral      | ? Unknown                                                   |
| 6. Endotracheal Tube – Route NFS |                                                             |

**Data Source Hierarchy Guide:**

1. Trauma/Triage/Hospital Flow Sheet.

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**  
**Sub-Section: Initial Assessment**  
**WI Variable: Respiration Assisted**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: Respiration Assisted?**

**Definition: Was the patient being assisted with breathing during the time the vitals were taken, either with mechanical ventilation or bag mask ventilation (BMV)**

**Field Values:**

- 1. Yes**
- 2. No**
- 3. Unknown**

**Additional Information:**

- **Assisted ventilation does not necessarily mean the patient was intubated, if the patient had a king airway, Combitube, LMA or was being ventilated with a bag mask ventilation (BMV)/Hand ventilated select yes.**
- **If the patient had a nasal or oral airway placed to facilitate ventilation, select yes.**

**Data Source Hierarchy Guide:**

- 1. Trauma/Triage/Hospital Flow Sheet.**

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Type of Assisted Respiration**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: If yes, type (if respiration assisted)**

**Definition: If the patient received respiration assistance, what type was it?**

**Field Values:**

- |                   |               |
|-------------------|---------------|
| 1. Bag valve mask | 4. Ventilator |
| 2. Nasal Airway   | ? Unknown     |
| 3. Oral Airway    |               |

**Additional Information:**

- This information is for facility use and will not be collected by the state or NTDB

**Data Source Hierarchy Guide:**

1. Trauma/Triage/Hospital Flow Sheet

**Associated Edit Checks (NTDB): None**

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Systolic Blood Pressure**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE (ED\_03)**

**DI V5 field: SBP (of SBP/DBP field)**

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

**Field Values:**

**1. Relevant value for the data element.**

**Additional information:**

- **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**
- 4. History & Physical**

**Associated Edit Checks (NTDB):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
4701	1	Invalid value
4702	2	Field cannot be blank
4704	3	SBP value exceeds the max of 300

**Section: Emergency Department (Initial Assessment)**

**WI Variable: Heart Rate (ed\_hr)**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL PULSE RATE (ED\_04)**

**DI V5 field: 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:**

1. Relevant value for the data element.

**Additional information:**

- 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):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
4801	1	Invalid value
4802	2	Field cannot be blank
4804	3	Pulse rate exceeds the max of 299

**Section: Emergency Department (Initial Assessment)**

**WI Variable: Unassisted Respiratory Rate or Assisted Respiratory Rate**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL RESPIRATORY RATE (ED\_06)**

**DI V5 field: Unassisted Resp Rate or Assisted Resp 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 the data element.

**Additional information:**

- If available, complete additional field: "Initial ED/Hospital Respiratory Assistance."
- Please note that first recorded/hospital vitals do not need to be from the same assessment.
- If Respiratory Assistance = Yes, complete field "Assisted Respiratory Rate." If not, complete field "Unassisted Respiratory Rate."

**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.

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Oxygen Saturation**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL OXYGEN SATURATION (ED\_08)**

**DI V5 field: 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.

**Data Source Hierarchy**

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

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: Supplemental Oxygen**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN (ED\_09)**

**DI V5 field: Supplemental O2**

**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**

- Y/N/Ukn/NA

**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**

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

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: GCS Eye (ed\_gcs\_eo)**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL GCS - EYE (ED\_10)**

**DI V5 field: GCS: Eye**

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

**Field values:**

- |                                                         |                                    |
|---------------------------------------------------------|------------------------------------|
| <b>1. No eye movement when assessed</b>                 | <b>4. Opens eyes spontaneously</b> |
| <b>2. Opens eyes in response to painful stimulation</b> | <b>/ Not Applicable</b>            |
| <b>3. Opens eyes in response to verbal stimulation</b>  | <b>? Unknown</b>                   |

**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**

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

**Associated Edit Checks (NTDB):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
5401	1	Value is not a valid menu option
5403	2	Field cannot be blank

Section: Emergency Department

Sub-Section: Initial Assessment

WI Variable: GCS Verbal (ed\_gcs\_vr)

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL GCS - VERBAL (ED\_11)

DI V5 field: GCS: Verbal

Definition: First recorded Glasgow Coma Score (Verbal) 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.

**Data Source Hierarchy**

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

Section: Emergency Department

Sub-Section: Initial Assessment

WI Variable: GCS Motor (ed\_gcs\_mr)

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL GCS - MOTOR (ED\_12)

DI V5 field: GCS: Motor

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

Field values:

**Pediatric ( $\leq 2$  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.

**Data Source Hierarchy**

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

**Section: Emergency Department**

**Sub-Section: Initial Assessment**

**WI Variable: GCS Total (ed\_gcs\_to)**

**WI CORE: Yes**

**NTDB Variable: INITIAL ED/HOSPITAL GCS - TOTAL (ED\_13)**

**DI V5 field: GCS: Total**

**Definition: First recorded Glasgow Coma Score (total) within 30 minutes or less of ED/hospital arrival.**

**Field values:**

- 1. Relevant value for data element**

**Additional information**

- **Utilize only if total score is available without component scores.**
- **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.**
- **Please note that first recorded/hospital vitals do not need to be from the same assessment.**

**Data Source Hierarchy**

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

**Associated Edit Checks (NTDB):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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
5704	4	ONE of the following: Initial ED/Hospital GCS - Eye, Initial ED/Hospital GCS - Verbal, or Initial ED/Hospital GCS - Motor is blank but Initial ED/Hospital GCS - Total is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded
5705	2	Field cannot be blank

**Section: Emergency Department**  
**Sub-Section: Initial Assessment**  
**WI Variable: RTS and Triage RTS (Calculated)**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: RTS and Triage RTS (auto-filled)**

**Definition: The receiving facility Revised Trauma Score is the sum of the coded values assigned to three physiological parameters: Glasgow Coma Scale, systolic blood pressure, and respiratory rate, taken from the initial readings at the receiving facility and multiplied by an assigned weight derived from regression analysis of patients in the Major Trauma Outcome Study. Automatically calculated from GCS, blood pressure and respiratory rate if there are numeric values.**

**Associated Edit Checks (NTDB): None**

Section: Emergency Department  
 Sub-Section: Labs/Toxicology  
 WI Variable: Alcohol Use Indicator  
 WI CORE: Yes  
 NTDB Variable: ALCOHOL USE INDICATOR (ED\_17)  
 DI V5 field: Alcohol Use Indicator

Definition: Use of alcohol by the patient.

Field values:

- |                                           |                                                |
|-------------------------------------------|------------------------------------------------|
| 1. No (not tested)                        | 4 Yes (confirmed by test [beyond legal limit]) |
| 2. No (confirmed by test)                 | / Not Applicable                               |
| 3. Yes (confirmed by test [trace levels]) | ? Unknown                                      |

Additional information:

- Blood alcohol concentration (BAC) may be documented at any facility (or setting) treating this patient event.
- "Trace levels" is defined as any alcohol level below the legal limit, but not zero.
- "Beyond legal limit" is defined as a blood alcohol concentration above the legal limit for the state in which the treating institution is located. Above any legal limit, DUI, DWI or DWAI, would apply here.
- If alcohol use is suspected, but not confirmed by test, record null value "Not Known/Not Recorded."

Note: If patient is under 21 years of age, any confirmed test level above zero is "Yes (confirmed by test [beyond legal limit])"

Data Source Hierarchy

1. Lab Results
2. Triage/Trauma/Hospital Flow Sheet
3. Nursing Notes/Flow Sheet
4. History & Physical

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
5901	1	Value is not a valid menu option
5902	2	Field cannot be blank

**Section: Emergency Department**  
**Sub-Section: Labs/Toxicology**  
**WI Variable: Drug Use Indicator**  
**WI CORE: Yes**  
**NTDB Variable: DRUG USE INDICATOR (ED\_18)**  
**DI V5 field: Drug Use Indicator**

**Definition: Use of drugs by the patient.**

**Field values:**

- |                                                  |                                                        |
|--------------------------------------------------|--------------------------------------------------------|
| <b>1. No (not tested)</b>                        | <b>4. Yes (confirmed by test [beyond legal limit])</b> |
| <b>2. No (confirmed by test)</b>                 | <b>/ Not Applicable</b>                                |
| <b>3. Yes (confirmed by test [trace levels])</b> | <b>? Unknown</b>                                       |

**Additional information:**

- Drug use may be documented at any facility (or setting) treating this patient event.
- "Illegal use drug" includes illegal use of prescription drugs.
- If drug use is suspected, but not confirmed by test, record null value "Not Known/Not Recorded."
- This data element refers to drug use by the patient and does not include medical treatment.
- Check all that apply.

**Data Source Hierarchy**

- 1. Lab Results**
- 2. Triage/Trauma/Hospital Flow Sheet**
- 3. Nursing Notes/Flow Sheet**
- 4. History & Physical**

**Associated Edit Checks (NTDB):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
6001	1	Value is not a valid menu option
6002	2	Field cannot be blank

## **Patient Tracking**

**Section: Patient Tracking**

**Sub-Section: Location/Service**

**WI Variable: Total ICU Days**

**WI CORE: Yes**

**NTDB Variable: TOTAL ICU LENGTH OF STAY (O\_01)**

**DI V5 field: ICU Days**

**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 that day as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS.
- The null value "Not Applicable" is used if the patient had no ICU days according to the above definition.

<b>Example #</b>	<b>Start Date</b>	<b>Start Time</b>	<b>Stop Date</b>	<b>Stop Time</b>	<b>LOS</b>
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	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU 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 in ICU on 3 separate calendar days)
K.	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

**Section: Patient Tracking**

**Sub-Section: Ventilator/Blood**

**WI Variable: Total Ventilator Days**

**WI CORE: Yes**

**NTDB Variable: TOTAL VENTILATOR DAYS (O\_02)**

**DI V5 field: 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 the 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.

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)

**Providers**  
**(No provider information is part of the CORE dataset)**

# Procedures

**Section: Procedures**

**WI Variable: Procedures (ICD-9)**

**WI CORE: Yes**

**NTDB Variable: ICD-9 HOSPITAL PROCEDURES (HP\_01)**

**DI V5 field: ICD-9 Procedure Code (Procedures ICD 9 & 10)**

**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-9-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.
- The null value "Not Known/Not Recorded" is used if not coding ICD-9.
- 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.

### **Diagnostic and Therapeutic Imaging**

Computerized tomographic studies \*  
stent) Diagnostic ultrasound (includes FAST) \*  
Doppler ultrasound of extremities \*

Angiography  
Angioembolization

Echocardiography  
Cystogram  
IVC filter  
Urethrogram

### **Cardiovascular**

Central venous catheter \*  
ventilation \* Pulmonary artery catheter \*  
Cardiac output monitoring \*  
Open cardiac massage  
CPR

### **CNS**

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

### **Musculoskeletal**

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

### **Genitourinary**

Ureteric catheterization (i.e. Ureteric  
Suprapubic cystostomy

### **Transfusion**

The following blood products should be  
captured over first 24 hours after hospital  
arrival:

Transfusion of red cells \*  
Transfusion of platelets \*  
Transfusion of plasma \*

### **Respiratory**

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

### **Gastrointestinal**

Endoscopy (includes gastroscopy,  
sigmoidoscopy, colonoscopy)  
Gastrostomy/jejunostomy (percutaneous  
or endoscopic)  
Percutaneous (endoscopic) gastrojejunoscopy

### **Other**

Hyperbaric oxygen  
Decompression chamber  
TPN \*

### Data Source Hierarchy

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
6501	1	Invalid value
6502	1	Procedures with the same code cannot have the same Hospital Procedure Start Date and Time.
6503	2	Field cannot be blank, must either (1) contain a valid ICD-9 code (2) be Not Known/Not Recorded if not coding ICD-9 or (3) be Not Applicable if no procedures were performed
6504	4	Field should not be Not Applicable unless patient had no procedures performed

**Section: Procedures**

**WI Variable: Procedures (ICD-10)**

**WI CORE: Yes**

**NTDB Variable: ICD-10 HOSPITAL PROCEDURES (HP\_02)**

**DI V5 field: ICD-10 Procedure Code (Procedures ICD 9 & 10)**

**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.
- The null value "Not Known/Not Recorded" is used if not coding ICD-10.
- 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.

**Diagnostic and Therapeutic Imaging**

Computerized tomographic studies \*  
stent) Diagnostic ultrasound (includes FAST) \*  
Doppler ultrasound of extremities \*  
Angiography  
Angioembolization

**Genitourinary**

Ureteric catheterization (i.e. Ureteric  
Suprapubic cystostomy

**Transfusion**

The following blood products should be captured over first 24 hours after hospital arrival:

Echocardiography  
Cystogram  
IVC filter  
Urethrogram

### **Cardiovascular**

Central venous catheter \*  
ventilation \* Pulmonary artery catheter \*  
Cardiac output monitoring \*  
Open cardiac massage  
CPR

### **CNS**

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

### **Musculoskeletal**

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

Transfusion of red cells \*  
Transfusion of platelets \*  
Transfusion of plasma \*

### **Respiratory**

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

### **Gastrointestinal**

Endoscopy (includes gastroscopy,  
sigmoidoscopy, colonoscopy)  
Gastrostomy/jejunostomy (percutaneous  
or endoscopic)  
Percutaneous (endoscopic) gastrojejunoscopy

### **Other**

Hyperbaric oxygen  
Decompression chamber  
TPN \*

### **Data Source Hierarchy**

- 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):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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

**Section: Procedures**

**WI Variable: Start Date**

**WI CORE: Yes**

**NTDB Variable: HOSPITAL PROCEDURE START DATE (HP\_03)**

**DI V5 field: Start (Date field) (Procedures ICD 9 & 10)**

**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

**Data Source Hierarchy**

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

**Section: Procedures**

**WI Variable: Start Time**

**WI CORE: Yes**

**NTDB Variable: HOSPITAL PROCEDURE START TIME (HP\_04)**

**DI V5 field: Start (Time Field) (Procedures ICD 9 & 10)**

**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.**

**Data Source Hierarchy**

- 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):**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
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

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: AIS Version**

**WI CORE: Yes**

**NTDB Variable: AIS Version (IS\_03)**

**DI V5 field: AIS Version**

**Definition:**

The software (and version) used to calculate Abbreviated Injury Scale (AIS) severity Code

**Field Values:**

1. AIS O5, Update 08 Version

**Additional Information:**

- Starting in 2016 only the AIS O5, Update 08 Version will be accepted by the NTDB

**Data Source Hierarchy Guide:**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
7301	1	Value is not a valid menu option
7302	2	Field cannot be blank

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: ISS (Calculated)**

**WI CORE: Yes**

**NTDB Variable: None (NTDB calculates ISS)**

**DI V5 field: ISS**

**Definition: Injury Severity Score (ISS) that reflects the patient's injuries**

**Field Values:**

- Relevant ISS values for the constellation of injuries

**Additional Information:**

- Variable is auto-filled

**Data Source Hierarchy Guide:**

**Associated Edit Checks (NTDB):**

Rule ID	Level	Message
7401	1	Invalid value
7402	3	Must be the sum of three squares

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: TRISS**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: TRISS**

**Definition: Trauma and Injury Severity score that is calculated using the Revised Trauma Score and The Injury Severity Score.**

**Field Values:**

- **Calculated TRISS score from data inputted into the registry expressed as a percentage (probability of survival)**

**Additional Information:**

- **Auto-Calculated.**

**Data Source Hierarchy Guide:**

- **Auto-Calculated**

**Associated Edit Checks (NTDB):**

**None**

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: Narrative**

**WI CORE: Available but not required**

**NTDB Variable: None**

**DI V5 field: Narrative**

**Definition:**

This is a free text box that registrars will put a narrative of the injuries into and the appropriate ICD 9 or ICD 10 codes will be extrapolated.

**Field Values:**

Free text used with tri—code software

**Additional Information:**

When entering diagnosis into Tri-Code ( Narrative) be as specific as possible when describing the injury. Instead of documenting “femur fracture”, you should be specific, for example, “Femur Fracture, Shaft, Communitied”. This will result in the most accurate AIS 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):**

**Associated Edit Checks**

Rule ID	Level	Message
6901	1	Invalid value
6902	2	Field cannot be blank, must either (1) contain a valid ICD-9 code or (2) be Not Applicable if not coding ICD-9
6903	2	If coding with ICD-9, then at least one diagnosis must be provided and meet inclusion criteria (800 - 959.9, except for 905 - 909.9, 910 - 924.9, 930 - 939.9)
6904	4	Field should not be Not Known/Not Recorded

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: First Diagnosis**

**WI CORE: Yes**

**NTDB Variable: ICD-9 Injury Diagnosis (DG\_02)**

**DI V5 field: ICD 9 Code and Description**

**Definition:**

- **Diagnosis related to all identified injuries**

**Field Values:**

- **Injury Diagnoses as defined by ICD-9-CM code range 800-959.9, except for 905-909.1, 910-924.9, 930-939.9. The maximum number of diagnoses that may be reported for an individual patient is 50.**

**Additional Information:**

- **ICD-9-CM 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**
- **The null value “Not Applicable” is used if not coding ICD-9.**

**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):**

**Associated Edit Checks**

<b>Rule ID</b>	<b>Level</b>	<b>Message</b>
0901	1	Invalid value
0902	2	Field cannot be blank, must either (1) contain a valid ICD-9 code or (2) be Not Applicable if not coding ICD-9
0903	2	If coding with ICD-9, then at least one diagnosis must be provided and meet inclusion criteria (800 - 959.9, except for 905 - 909.9, 910 - 924.9, 930 - 939.9)
0904	4	Field should not be Not Known/Not Recorded

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: ICD-10 First Diagnosis**

**WI CORE: Yes**

**NTDB Variable: ICD-10 Injury Diagnoses (DG\_03)**

**DI V5 field: ICD 10 Code and Description**

**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.
- The Null Value “Not applicable” is used if not coding ICD-10.

**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):**

**Associated Edit Checks**

Rule ID	Level	Message
8701	1	Invalid value (ICD-10 CM only)
8702	2	Field cannot be blank, must either (1) contain a valid ICD-10 code or (2) be Not Applicable if not coding ICD-10
8703	2	If coding with ICD-10, then 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	If coding with ICD-10, then at least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CA only)

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: First Predot**

**WI CORE: Yes**

**NTDB Variable: AIS Predot Code (IS\_01)**

**DI V5 field: PreDot**

**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

**Additional Information:**

- Web Portal users will have this information automatically pulled from the Narrative.

**Data Source Hierarchy Guide:**

1. Auto-populated in the registry software

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: AIS Severity**

**WI CORE: Yes**

**NTDB Variable: AIS Severity (IS\_02)**

**DI V5 field: Severity**

**Definition:**

- The Abbreviated Injury Scale (AIS) severity codes that reflect the patient’s injuries.

**Field Values:**

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:**

- The field value (9) “Not possible to assign” would be chosen if it is not possible to assign a severity to an injury.
- Severity is auto-populated in the web portal

**Data Source Hierarchy Guide:**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
7101	1	Value is not a valid menu option
7103	2	Field cannot be blank

**Section: Diagnosis**  
**Sub-Section: Injury Coding**  
**WI Variable: ISS Body Region**  
**WI CORE: Yes**  
**NTDB Variable: None**  
**DI V5 field: ISS Body Region**

**Definition:**

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

**Field Values:**

1. Head or Neck
2. Face
3. Chest
4. Abdominal or Pelvic contents
5. Extremities or Pelvic girdle
6. External

**Additional Information:**

- Auto-populated by tricode
- 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:**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
7201	1	Invalid value
7202	5	If completed, then AIS Severity must be completed.
7203	5	If completed, then AIS Version must be completed.

**Section: Diagnosis**

**Sub-Section: Comorbidities**

**WI Variable: Pre-Hospital Arrest**

**WI CORE: Yes**

**NTDB Variable: Pre-Hospital Cardiac Arrest (P\_20)**

**DI V5 field: Prehospital Cardiac Arrest ?**

**Definition:**

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

**Field Values:**

1. Yes
2. No
3. Unknown

**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):**

**Associated Edit Checks**

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

**Section: Diagnosis**

**Sub-Section: Injury Coding**

**WI Variable: Comorbidities**

**WI CORE: Yes**

**NTDB Variable: Co-Morbid Conditions**

**DI V5 field: Comorbidities**

**Definition:**

- **Pre-existing co-morbid factors present before patient arrival at the ED/Hospital.**

**Field Values:**

- |                                                |                                           |
|------------------------------------------------|-------------------------------------------|
| 1. No Known Co-Morbid Conditions               | 15. History of Myocardial Infarction      |
| 2. Alcoholism                                  | 16. History of PVD                        |
| 3. Bleeding Disorder                           | 17. Hypertension Requiring Medication     |
| 4. Currently Receiving Chemotherapy for Cancer | 18. Prematurity                           |
| 5. Congenital Anomalies                        | 19. Chronic Obstructive Pulmonary Disease |
| 6. Congestive Heart Failure                    | 20. Steroid Use                           |
| 7. Current Smoker                              | 21. Cirrhosis                             |
| 8. Chronic Renal Failure                       | 22. Dementia                              |
| 9. Cerebrovascular Accident (CVA)              | 23. Major Psychiatric Illness             |
| 10. Diabetes Mellitus                          | 24. Drug Use Disorder                     |
| 11. Disseminated Cancer                        | 25. Attention Deficit Disorder/ADHD       |
| 12. Advanced Directive Limiting Care           | 26. Other                                 |
| 13. Functionally dependent Health Status       | 27. Not Applicable Remove                 |
| 14. History of Angina within 30 Days           | 28. Unknown                               |

**Additional Information:**

- **The Null Value “Not Applicable” is used for patients with no known co-morbid conditions.**
- **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.**
- **Check all that apply**

**Co-Morbid Conditions Continued:**

**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):**

**Associated Edit Checks**

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 Do Not Resuscitate (DNR) document or similar advanced directive recorded prior to injury.

**Alcohol use disorder** (Consistent with APA DSM 5): Diagnosis of alcohol use disorder documented in the patient medical record.

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

**Bleeding disorder:** Any condition that places the patient at risk for bleeding in which there is a problem with the body's blood clotting process (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications.) Do not include patients on chronic aspirin therapy.

**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.)

**Chronic Obstructive Pulmonary Disease (COPD):** Severe chronic lung disease, chronic obstructive pulmonary disease (COPD) such as emphysema and/or chronic bronchitis resulting 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.
- Do not include patients whose only pulmonary disease is acute asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.

**Chronic renal failure:** Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration.

**Cirrhosis:** Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. 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. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.

**Congenital Anomalies:** Documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic congenital anomaly.

**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. 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 admission. 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. Exclude patients who smoke cigars or pipes or use 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.)

**Diabetes mellitus:** Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent.

**Disseminated cancer:** Patients who have cancer that has spread to one site 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. 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, bone.)

**Drug use disorder (Consistent with APA DSM 5):** Diagnosis of drug use disorder documented in the patient 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) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, 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.

**History of angina within 30 days:** Documentation of chest pain or pressure, jaw pain, arm pain, or other equivalent discomfort suggestive of cardiac ischemia present within the last 30 days from hospital arrival date.

**History of myocardial infarction:** The history of a non-Q wave, or a Q wave infarction in the six months prior to injury and diagnosed in the patient's medical record.

**History of Peripheral Vascular disease (PVD):** Any type of operative (open) or interventional radiology angioplasty or revascularization procedure for atherosclerotic PVD (e.g., aorta-femoral, femoral-femoral, femoral-popliteal, balloon angioplasty, stenting, etc.) Patients who have had amputation from trauma or resection/repair of abdominal aortic aneurysms, including Endovascular Repair of Abdominal Aortic Aneurysm (EVAR,) would not be included.

**Hypertension requiring medication:** History of a persistent elevation of systolic blood pressure >140mm Hg and a diastolic blood pressure >90mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, angiotensin-converting enzyme (ACE) inhibitors, calcium channel blockers.)

**Major psychiatric illness:** Documentation of the presence of pre-injury major depressive disorder, bipolar disorder, schizophrenia, anxiety/panic disorder, borderline or antisocial personality disorder, and/or adjustment disorder/post-traumatic stress disorder.

**Prematurity:** Documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth. Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.

**Steroid use:** Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., prednisone, dexamethasone in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease.) Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

# Outcome

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Discharge Status**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Discharge Status**

**Definition:**

- **The status of the patient at discharge (alive or dead)**

**Field Values:**

1. **Alive**
2. **Dead**

**Additional Information:**

- **Not Applicable should not be used for this field**
- **Unknown should not be used for this field**

**Data Source Hierarchy Guide:**

1. **Discharge Summary**

**Associated Edit Checks (NTDB): None**

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Hospital Discharge Order Date**

**WI CORE: Yes**

**NTDB Variable: Hospital Discharge Date (O\_03)**

**DI V5 field: Hospital Discharge Order**

**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)
- 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)

**Data Source Hierarchy Guide:**

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

## Hospital Discharge Date Continued:

### Associated Edit Checks (NTDB):

#### Associated Edit Checks

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)

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Discharge Date**

**WI Core: Yes**

**NTDB: None**

**DI V5 Field: Discharge/Death Date**

**Definition:**

- The Date the patient expired or was physically discharged from the ED (Separate from the order for discharge)

**Field Values:**

- Date

**Additional Information**

- Collected as MM-DD-YYYY

**Data Source Hierarchy Guide:**

1. Nursing Notes/Flow Sheet

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Discharge time**

**WI Core: Yes**

**NTDB: None**

**DI V5 Field: Discharge/Death Time**

**Definition:**

- The time the patient expired or was physically discharged from the ED (Separate from the order for discharge)

**Field Values:**

- Time

**Additional Information**

- Collected as HH:MM

**Data Source Hierarchy Guide:**

1. Nursing Notes/Flow Sheet

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Discharge Time**

**WI CORE: Yes**

**NTDB Variable: Hospital Discharge Time (O\_04)**

**DI V5 field: Hospital Discharge Order: Time**

**Definition:**

- The time the patient was 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).
- 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.

**Data Source Hierarchy Guide:**

1. Discharge Instructions
2. Nursing Notes/Flow Sheets
3. Case Management/Social Services Notes
4. Discharge Summary

**Discharge Time Continued:**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

Rule ID	Level	Message
7801	1	Time is not valid
7802	1	Time out of range
7803	2	Field cannot be blank
7804	4	Hospital Discharge Time is earlier than EMS Dispatch Time
7805	4	Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time
7806	4	Hospital Discharge Time is earlier than EMS Unit Scene Departure Time
7807	4	Hospital Discharge Time is earlier than ED/Hospital Arrival Time
7808	4	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)

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Total ICU Days**

**WI CORE: Yes**

**NTDB Variable: Total ICU Length of Stay (O\_01)**

**DI V5 field: Total Days: ICU**

**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

**Additional Information:**

- Recorded in full day increments with any partial calendar day counted as a full calendar day.
- The Calculation assumed that the date and time starting and stopping the 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 that day as one calendar day.
- At no time should the ICU LOS exceed the Hospital LOS
- The Null Value "Not applicable " is used if the patient had no ICU days according to the above definition.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

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	
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in ICU 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 in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Total Ventilator Days**

**WI CORE: Yes**

**NTDB Variable: Total Ventilator Days (O\_02)**

**DI V5 field: Total Days: Ventilator**

**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 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 total vent days cannot be calculated.
- At no time should the Total Vent days exceed the hospital LOS
- The Null Value "Not Applicable" should be used if the patient was not on the ventilator according to the above definition.

**Data Source Hierarchy Guide:**

1. Respiratory Therapy Notes/ Flow Sheet
2. ICU Flow Sheet
3. Progress Notes

**Total Ventilator Days Continued:**

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

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)

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Total Facility Days (Calculated)**

**WI CORE: Yes**

**NTDB Variable: None**

**DI V5 field: Total Days: Hospital**

**Definition:**

- The total number of days the patient was in your facility .

**Field Values:**

- Relevant value for data element

**Additional Information:**

- This is auto-calculated by the patient tracking feature in the web portal

**Data Source Hierarchy Guide:**

- Auto-calculated.

**Associated Edit Checks (NTDB): None**

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Facility Disposition**

**WI CORE: Yes**

**NTDB Variable: Hospital Discharge Disposition (O\_05)**

**DI V5 field: Discharged To**

**Definition:**

- **The disposition of the patient when discharged from the hospital.**

**Field Values:**

- **Home or self-care (routine discharge)**
- **Home with services**
- **Left AMA (Against medical advice)**
- **Correctional Facility/Court/Law Enforcement**
- **Morgue**
- **Child Protective Agency**
- **Acute Care Facility**
- **Intermediate Care Facility**
- **Skilled Nursing Facility**
- **Rehab (inpatient)**
- **Long –Term Care**
- **Hospice**
- **Mental Health /Psychiatric Hospital (inpatient)**
- **Nursing Home**
- **Another type of inpatient facility not defined elsewhere**
- **Unknown**

**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)**
- **Disposition to any other medical facility should be coded as discharged to another type of inpatient facility not defined elsewhere**

## Hospital Discharge Disposition Continued:

### Data Source Hierarchy Guide:

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

### Associated Edit Checks (NTDB):

#### Associated Edit Checks

Rule ID	Level	Message
7901	1	Value is not a valid menu option
7902	2	Field cannot be blank
7903	2	Field must be Not Applicable when ED Discharge Disposition = 5 (Died)

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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 Discharge Date are not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded

**Section: Outcome**

**Sub-Section: Initial Discharge**

**WI Variable: Discharge to Alternative Caregiver**

**WI CORE: Yes**

**NTDB Variable: Caregiver at discharge**

**DI V5 field: Discharge to Alternate Caregiver**

**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. Unknown
4. N/A

**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” should be used for patients where report of Physical abuse is “No” (Injury Tab)
- The null value “Not Applicable” should be used if the patient expires prior to discharge.

**Data Source Hierarchy Guide:**

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

**Associated Edit Checks (NTDB):**

**Associated Edit Checks**

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

**Data Source Hierarchy Guide:**

1. Case management notes
2. Discharge Summary
3. Nursing Notes/Flow Sheet
4. Progress Notes.

**Associated Edit Checks (NTDB):None**

- If patient was not transferred from your facility then select N/A

**Data Source Hierarchy Guide:**

1. Discharge Summary
2. Case Management Notes
3. Nursing Notes/Flow sheets

**Associated Edit Checks (NTDB): None**

**Section: Outcome**

**Sub-Section: Billing**

**WI Variable: Primary Method of Payment**

**WI CORE: Yes**

**NTDB Variable: Primary Method of Payment (F\_01)**

**DI V5 field: Primary Payor**

**Definition:**

- **Primary source of payment for hospital care.**

**Field Values:**

- **Medicaid**
- **Not Billed (for any reason)**
- **Self-Pay**
- **Private/Commercial Insurance**
- **Medicare**
- **Other Government**
- **Other**

**Additional Information:**

- **No Fault Automobile, workers compensation and Blue Cross/Blue Shield were retired in 2015.**
- **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):**

### Associated Edit Checks

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

# QA Tracking

**Section: QA Tracking**

**Sub-Section: QA Items**

**WI Variable: Complications**

**WI CORE: Yes**

**NTDB Variable: Hospital Complications ( Q\_01)**

**DI V5 field: NTDB Complications**

**Definition:**

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

**Field Values:**

- Other
- Acute Kidney Injury
- Adult Respiratory Distress syndrome (ARDS)
- Cardiac Arrest with CPR
- Decubitus Ulcer
- Deep Surgical site infection
- Drug or Alcohol withdrawal syndrome
- Deep vein thrombosis (DVT)
- Extremity compartment syndrome
- Myocardial infarction
- Organ/Space surgical site infection
- Pulmonary Embolism
- Stroke/CVA
- Superficial surgical site infection
- Unplanned intubation
- Osteomyelitis
- Unplanned return to OR
- Unplanned admission to the ICU
- Severe Sepsis
- Catheter-Associated urinary tract infection (CAUTI)
- Central Line Associated bloodstream infection (CLABSI)
- Ventilator-Associated Pneumonia (VAP)

**Additional Information:**

- The Null value “Not Applicable” should be used for patients with no complications.
- 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.
- For all hospital complications that follow the CDC definition [e.g. VAP, CAUTI, CLASBI, Osteomyelitis] always use the most recent definition provided by the CDC.
- Check all that apply
- Graft/prosthesis/flap failure was retired in 2016
- Pneumonia was retired in 2016 (VAP was added)
- Urinary Tract infection was retired in 2016 (CAUTI was added)
- Catheter related blood stream infection was retired in 2016 (Central-Line Associated bloodstream infection was added).

**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):**

**Associated Edit Checks**

Rule ID	Level	Message
8101	1	Value is not a valid menu option
8102	2	Field cannot be blank
8103	3	Hospital Complications include Ventilator-associated pneumonia although Total Ventilator Days is Not Applicable. Please verify.

## **HOSPITAL COMPLICATIONS**

**Acute Kidney Injury:** Acute kidney injury, AKI (stage 3), is an abrupt reduction of kidney function defined as:

Increase in serum creatinine (SCr) of more than or equal to 3x baseline

or;

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

or;

Patients  $>18$  years with a decrease in  $e\text{GFR}$  to  $< 35\text{ ml/min per } 1.73\text{ m}^2$

or;

Reduction in urine output of  $< 0.3\text{ ml/kg/hr}$  for  $\geq 24$  hrs.

or;

Anuria for  $\geq 12$  hrs.

or;

Requiring renal replacement therapy (e.g. continuous renal replacement therapy (CRRT) or periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration).

NOTE: 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):**

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: (at a minimum)	$200 < \text{PaO}_2/\text{FiO}_2 \leq 300$ With PEEP or CPAP $\geq 5\text{ cmH}_2\text{O}$

**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.

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.

**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°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<sup>5</sup> 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°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.

**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°C)
  - hypothermia (<36.0°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  $\geq 10^5$  CFU/ml.

**Central line-associated bloodstream infection** (*Consistent with the January 2014 CDC Defined CLABSIs*): 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

A CL or UC was 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 LCBI criteria must be fully met on the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access as an inpatient is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line.

**January 2014 CDC Criterion LCBI 1:**

Patient has a recognized pathogen cultured from one or more blood cultures

AND

Organism cultured from blood is not related to an infection at another site

OR

**January 2014 CDC Criterion LCBI 2:**

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

AND

positive laboratory results are 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 cultured from two or more blood cultures drawn on separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements

OR

**January 2014 CDC Criterion LCBI 3:**

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

AND

positive laboratory results are 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 cultured from two or more blood cultures drawn on the same or consecutive days and separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements.

**Decubitus ulcer:** Any partial or full thickness loss of dermis resulting from pressure exerted by the patient's weight against a surface. Deeper tissues may or may not be involved. Equivalent to NPUAP Stages II – IV and NPUAP “unstageable” ulcers. EXCLUDES intact skin with non-blanching redness (NPUAP Stage I,) which is considered reversible tissue injury.

**Deep surgical site infection:** A deep incisional SSI must meet one of the following criteria:

Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision; AND patient has at least one of the following:

- Purulent drainage from the deep incision but not from the organ/space component of the surgical site of the following:
- A deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38C,) or localized pain or tenderness. A culture negative finding does not meet this criterion.
- An abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination.
- Diagnosis of a deep incisional SSI by a surgeon or attending physician.

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

- 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)
- 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 [leg] incision for CBGB.)

**REPORTING INSTRUCTION:** Classify infection that involves both superficial and deep incision sites as deep incisional SSI.

**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. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.

**Drug or alcohol withdrawal syndrome:** A set of symptoms that may occur when a person who has been habitually drinking too much alcohol or habitually using certain drugs (e.g., narcotics, benzodiazepine) experiences physical symptoms upon suddenly stopping consumption. Symptoms may include: activation syndrome (i.e., tremulousness, agitation, rapid heartbeat and high blood pressure,) seizures, hallucinations or delirium tremens.

**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. 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:** A new acute myocardial infarction occurring during hospitalization (within 30 days of injury.)

**Organ/space surgical site infection:** An infection that occurs within 30 days after an operation and infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, which was opened or manipulated during a procedure; and at least one of the following, including:

- Purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space.
- Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space.
- An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination
- Diagnosis of an organ/space SSI by a surgeon or attending physician.

**Osteomyelitis** (Consistent with the *January 2015 CDC definition of Bone and Joint infection*): Bone and Joint infection that meets at least **one** of the following criteria:

- Patient has organisms cultured from bone.
- Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam
- Patient has at least **two** of the following localized signs or symptoms with no other recognized cause:
  - Fever (38° C)
  - swelling
  - pain or tenderness
  - Heat
  - Drainage

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

- Organisms cultured from blood in a patient with imaging test evidence of infection
- Positive non-cultured diagnostic lab test on blood (e.g., antigen test, PCR)
- Imaging test evidence of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]

**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.

**Severe sepsis:** Sepsis and/or Severe Sepsis defined as an obvious source of infection with bacteremia and two or more of the following:

- Temp  $>38^{\circ}$  C or  $<36^{\circ}$  C
- WBC count  $>12,000/\text{mm}^3$ , or  $> 20\%$ immature (source of infection)
- Hypotension – (Severe Sepsis)
- Evidence of hypo perfusion: (Severe Sepsis)
- Anion gap or lactic acidosis or Oliguria, or Altered mental status.

**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.

**Superficial surgical site infection:** An infection that occurs within 30 days after an operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following:

- Purulent drainage, with or without laboratory confirmation, from the superficial incision.
- Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision.
- At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat and superficial incision is deliberately opened by the surgeon, unless incision is culture-negative.
- Diagnosis of superficial incisional surgical site infection by the surgeon or attending physician.

Do not report the following conditions as superficial surgical site infection:

- Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration.)
- Infected burn wound.
- Incisional SSI that extends into the fascial and muscle layers (see deep surgical site infection.)

**Unplanned admission to ICU:**

**INCLUDE:**

- Patients admitted to the ICU after initial transfer to the floor.
- Patients with an unplanned return to the ICU after initial ICU discharge.

**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.

**Unplanned return to the OR:** Unplanned return to the operating room after initial operation management for a similar or related previous procedure.

**Ventilator-associated Pneumonia** (*Consistent with the January 2015 CDC Defined VAP*): 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):**

RADIOLOGY	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> 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 <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), <b>one definitive</b> chest radiograph is acceptable.</p>	<p>At least <b>one</b> 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>&lt;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 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 <b>dyspnea</b>, 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>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Positive growth in blood culture not related to another source of infection</li> <li>• Positive growth in culture of pleural fluid</li> <li>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing)</li> <li>• <math>\geq 5\%</math> 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 <b>one</b> 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):**

RADIOLOGY	SIGNS/SYMPTOMS	LABORATORY
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> 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 <b>without</b> underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic</p>	<p>At least <b>one</b> 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>&lt;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 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,</li> </ul>	<p>At least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• Positive culture of virus, Legionella or Chlamydia from respiratory secretions</li> <li>• Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus, Bordetella, Chlamydia, Mycoplasma, Legionella (e.g., EIA &lt; FAMA &lt; shell vial assay, PCR, micro-IF)</li> <li>• Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</li> <li>• Fourfold rise in L. pneumophila serogroup 1 antibody titer to <math>\geq 1:128</math> in paired acute and convalescent sera by indirect IFA.</li> <li>• Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA</li> </ul>

obstructive pulmonary disease), <b>one definitive</b> chest radiograph is acceptable.	<ul style="list-style-type: none"> <li>• or <b>dyspnea</b>, 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>	
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**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:**

RADIOLOGY	SIGNS/SYMPTOMS
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> 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), <b>one definitive</b> chest radiograph 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><b>AND</b> at least <b>three</b> of the following:</p> <ul style="list-style-type: none"> <li>• Temperature instability</li> <li>• Leukopenia (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> 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:**

RADIOLOGY	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest radiographs with at least <b>one</b> of the following:</p> <ul style="list-style-type: none"> <li>• New or progressive <b>and</b> 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), <b>one definitive</b> chest radiograph is acceptable.</p>	<p>At least <b>three</b> 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 (&lt;4000 WBC/mm<sup>3</sup>) <b>or</b> 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>

**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.