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Outcome Information

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Section C: REPORT WRITER DATASET ELEMENTS

- RW Elements
About this Data Dictionary

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

This is the fourth edition of the dictionary and incorporates changes in requirements from the National Trauma Data Bank (NTDB); the Wisconsin Trauma Care System; and any changes in data entry resulting from the transition in registry vendors.

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

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

Inclusion Criteria

Admission Dates: January 1, 2017 to December 31, 2017

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-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.
IN ADDITION TO THE DIAGNOSIS ABOVE, ONE OF THE FOLLOWING MUST ALSO BE TRUE TO QUALIFY AS A REPORTABLE TRAUMA:

- 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)

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

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

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

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

These values are to be used as the null Values:

1. Not Applicable applies if, at the time of the patient care documentation, the information requested was “Not Applicable” to the patient. For example, variables documenting EMS care would be “Not Applicable” if a patient self-transported to the hospital.

2. Not Known/Not Documented/Not Recorded/Unknown are interchangeable: This null value applies if, at the time of patient care documentation, information was “not known” to the patient, family, healthcare provider or no value for the element was recorded for the patient. This null value should be used in situations when the documentation was incomplete or missing.

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

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

This data dictionary contains required fields for 2017 diagnoses. The data items on the following pages are listed by category. Each data item description contains:

- **A. Section**
- **B. WI CORE**
- **C. NTDB Variable**
- **D. ImageTrend Field**
- **E. Definition**
- **F. Field Values**
- **G. Additional Information**
- **H. Data Source Hierarchy Guide**
- **I. Associated Edit Checks (NTDB)**

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<tr>
<th></th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A</td>
<td>Identifies the Tab under which the element is displayed on the data entry form</td>
</tr>
<tr>
<td>B</td>
<td>Identifies if the element is required by the State of Wisconsin (Yes/No)</td>
</tr>
<tr>
<td>C</td>
<td>Variable’s name as it appears within the NTDB data dictionary</td>
</tr>
<tr>
<td>D</td>
<td>The element title displayed on the data entry form</td>
</tr>
<tr>
<td>E</td>
<td>Here is the data element definition will be found.</td>
</tr>
<tr>
<td>F</td>
<td>Lists all available values for data element entry</td>
</tr>
<tr>
<td>G</td>
<td>Any additional pertinent information to this data element</td>
</tr>
<tr>
<td>H</td>
<td>Lists the appropriate sources for this information</td>
</tr>
<tr>
<td>I</td>
<td>If the element is NTDB required, the associated validity rules will be displayed here.</td>
</tr>
<tr>
<td>J</td>
<td>ImageTrend Data Element Number</td>
</tr>
</tbody>
</table>
NATIONAL TRAUMA DATA BANK ELEMENTS
Section: Demographic

WI CORE: Yes

NTDB Variable: Patient’s Home Zip/Postal Code (D_01)

ImageTrend 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
- Not Known is indicated by typing “99999”

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
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<td>0002</td>
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</table>
Section: Demographics
WI CORE: Yes
NTDB Variable: Patient’s Home Country (D_02)
ImageTrend 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)

<table>
<thead>
<tr>
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<tr>
<td>0105</td>
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<td>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</td>
</tr>
</tbody>
</table>
Section: Demographics

WI CORE: Yes

NTDB Variable: Patient’s Home State (D_03)

ImageTrend 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.
- Element will default to Wisconsin when ZIP is 99999

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission form

**Associated Edit Checks (NTDB)**

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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>

Section: Demographics

WI CORE: Yes

NTDB Variable: Patient’s Home County (D_04)

ImageTrend 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.
- When ZIP is 99999, element will populate as “Not Known”.

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

<table>
<thead>
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</table>
Section: Demographics

WI CORE: Yes

NTDB Variable: Patient’s Home City (D_05)

ImageTrend 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.
- When ZIP is 99999, element will populate as “Not Known”

Data Source Hierarchy Guide:
1. ED Admission Form
2. Billing Sheet / Medical Records Coding Summary Sheet
3. EMS Run Sheet
4. Triage Form / Trauma Flow Sheet
5. ED Nurse’s Notes

Associated Edit Checks (NTDB)

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<td>0402</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Demographic

WI CORE: Yes

NTDB Variable: Alternate Home Residence (D_06)

ImageTrend Field: Alternate Residence

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

Field Values:
1. Homeless
2. Undocumented Citizen
3. Migrant Worker

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

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<td>Value is not a valid menu option</td>
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<td>0502</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Demographic

WI CORE: Yes

NTDB Variable: Date of Birth (D_07)

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

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report
6. Case mgmt./Social service notes

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tr>
<td>0601</td>
<td>1</td>
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</tr>
<tr>
<td>0602</td>
<td>1</td>
<td>Date out of range</td>
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<td>0603</td>
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<td>Field cannot be blank</td>
</tr>
<tr>
<td>0605</td>
<td>3</td>
<td>Field should not be Not Known/Not Recorded</td>
</tr>
<tr>
<td>0606</td>
<td>2</td>
<td>Date of Birth is later than EMS Dispatch Date</td>
</tr>
<tr>
<td>0607</td>
<td>2</td>
<td>Date of Birth is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>0608</td>
<td>2</td>
<td>Date of Birth is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>0609</td>
<td>2</td>
<td>Date of Birth is later than Injury Date</td>
</tr>
<tr>
<td>0610</td>
<td>2</td>
<td>Date of Birth is later than ED Discharge Date</td>
</tr>
<tr>
<td>0611</td>
<td>2</td>
<td>Date of Birth is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>0612</td>
<td>2</td>
<td>Date of Birth + 120 years must be less than Injury Date</td>
</tr>
<tr>
<td>0613</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Demographics
WI CORE: Yes
NTDB Variable: Age (D_08)
ImageTrend 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.
- If date of birth is not known, leave blank.
- Used to calculate patient age in minutes, hours, days, months or years.
- If date of birth is “not known/not recorded” complete variables Age and Age Units
- If date of birth equals ED/Hospital Arrival Date, then the age and Age Units variables must be completed.
- Must also complete variable: Age Units.

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>0701</td>
<td>1</td>
<td>Age is outside the valid range of 0 – 120</td>
</tr>
<tr>
<td>0703</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>0704</td>
<td>3</td>
<td>Injury Date minus Date of Birth should equal submitted Age as expressed in the Age Units specified.</td>
</tr>
<tr>
<td>0705</td>
<td>4</td>
<td>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.</td>
</tr>
<tr>
<td>0707</td>
<td>2</td>
<td>Field must be Not Applicable when Age units is Not Applicable</td>
</tr>
<tr>
<td>0708</td>
<td>2</td>
<td>Field must be Not Known/Not Recorded when Age Units is Not Known/Not Recorded</td>
</tr>
</tbody>
</table>
Section: Demographics

WI CORE: Yes

NTDB Variable: Age Units (D_09)

ImageTrend Field: Age Units

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

Field Values:
1. Hours
2. Days
3. Months
4. Years
5. Minutes

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

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form
4. Triage/Trauma Flow Sheet
5. EMS Run Report.

Associated Edit Checks (NTDB)

<table>
<thead>
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</table>
Section: Demographics

WI CORE: Yes

NTDB Variable: Race (D_10)

ImageTrend Field: Race

Definition:

- The patient’s race

Field Values:

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

Additional Information:

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

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

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</table>
Section: Demographics

WI CORE: Yes

NTDB Variable: Ethnicity (D_11)

ImageTrend Field: Ethnicity

Definition:
- The patient’s ethnicity.

Field Values:
1. Hispanic or Latino
2. Not Hispanic or Latino
3. Not Known/Not Recorded

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

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

Associated Edit Checks (NTDB)

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</table>
Section: Demographics

TR1.15

WI CORE: Yes

NTDB Variable: Sex (D_12)

ImageTrend Field: Sex

Definition:

- The patient’s sex

Field Values:

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

Additional Information:

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

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

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</table>
Injury
Section: Demographics  
WI CORE: Yes  
NTDB Variable: Injury Incident Date (I_01)  
ImageTrend Field: Injury Incident Date

Definition:
- The Date the injury occurred.

Field Values:
- Relevant value for data element

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

Data Source Hierarchy Guide:
1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet

Associated Edit Checks (NTDB)

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<td>1203</td>
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<tr>
<td>1204</td>
<td>4</td>
<td>Injury Incident Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>1205</td>
<td>4</td>
<td>Injury Incident Date is later than EMS Dispatch Date</td>
</tr>
<tr>
<td>1206</td>
<td>4</td>
<td>Injury Incident Date is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>1207</td>
<td>4</td>
<td>Injury Incident Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>1208</td>
<td>4</td>
<td>Injury Incident Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>1209</td>
<td>4</td>
<td>Injury Incident Date is later than ED Discharge Date</td>
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<tr>
<td>1210</td>
<td>4</td>
<td>Injury Incident Date is later than Hospital Discharge Date</td>
</tr>
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<td>1211</td>
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<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Injury

 WI CORE: Yes

 NTDB Variable: Injury Incident Time (I_02)

 ImageTrend Field: Time

 Definition:
 - The time the injury occurred.

 Field Values:
 - Relevant value for data element

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

 Data Source Hierarchy Guide:
 1. EMS Run Report
 2. Triage/Trauma Flow Sheet
 3. History & Physical
 4. Face Sheet.

 Associated Edit Checks (NTDB)

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<td>Field cannot be blank</td>
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<tr>
<td>1304</td>
<td>4</td>
<td>Injury Incident Time is later than EMS Dispatch Time</td>
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<tr>
<td>1305</td>
<td>4</td>
<td>Injury Incident Time is later than EMS Unit Arrival on Scene Time</td>
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<td>1306</td>
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</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Work-Related (I_03)

ImageTrend Field: Was the Injury Work Related?

Definition:
- Indication of whether the injury occurred during paid employment

Field Values:
1. Yes
2. No
3. Not Known/Not Recorded

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

Data Source Hierarchy Guide:
1. EMS Run Report
2. Triage/Trauma Flow Sheet
3. History & Physical
4. Face Sheet
5. Billing Sheet

Associated Edit Checks (NTDB)

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<td>Work-Related should be 1 (Yes) when Patient’s Occupation is not “Not Applicable” or “Not Known/Not Recorded”</td>
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<tr>
<td>1406</td>
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<td>Work-Related should be 1 (Yes) when Patient’s Occupational Industry is not “Not Applicable” or “Not Known/Not Recorded”</td>
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<tr>
<td>1407</td>
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<td>Field cannot be Not Applicable</td>
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</tbody>
</table>
Section: Injury

NTDB Variable: Patient's Occupational Industry (I_04)
ImageTrend 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
16. Not Known/Not Recorded

Additional Information:
- Only completed if injury is work-related
- If Work related, also complete Patient’s Occupation
- Not Applicable is used if not work related.

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

Associated Edit Checks (NTDB)

<table>
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<td>1504</td>
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<td>Field cannot be blank</td>
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</tbody>
</table>
PATIENT’S OCCUPATIONAL INDUSTRY: The occupational history associated with the patient’s work environment.

Field Value Definitions:

Finance and Insurance - The Finance and Insurance sector comprises establishments primarily engaged in financial transactions (transactions involving the creation, liquidation, or change in ownership of financial assets) and/or in facilitating financial transactions. Three principal types of activities are identified:
1. Raising funds by taking deposits and/or issuing securities and, in the process, incurring liabilities.
2. Pooling of risk by underwriting insurance and annuities.
3. Providing specialized services facilitating or supporting financial intermediation, insurance, and employee benefit programs.

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

Retail Trade - The Retail Trade sector comprises establishments engaged in retailing merchandise, generally without transformation, and rendering services incidental to the sale of merchandise. The retailing process is the final step in the distribution of merchandise; retailers are, therefore, organized to sell merchandise in small quantities to the general public. This sector comprises two main types of retailers:
1. Store retailers operate fixed point-of-sale locations, located and designed to attract a high volume of walk-in customers.
2. Non-store retailers, like store retailers, are organized to serve the general public, but their retailing methods differ.

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

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

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

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

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

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

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

**Information Services** - The Information sector comprises establishments engaged in the following processes:
- producing and distributing information and cultural products,
- providing the means to transmit or distribute these products as well as data or communications,
- processing data.

**Wholesale Trade** - The Wholesale Trade sector comprises establishments engaged in wholesaling merchandise, generally without transformation, and rendering services incident 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
WI CORE: Yes
NTDB Variable: Patient’s Occupation (I_05)
ImageTrend Field: Occupation

Definition:
- The occupation of the patient.

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 Occupations
19. Personal Care And Service Occupations
20. Office and Administrative Support Occupations
21. Construction and Extraction Occupations
22. Production Occupations
23. Military Specific Occupations
24. Not Applicable
25. Not Known/Not Recorded

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

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

Associated Edit Checks (NTDB)

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Section: Injury

WI CORE: Yes

NTDB Variable: ICD-10 Primary External Cause Code (I_06) and ICD-10 Additional External Cause Code (I_08)

ImageTrend Field: ICD 10 External Cause Code

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

Field Values:
- Relevant ICD-10-CM code value for injury event.

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

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

Associated Edit Checks (NTDB)

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<td>E-Code is not a valid ICD-10-CM code (ICD-10 CM only)</td>
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<td>Should not be Y92.X/Y92.XX/Y92.XXX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
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<td>ICD-10 External Cause Code should not be Y93.X/Y93.XX (where X is A-Z or 0-9) (ICD-10 CM only)</td>
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<td>E-Code is not a valid ICD-10-CA code (ICD-10 CA only)</td>
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<td>Field cannot be Not Applicable</td>
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Section: Injury

WI CORE: Yes

NTDB Variable: ICD-10 Place of Occurrence External Cause Code (I_07)

ImageTrend Field: ICD10 Location

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

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

Associated Edit Checks (NTDB)

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<td>9003</td>
<td>3</td>
<td>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)</td>
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<td>Place of Injury code should be U98X (where X is 0-9) (ICD-10 CA only)</td>
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<td>Field cannot be Not Applicable</td>
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</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Incident Location Zip/Postal Code (I_09)

ImageTrend Field: ZIP

Definition:
- The ZIP/Postal code of the incident Location

Field Values:
- Relevant Value for Data Element

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

Data Source Hierarchy Guide:
1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet

Associated Edit Checks (NTDB)

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<tr>
<td>2006</td>
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<td>Field cannot be Not Applicable</td>
</tr>
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</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Incident Country (I_10)

ImageTrend 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)

Data Source Hierarchy Guide:
1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tbody>
<tr>
<td>2101</td>
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<tr>
<td>2102</td>
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<td>Field cannot be blank</td>
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<td>2104</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
<tr>
<td>2105</td>
<td>2</td>
<td>Field cannot be “Not Known/Not Recorded” when Incident Location ZIP/Postal code is not “Not Known/Not Recorded”</td>
</tr>
</tbody>
</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Incident State (I_11)

ImageTrend 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
- Element will default to Wisconsin when ZIP is 99999

Data Source Hierarchy Guide:
1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses’ Notes

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
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<th>Message</th>
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<tbody>
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<td>2203</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Incident County (I_12)

ImageTrend 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.
- The null value “Not Applicable” is used if incident Location ZIP/Postal Code is reported.

Data Source Hierarchy Guide:
1. EMS Run Sheet
2. Triage Form/Trauma Flow Sheet
3. ED Nurses’ Notes

Associated Edit Checks (NTDB)

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</tr>
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</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Incident City (I_13)

ImageTrend 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.
- The null value “Not Applicable” is used if Incident Location ZIP/Postal Code is reported.
- If Incident Country is not US, report the null value “Not Applicable”
- When ZIP is “99999”, element will populate as “Not Known”

Data Source Hierarchy Guide:
1. EMS Run Report
2. Triage/Trauma Flow Sheet

Associated Edit Checks (NTDB)

<table>
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<tr>
<td>2403</td>
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<td>Field cannot be blank</td>
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</tbody>
</table>
Section: Injury
WI CORE: Yes
NTDB Variable: Protective Devices (I_14), Child Specific Restraint (I_15), Airbag Deployment (I_16)
ImageTrend Field: Protective Devices (multiple)

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

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

Data Elements:
- Airbag Present (TR29.3)
- Airbag not Deployed (TR29.20)
- Airbag Deployed Side (TR29.19)
- Airbag Deployed Front (TR29.21)
- Airbag Deployed Other (TR29.22)
- Child Restraint (TR29.13)
- Child Booster Seat (TR29.17)
- Child Car Seat (TR29.15)
- Infant Car Seat (TR29.16)
- Three Point Restraint (TR29.23)
- Lap Belt (TR29.11)
- Shoulder Belt (TR29.14)
- Personal Floatation Device (TR29.8)
- Eye Protection (TR29.6)
- Helmet (TR29.2)
- Protective Clothing (TR29.7)
- Protective Non-Clothing Gear (TR29.12)
- Other (TR29.9)
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.
- Certain elements do not have a Not Applicable option. For specific elements in question, reference the NTDB dictionary.
- Selecting “Yes” for Airbag Present (TR29.2) will display Airbag not Deployed (TR29.20), Airbag Deployed Side (TR29.19), Airbag Deployed Front (TR29.21), and Airbag Deployed Other (TR29.22).
- Selecting “Yes” for Child Restraint (TR29.13) will display Infant Car Seat (TR29.16), Child Car Seat (TR29.15), and Child Booster Seat (TR29.17).
- When Three Point Restraint (TR29.23) is “Yes”, Lap Belt (TR29.11) and Shoulder Belt (TR29.14) will auto-populate as “Yes”.

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

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<td>2502</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>2505</td>
<td>3</td>
<td>Protective Device should be 6 (Child Restraint) when Child Specific Restraint is not “Not Applicable” or “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>2506</td>
<td>3</td>
<td>Protective Device should be 8 (Airbag Present) when Airbag Deployment is not “Not Applicable” or “Not Known/Not Recorded”</td>
</tr>
<tr>
<td>2507</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Injury
WI CORE: Yes
NTDB Variable: Report of Physical Abuse (I_17)
ImageTrend 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
3. Not Known/Not Recorded

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

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

Associated Edit Checks (NTDB)

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<td>9202</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
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<tr>
<td>9203</td>
<td>2</td>
<td>Filed cannot be blank</td>
</tr>
</tbody>
</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Investigation of Physical Abuse (I_18)

ImageTrend 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
3. Not Applicable
4. Not Known/Not Recorded

Additional Information:
- This includes, but is not limited to, a report of child, elder, spouse or intimate partner abuse
- Only complete when report of physical abuse is yes.
- The null value of “Not Applicable” 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.

Associated Edit Checks (NTDB)

<table>
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<tr>
<td>9303</td>
<td>3</td>
<td>Field should not be Not Applicable when Report of Physical Abuse = 1 (Yes)</td>
</tr>
</tbody>
</table>
Section: Injury

WI CORE: Yes

NTDB Variable: Caregiver at discharge (I_19)

ImageTrend 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. Not Applicable
4. Not Known/Not Recorded

Additional Information:

- Only complete when report of Physical abuse (Injury tab) is yes
- Only complete for patients less than 18 year of age, excluding emancipated minors.
- The Null Value “Not Applicable” 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)

<table>
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<td>9402</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Pre-hospital Information
**Section: Pre-hospital**

**NTDB Variable:** EMS Dispatch Date (P_01)

**ImageTrend Field:** EMS Dispatched Date

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

**Field Values:**
- Relevant value for the data element.

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

**Data Source Hierarchy Guide:**

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>2801</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>2802</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>2803</td>
<td>3</td>
<td>EMS Dispatch Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>2804</td>
<td>4</td>
<td>EMS Dispatch Date is later than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>2805</td>
<td>4</td>
<td>EMS Dispatch Date is later than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>2806</td>
<td>3</td>
<td>EMS Dispatch Date is later than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>2807</td>
<td>4</td>
<td>EMS Dispatch Date is later than ED Discharge Date</td>
</tr>
<tr>
<td>2808</td>
<td>3</td>
<td>EMS Dispatch Date is later than Hospital Discharge Date</td>
</tr>
<tr>
<td>2809</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: EMS Dispatch Time (p_02)
ImageTrend Field: EMS Dispatch 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.
- Leave blank for patients not transported by EMS.

Data Source Hierarchy Guide:

1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
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<tbody>
<tr>
<td>2901</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>2902</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>2903</td>
<td>4</td>
<td>EMS Dispatch Time is later than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>2904</td>
<td>4</td>
<td>EMS Dispatch Time is later than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>2905</td>
<td>4</td>
<td>EMS Dispatch Time is later than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>2906</td>
<td>4</td>
<td>EMS Dispatch Time is later than ED Discharge Time</td>
</tr>
<tr>
<td>2907</td>
<td>4</td>
<td>EMS Dispatch Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>2908</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: EMS UNIT ARRIVAL TIME AT SCENE OR TRANSFERRING FACILITY (p_04)
ImageTrend Field: EMS Arrive Scene

Definition:

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

Field Values:

- Relevant value for the data element.

Additional information

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

1. EMS Run Report

<table>
<thead>
<tr>
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<th>Level</th>
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<tbody>
<tr>
<td>3101</td>
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<td>Time is not valid</td>
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<td>Time out of range</td>
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<tr>
<td>3103</td>
<td>4</td>
<td>EMS Unit Arrival on Scene Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>3104</td>
<td>4</td>
<td>EMS Unit Arrival on Scene Time is later than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>3105</td>
<td>4</td>
<td>EMS Unit Arrival on Scene Time is later than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>3106</td>
<td>4</td>
<td>EMS Unit Arrival on Scene Time is later than ED Discharge Time</td>
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<tr>
<td>3107</td>
<td>4</td>
<td>EMS Unit Arrival on Scene Time is later than Hospital Discharge Time</td>
</tr>
<tr>
<td>3108</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY (p_06)

ImageTrend Field: EMS Leave Scene

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).
- Leave blank for patients not transported by EMS

Data Source Hierarchy Guide:

1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
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<tr>
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<td>Time out of range</td>
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<tr>
<td>3303</td>
<td>4</td>
<td>EMS Unit Scene Departure Time is earlier than EMS Dispatch Time</td>
</tr>
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<td>3304</td>
<td>4</td>
<td>EMS Unit Scene Departure Time is earlier than EMS Unit Arrival on Scene Time</td>
</tr>
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<td>3305</td>
<td>4</td>
<td>EMS Unit Scene Departure Time is later than ED/Hospital Arrival Time</td>
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<td>3306</td>
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<td>EMS Unit Scene Departure Time is later than the ED Discharge Time</td>
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<td>3307</td>
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<td>EMS Unit Scene Departure Time is later than Hospital Discharge Time</td>
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<tr>
<td>3308</td>
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<td>Field cannot be blank</td>
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</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: Transport Mode (P_07)

ImageTrend Field: Transport Mode

Definition:
- The Mode of Transport delivering the patient to your hospital.

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

Data Source Hierarchy Guide:
1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
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<th>Level</th>
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<tr>
<td>3402</td>
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<td>Field cannot be blank</td>
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<tr>
<td>3403</td>
<td>4</td>
<td>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</td>
</tr>
</tbody>
</table>
Section: Pre-hospital
WI CORE: Yes
NTDB Variable: Other Transport Mode (p_08)
ImageTrend 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
2. Helicopter Ambulance
3. Fixed-wing Ambulance
4. Private Vehicle/Walk-in
5. Police
6. Other
7. Not applicable
8. Unknown

Data Source Hierarchy Guide:
1. EMS Run Report
2. Nurses Notes

Additional Information
- This field is not manually entered, and is calculated by the ImageTrend system
- 3rd party users follow submissions guidelines

Associated Edit Checks (NTDB)

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</table>
Section: Pre-hospital

WICORE: Yes

NTDB Variable: INITIAL FIELD SYSTOLIC BLOOD PRESSURE (p_09)

ImageTrend Field: SBP

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

Field Values:
- Relevant value for the data element.

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

Data Source Hierarchy Guide:
1. EMS Report

Associated Edit Checks

<table>
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<tr>
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<th>Level</th>
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<td>3602</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>3603</td>
<td>3</td>
<td>SBP exceeds the max of 300</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: INITIAL FIELD PULSE RATE (p_10)

ImageTrend Field: Pulse Rate

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

Field Values:
- Relevant value for the data element.

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

Data Source Hierarchy Guide:

1. EMS Report

Associated Edit Checks (NTDB)

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<td>Invalid value</td>
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<tr>
<td>3702</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>3703</td>
<td>3</td>
<td>Pulse rate exceeds the max of 299</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: INITIAL FIELD RESPIRATORY RATE (p_11)

ImageTrend Field: Pre-hospital Respiratory Rate

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

Field Values:
- Relevant value for the data element.

Additional Information
- Leave blank if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Completion of this field will show Pre-hospital Respiratory Assistance (TR18.80)
- If Not Known/Not Recorded, leave blank

Data Source Hierarchy Guide:
1. EMS Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3801</td>
<td>1</td>
<td>Invalid value. RR cannot be &gt; 99 for age in years &gt;= 6 OR RR cannot be &gt; 120 for age in years &lt; 6. If age and age units are not valued, RR cannot be &gt; 120.</td>
</tr>
<tr>
<td>3802</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>3803</td>
<td>3</td>
<td>Invalid, out of range. RR cannot be &gt; 99 and &lt;=120 for age in years &lt; 6. If age and age units are not valued, RR cannot be &gt; 99.</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: INITIAL FIELD OXYGEN SATURATION (p_12)
ImageTrend Field: O2Sat

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

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

Additional Information
- The null value "Not Known/Not Recorded" is used if the patient is transferred to your facility with no EMS Run Report from the scene of injury.
- Value should be based upon assessment before administration of supplemental oxygen.
- If Not Known/Not Recorded, leave blank.

Data Source Hierarchy Guide:
1. EMS Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>3901</td>
<td>1</td>
<td>Pulse oximetry is outside the valid range of 0 - 100</td>
</tr>
<tr>
<td>3902</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
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
5. Not Known/Not Recorded

Additional Information

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

Data Source Hierarchy Guide:

1. EMS Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
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<tr>
<td>4001</td>
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<td>Value is not a valid menu option</td>
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<tr>
<td>4003</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

TR18.61.2 (Adult), TR18.61.0 (Pediatric)

WI CORE: Yes

NTDB Variable: INITIAL FIELD GCS – VERBAL (p_14)

ImageTrend Field: GCS Verbal

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

Field Values

**Pediatric (≤ 2 years):**

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

**Adult**

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

Additional Information

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

Data Source Hierarchy

1. EMS Run Report

**Associated Edit Checks (NTDB)**

<table>
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<td>4101</td>
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<td>4103</td>
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<td>Field cannot be blank</td>
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</tbody>
</table>
Section: Pre-hospital

TR18.62.2 (Adult), TR18.62.0 (Pediatric)

WI CORE: Yes

NTDB Variable: INITIAL FIELD GCS – MOTOR (p_15)

ImageTrend Field: GCS Motor

Definition:

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

Field Values

**Pediatric (≤ 2 years):**

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

**Adult**

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

Additional Information

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

Data Source Hierarchy

1. EMS Run Report

**Associated Edit Checks (NTDB)**

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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: INITIAL FIELD GCS – TOTAL (p_16)

ImageTrend Field: GCS Total Calc

Definition:

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

Field Values

- Relevant value for data element

Additional Information

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

Data Source Hierarchy

1. EMS Run Report

Associated Edit Checks (NTDB)

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<th>Level</th>
<th>Message</th>
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<tr>
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<td>GCS Total is outside the valid range of 3 - 15</td>
</tr>
<tr>
<td>4303</td>
<td>4</td>
<td>Initial Field GCS - Total does not equal the sum of Initial Field GCS - Eye, Initial Field GCS - Verbal, and Initial Field GCS - Motor</td>
</tr>
<tr>
<td>4304</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: ED/TTA  
WI CORE: Yes  
NTDB Variable: Inter-Facility Transfer (P_17)  
ImageTrend Field: Inter-Facility Transfer (auto-calculated)

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

Field Values:
1. Yes  
2. No

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

Data Source Hierarchy Guide:
1. EMS Run Report  
2. Triage/Trauma Flow Sheet  
3. History & Physical

Associated Edit Checks (NTDB)

<table>
<thead>
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<td>4404</td>
<td>3</td>
<td>Field should not be Not Known/Not Recorded</td>
</tr>
<tr>
<td>4405</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

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

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

Data Source Hierarchy
1. EMS Run Report

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
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<td>9502</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: VEHICULAR, PEDESTRIAN, OTHER RISK INJURY (p_19)

ImageTrend Field: Prehospital Triage Rationale

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

Field Values:
1. Fall adults: > 20 ft. (one story is equal to 10 ft.)
2. Fall children: > 10 ft. or 2-3 times the height of the child
3. Crash intrusion, including roof: > 12 in. occupant site; > 18 in. any site
4. Crash ejection (partial or complete) from automobile
5. Crash death in same passenger compartment
6. Crash vehicle telemetry data (AACN) consistent with high risk injury
7. Auto v. pedestrian/bicyclist thrown, run over, or >20 MPH impact
8. Motorcycle crash > 20 mph
9. For adults > 65; SBP < 110
10. Patients on anticoagulants and bleeding disorders
11. Pregnancy > 20 weeks
12. EMS provider judgment
13. Burns
14. Burns with Trauma

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

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tr>
<td>9601</td>
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<td>Value is not a valid menu option</td>
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<td>9602</td>
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<td>Field cannot be blank</td>
</tr>
</tbody>
</table>
Section: Pre-Hospital

WI CORE: Yes

NTDB Variable: Pre-Hospital Cardiac Arrest (P_20)

ImageTrend Field: Pre-Hospital Cardiac Arrest

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

Field Values:
1. Yes
2. No
3. Not Known/Not Recorded

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

Data Source Hierarchy Guide:
1. EMS Run Report
2. Nursing Notes/Flow Sheet
3. History & Physical
4. Transfer Notes

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tbody>
<tr>
<td>9701</td>
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<tr>
<td>9702</td>
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<td>Field cannot be blank</td>
</tr>
<tr>
<td>9703</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Emergency Department/Trauma Team Activation Information
Section: ED/TTA

WI CORE: Yes

NTDB Variable: ED/HOSPITAL ARRIVAL DATE (ED_01)

ImageTrend Field: ED/Hospital Arrival Date

Definition:
- The date the patient arrived to the ED/hospital

Field Values
- Relevant value for data element

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

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

Associated Edit Checks (NTDB)

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

WI CORE: Yes

NTDB Variable: ED/HOSPITAL ARRIVAL TIME (ED_02)

ImageTrend Field: 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)

<table>
<thead>
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<tbody>
<tr>
<td>4601</td>
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<td>Time is not valid</td>
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<tr>
<td>4602</td>
<td>1</td>
<td>Time out of range</td>
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<td>4603</td>
<td>2</td>
<td>Field cannot be blank</td>
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<tr>
<td>4604</td>
<td>4</td>
<td>ED/Hospital Arrival Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>4605</td>
<td>4</td>
<td>ED/Hospital Arrival Time is earlier than EMS Unit Arrival</td>
</tr>
<tr>
<td></td>
<td></td>
<td>on Scene Time</td>
</tr>
<tr>
<td>4606</td>
<td>4</td>
<td>ED/Hospital Arrival Time is earlier than EMS Unit Scene</td>
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<td></td>
<td></td>
<td>Departure Time</td>
</tr>
<tr>
<td>4607</td>
<td>4</td>
<td>ED/Hospital Arrival Time is later than ED Discharge Time</td>
</tr>
<tr>
<td>4608</td>
<td>4</td>
<td>ED/Hospital Arrival Time is later than Hospital Discharge</td>
</tr>
<tr>
<td>4609</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Initial Assessment
WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE (ED_03)
ImageTrend Field: SBP

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.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If Not Known/Not Recorded, leave blank.

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes
4. History & Physical

### Associated Edit Checks (NTDB)

<table>
<thead>
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<tbody>
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<td>Invalid Value</td>
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<td>Field cannot be blank</td>
</tr>
<tr>
<td>4704</td>
<td>3</td>
<td>SBP value exceeds the max of 300</td>
</tr>
<tr>
<td>4705</td>
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<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL PULSE RATE (ED_04)
ImageTrend 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.
- Measurement recorded must be without the assistance of CPR or any type of mechanical chest compression device. For those patients who are receiving CPR or any type of mechanical chest compressions, report the value obtained while compressions are paused.
- If Not Known/Not Recorded, leave blank.

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

<table>
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</thead>
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<td>1</td>
<td>Invalid Value</td>
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<tr>
<td>4802</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>4804</td>
<td>3</td>
<td>Pulse rate exceeds the max of 299</td>
</tr>
<tr>
<td>4805</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Section: Initial Assessment

TR18.30 (C), TR18.30.1 (F), TR18.147

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL TEMPERATURE (ED_05)

ImageTrend Field: Patient Temperature/Temperature 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: Route:
1. C (Celsius) – TR18.30 1. Oral
2. F (Fahrenheit) – TR18.30.1 2. Tympanic
                             3. Rectal
                             4. Axillary
                             5. Temporal
                             6. Other
                             7. Not Known/Not Recorded

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

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks (NTDB):

<table>
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<th>Level</th>
<th>Message</th>
</tr>
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<tbody>
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<td>1</td>
<td>Invalid value</td>
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<tr>
<td>4902</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>4903</td>
<td>3</td>
<td>Temperature exceeds the max of 45.0 Celsius</td>
</tr>
<tr>
<td>4904</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
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</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL RESPIRATORY RATE (ED_06)
ImageTrend Field: Initial ED/Hospital Respiratory Rate

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

Field Values:
- Relevant value for the data element.

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

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
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<tbody>
<tr>
<td>5001</td>
<td>1</td>
<td>Invalid value. RR cannot be &gt; 99 for age in years &gt;= 6 OR RR cannot be &gt; 120 for age in years &lt; 6. If age and age units are not valued, RR cannot be &gt; 120.</td>
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<td>5002</td>
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<td>Field cannot be blank</td>
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<td>5005</td>
<td>3</td>
<td>Invalid, out of range. RR cannot be &gt; 99 and &lt;=120 for age in years &lt; 6. If age and age units are not valued, RR cannot be &gt; 99.</td>
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<td>5006</td>
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</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE (ED_07)
ImageTrend Field: Resp. Assistance

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

Field Values:
- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable
- Not Known/Not Recorded

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

Data Source Hierarchy Guide
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Respiratory Therapy Notes/Flow Sheet

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
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<td>5102</td>
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Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL OXYGEN SATURATION (ED_08)
ImageTrend Field: O2Sat

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

Field Values
- Relevant value for data element

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

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

Associated Edit Checks (NTDB):

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<th>Message</th>
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<tr>
<td>5201</td>
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<td>Pulse oximetry is outside the valid range of 0 - 100</td>
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<td>5205</td>
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</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN (ED_09)

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

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

Data Source Hierarchy
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet

Associated Edit Checks (NTDB):

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<td>Field cannot be blank when Initial ED/Hospital Oxygen Saturation is not: (1) blank, (2) Not Applicable, or (3) Not Known/Not Recorded</td>
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</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL GCS - EYE (ED_10)

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

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

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

Associated Edit Checks (NTDB):

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</table>
Section: Initial Assessment  TR18.15.2 (Adult), TR18.15.0 (Pediatrics)

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL GCS - VERBAL (ED_11)

ImageTrend Field: GCS Verbal

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

Field values:

**Pediatric (≤ 2 years):**

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

**Adult**

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

Additional Information

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

Data Source Hierarchy

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

**Associated Edit Checks (NTDB):**

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</table>
Section: Initial Assessment  
TR18.16.2 (Adult), TR18.16.0 (Pediatrics)

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL GCS - MOTOR (ED_12)

ImageTrend Field: GCS: Motor

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

Field values:

**Pediatric (≤ 2 years):**

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

**Adult**

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

Additional Information

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

Data Source Hierarchy

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

Associated Edit Checks (NTDB):

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</table>
Section: Initial Assessment
WI CORE: Yes
NTDB Variable: INITIAL ED/HOSPITAL GCS - TOTAL (ED_13)
ImageTrend Field: GCS Total Calc

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
- 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):

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<tr>
<td>5701</td>
<td>1</td>
<td>GCS Total is outside the valid range of 3 - 15</td>
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<td>5703</td>
<td>4</td>
<td>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</td>
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<td>5705</td>
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</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: Initial ED/Hospital GCS Assessment Qualifiers (ED_14)

ImageTrend Field: GCS Qualifier

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

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

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

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Physician Notes/Flow Sheet
## Associated Edit Checks (NTDB)

<table>
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<tr>
<td>5803</td>
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</tbody>
</table>
Section: Initial Assessment
TR1.6.1 (in), TR1.6 (cm)

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL HEIGHT (ED.15)
ImageTrend Field: Height (inches) & Height (cm)

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

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

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

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks (NTDB):

<table>
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<tr>
<td>8501</td>
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<td>8502</td>
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<tr>
<td>8503</td>
<td>3</td>
<td>Height exceeds the max of 244 (cm)</td>
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<tr>
<td>8504</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
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</tbody>
</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: INITIAL ED/HOSPITAL WEIGHT (ED_16)

ImageTrend Field: Weight (lbs) & (kg)

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

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

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

Data Source Hierarchy Guide:
1. Triage/Trauma/Hospital Flow Sheet
2. Nurses Notes/Flow Sheet
3. Pharmacy Record

Associated Edit Checks (NTDB):

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<tr>
<td>8603</td>
<td>3</td>
<td>Weight exceeds the max of 907 (kg)</td>
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<td>8604</td>
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<td>Field cannot be Not Applicable</td>
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</tbody>
</table>
Section: Initial Assessment  
TR18.91  
WI CORE: Yes  
NTDB Variable: DRUG SCREEN (ED_17)  
ImageTrend Field: Drug Screen

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

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

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

Data Source Hierarchy:
1. Lab Results  
2. Transferring Facility Records

Associated Edit Checks (NTDB):

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<td>6013</td>
<td>2</td>
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</table>
Section: Initial Assessment

TR18.46

WI CORE: Yes

NTDB Variable: ALCOHOL SCREEN (ED_18)

ImageTrend Field: Alcohol Use Indicator

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

Field values:
1. Yes
2. No

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

Data Source Hierarchy
1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB):

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</tbody>
</table>
Section: Initial Assessment

WI CORE: Yes

NTDB Variable: ALCOHOL SCREEN RESULTS (ED_19)
ImageTrend Field: Blood Alcohol Content

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

Field Values:
- Relevant value for data element

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

Data Source Hierarchy Guide

1. Lab Results
2. Transferring Facility Records

Associated Edit Checks (NTDB):

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</tbody>
</table>
Section: ED/TTA
WI CORE: Yes
NTDB Variable: ED DISCHARGE DISPOSITION (E_20)
ImageTrend Field: ED Discharge Disposition

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

Field Values:

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

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

Associated Edit Checks (NTDB)

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<td>6106</td>
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<td>Field cannot be Not Applicable when Hospital Discharge Date is Not Applicable</td>
</tr>
</tbody>
</table>
Section: ED/TTA

WI CORE: Yes

NTDB Variable: SIGNS OF LIFE (ED_21)

ImageTrend 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
2. Arrived with signs of life
3. Not Known/Not Recorded

Additional Information

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

Data Source Hierarchy

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)

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<td>Field should not be Not Known/Not Recorded</td>
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<td>Field cannot be Not Applicable</td>
</tr>
<tr>
<td>6208</td>
<td>3</td>
<td>Field is 1 (Arrived with NO signs of life) when Initial ED/Hospital SBP &gt; 0, Pulse &gt; 0,</td>
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<tr>
<td>6209</td>
<td>3</td>
<td>Field is 2 (Arrived with signs of life) when Initial ED/Hospital SBP = 0, Pulse = 0,</td>
</tr>
</tbody>
</table>
Section: ED/TTA

WI CORE: Yes

NTDB Variable: ED DISCHARGE DATE (ED_22)

ImageTrend Field: ED Discharge Order Date

Definition:
- The date the order was written for the patient to be discharged from the ED.

Field Values
- Relevant value for data element

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

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

Associated Edit Checks (NTDB)

<table>
<thead>
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<td>ED Discharge Date is earlier than ED/Hospital Arrival Date</td>
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<td>6308</td>
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<td>ED Discharge Date is later than Hospital Discharge Date</td>
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<td>6309</td>
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<td>ED Discharge Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>6310</td>
<td>3</td>
<td>ED Discharge Date minus ED/Hospital Arrival Date is greater than 365 days</td>
</tr>
</tbody>
</table>
Section: ED/TTA

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

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

Associated Edit Checks (NTDB)

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<td>6408</td>
<td>4</td>
<td>ED Discharge Time is later than Hospital Discharge Time</td>
</tr>
</tbody>
</table>
Procedure Information
Section: Procedures

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

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

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

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

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

Transfusion
- Transfusion of red cells* (only capture first 24 hours after hospital arrival)
- Transfusion of platelets* (only capture first 24 hours after hospital arrival)
- Transfusion of plasma* (only capture first 24 hours after hospital arrival)
CNS
Insertion of ICP monitor *
Ventriculostomy *
Cerebral oxygen monitoring *

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

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

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

Data Source Hierarchy

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):

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<td>Procedures with the same code cannot have the same Hospital Procedure Start Date and Time</td>
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<tr>
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<td>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</td>
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<tr>
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Section: Procedures  TR200.8
WI CORE: Yes  
NTDB Variable: HOSPITAL PROCEDURE START DATE (HP_02)  
ImageTrend Field: Date Performed

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

Field values:  
- Relevant value for the data element

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

Data Source Hierarchy

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):

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</table>
Section: Procedures

WI CORE: Yes

NTDB Variable: HOSPITAL PROCEDURE START TIME (HP_03)

ImageTrend Field: Time

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

Field values:
- Relevant value for the data element

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

Data Source Hierarchy

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):

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</table>
Diagnosis Information
Section: Diagnosis

TR21.21

WI CORE: Yes

NTDB Variable: Co-Morbid Conditions (DG_01)

ImageTrend Field: Comorbidities

Definition:

- Pre-existing co-morbid factors.

Field Values:

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

Additional Information:

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

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

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</tbody>
</table>
CO-MORBID CONDITIONS

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

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

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

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

<table>
<thead>
<tr>
<th>ANTICOAGULANTS</th>
<th>ANTIPLATELET AGENTS</th>
<th>THROMBIN INHIBITORS</th>
<th>THROMBOLYTIC AGENTS</th>
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<tr>
<td>Fondaparinux</td>
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<td>Bevalorudin</td>
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<td>Dipyridamole</td>
<td>Argatroban</td>
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<td>Lepirudin, Hirudin</td>
<td>Tenacteplase</td>
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<td>Drotrecogin alpha</td>
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<tr>
<td>Heparin</td>
<td>Ticagrelor</td>
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</tr>
</tbody>
</table>

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

**Bleeding disorder**: *(Consistent with the American Society of Hematology, 2015. Always use the most*
recent definition provided by the American Society of Hematology.) A group of conditions that result when the blood cannot clot properly, present prior to injury. A Bleeding Disorder diagnosis must be documented in the patient’s medical record (e.g. Hemophilia, von Willenbrand Disease, Factor V Leiden.)

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

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

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

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

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

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

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

Congestive Heart Failure: The inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure, present prior to injury. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset of increasing symptoms within 30 days prior to injury. Common manifestations are:
Abnormal limitation in exercise tolerance due to dyspnea or fatigue
• Orthopnea (dyspnea on lying supine)
• Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea)
• Increased jugular venous pressure
• Pulmonary rales on physical examination
• Cardiomegaly
• Pulmonary vascular engorgement

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

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

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

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

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

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

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

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

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

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

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

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

WI CORE: Yes

NTDB Variable: ICD-10 Injury Diagnoses (DG_02)

ImageTrend Field: ICD 10 Diagnosis

Definition:
- Diagnoses related to all identified injuries.

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

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

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

Associated Edit Checks (NTDB)

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<th>Level</th>
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<td>At least one diagnosis must be provided and meet inclusion criteria. (ICD-10 CM only)</td>
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<td>At least one diagnosis must be provided and meet inclusion criteria (ICD-10 CA only)</td>
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</table>
Injury Severity Information
Section: Diagnosis

WI CORE: Yes

NTDB Variable: AIS Predot Code (IS_01)

ImageTrend Field: ICD 10 AIS Codes

Definition:

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

Field Values:

- The predot code is the 6 digits preceding the decimal point in an associated AIS code
- In ImageTrend, this field includes both the AIS PreDot (IS_01) and AIS Severity (IS_02) Codes:

  1. Minor Injury
  2. Moderate Injury
  3. Serious Injury
  4. Severe Injury
  5. Critical Injury
  6. Maximum Injury, Virtually Unsurvivable
  7. Not Possible to Assign

Additional Information:

- Smart search and category search available for users.

Data Source Hierarchy Guide:

1. AIS Coding Manual

Associated Edit Checks (NTDB)

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7001</td>
<td>1</td>
<td>Invalid Value</td>
</tr>
<tr>
<td>7004</td>
<td>3</td>
<td>AIS codes submitted are not valid AIS 05, Update 08 codes</td>
</tr>
<tr>
<td>7007</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>7008</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Outcome Information
Section: Outcome

NTDB Variable: TOTAL ICU LENGTH OF STAY (O_01)

ImageTrend Field: Total 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.
- This field is auto-calculated, but can be manually edited/entered.

<table>
<thead>
<tr>
<th>Example #</th>
<th>Start Date</th>
<th>Start Time</th>
<th>Stop Date</th>
<th>Stop Time</th>
<th>LOS</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (one calendar day)</td>
</tr>
<tr>
<td>B.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>1 day (two episodes within one calendar day)</td>
</tr>
<tr>
<td></td>
<td>01/01/11</td>
<td>16:00</td>
<td>01/01/11</td>
<td>18:00</td>
<td>1 day (two episodes within one calendar day)</td>
</tr>
<tr>
<td>C.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>04:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td></td>
<td>01/02/11</td>
<td>16:00</td>
<td>01/02/11</td>
<td>18:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td>D.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>16:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td></td>
<td>01/02/11</td>
<td>09:00</td>
<td>01/02/11</td>
<td>18:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td>E.</td>
<td>01/01/11</td>
<td>01:00</td>
<td>01/01/11</td>
<td>16:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td></td>
<td>01/02/11</td>
<td>09:00</td>
<td>01/02/11</td>
<td>21:00</td>
<td>2 days (episodes on two separate calendar days)</td>
</tr>
<tr>
<td>F.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/01/11</td>
<td>16:00</td>
<td>1 day (patient was in ICU on one separate day)</td>
</tr>
<tr>
<td>G.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on two separate calendar days)</td>
</tr>
<tr>
<td>H.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on two separate calendar days)</td>
</tr>
<tr>
<td></td>
<td>01/02/11</td>
<td>18:00</td>
<td>Unknown</td>
<td>Unknown</td>
<td>2 days (patient was in ICU on two separate calendar days)</td>
</tr>
<tr>
<td>I.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on two separate calendar days)</td>
</tr>
<tr>
<td>J.</td>
<td>01/01/11</td>
<td>Unknown</td>
<td>01/02/11</td>
<td>16:00</td>
<td>2 days (patient was in ICU on two separate calendar days)</td>
</tr>
</tbody>
</table>
Data Source Hierarchy Guide:
1. ICU Flow Sheet
2. Nursing Notes/Flow Sheet

Associated Edit Checks (NTDB):

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

TR26.58

WI CORE: Yes

NTDB Variable: TOTAL VENTILATOR DAYS (O_02)

ImageTrend 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.
- This field is auto-calculated, but can be manually edited/entered.
## Associated Edit Checks (NTDB)

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

WI CORE: Yes

NTDB Variable: Hospital Discharge Date (O_03)

ImageTrend Field: Hospital Discharge Order Date

Definition:
- The date the order was written for the patient to be discharged from the hospital.

Field Values:
- Relevant value for data element.

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

Data Source Hierarchy Guide:

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

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7701</td>
<td>1</td>
<td>Date is not valid</td>
</tr>
<tr>
<td>7702</td>
<td>1</td>
<td>Date out of range</td>
</tr>
<tr>
<td>7703</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>7704</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Dispatch Date</td>
</tr>
<tr>
<td>7705</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Unit Arrival on Scene Date</td>
</tr>
<tr>
<td>7706</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than EMS Unit Scene Departure Date</td>
</tr>
<tr>
<td>7707</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than ED/Hospital Arrival Date</td>
</tr>
<tr>
<td>7708</td>
<td>2</td>
<td>Hospital Discharge Date is earlier than ED Discharge Date</td>
</tr>
<tr>
<td>7709</td>
<td>3</td>
<td>Hospital Discharge Date is earlier than Date of Birth</td>
</tr>
<tr>
<td>7710</td>
<td>3</td>
<td>Hospital Discharge Date minus Injury Incident Date is greater than 365 days, please verify this is correct</td>
</tr>
<tr>
<td>7711</td>
<td>3</td>
<td>Hospital Discharge Date minus ED/Hospital Arrival Date is greater than 365 days, please verify this is correct</td>
</tr>
<tr>
<td>7712</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 4,6,9,10, or 11</td>
</tr>
<tr>
<td>7713</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 5 (Died)</td>
</tr>
</tbody>
</table>
Section: Outcome

TR25.94

WI CORE: Yes

NTDB Variable: Hospital Discharge Time (O_04)

ImageTrend Field: Hospital Discharge Order Time

Definition:

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

Field Values:

- Relevant value for data element

Additional Information:

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

Data Source Hierarchy Guide:

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

Associated Edit Checks

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7801</td>
<td>1</td>
<td>Time is not valid</td>
</tr>
<tr>
<td>7802</td>
<td>1</td>
<td>Time out of range</td>
</tr>
<tr>
<td>7803</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>7804</td>
<td>4</td>
<td>Hospital Discharge Time is earlier than EMS Dispatch Time</td>
</tr>
<tr>
<td>7805</td>
<td>4</td>
<td>Hospital Discharge Time is earlier than EMS Unit Arrival on Scene Time</td>
</tr>
<tr>
<td>7806</td>
<td>4</td>
<td>Hospital Discharge Time is earlier than EMS Unit Scene Departure Time</td>
</tr>
<tr>
<td>7807</td>
<td>4</td>
<td>Hospital Discharge Time is earlier than ED/Hospital Arrival Time</td>
</tr>
<tr>
<td>7808</td>
<td>4</td>
<td>Hospital Discharge Time is earlier than ED Discharge Time</td>
</tr>
<tr>
<td>7809</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 4,6,9,10, or 11</td>
</tr>
<tr>
<td>7810</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 5 (Died)</td>
</tr>
</tbody>
</table>
Section: Outcome
WI CORE: Yes
NTDB Variable: Hospital Discharge Disposition (O_05)
ImageTrend Field: Hospital Discharge Disposition

Definition:
- The disposition of the patient when discharged from the hospital.

Field Values:

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

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

Data Source Hierarchy Guide:

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

Associated Edit Checks (NTDB)

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<tr>
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<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>7901</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>7902</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>7903</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 5 (Died)</td>
</tr>
<tr>
<td>7907</td>
<td>2</td>
<td>Field must be Not Applicable when ED Discharge Disposition = 4, 6, 9,</td>
</tr>
<tr>
<td></td>
<td></td>
<td>10, or 11</td>
</tr>
<tr>
<td>7908</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
<tr>
<td>7909</td>
<td>2</td>
<td>Field cannot be &quot;Not Known/Not Recorded&quot; when Hospital Arrival Date</td>
</tr>
<tr>
<td></td>
<td></td>
<td>and Hospital</td>
</tr>
</tbody>
</table>
Financial Information
Section: Outcome

WI CORE: Yes

NTDB Variable: Primary Method of Payment (F_01)

ImageTrend Field: Primary Method of Payment

Definition:
- Primary source of payment for hospital care.

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

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

Data Source Hierarchy Guide:
1. Billing Sheet
2. Admission Form
3. Face Sheet

**Associated Edit Checks (NTDB)**

<table>
<thead>
<tr>
<th>Rule ID</th>
<th>Level</th>
<th>Message</th>
</tr>
</thead>
<tbody>
<tr>
<td>8001</td>
<td>1</td>
<td>Value is not a valid menu option</td>
</tr>
<tr>
<td>8002</td>
<td>2</td>
<td>Field cannot be blank</td>
</tr>
<tr>
<td>8003</td>
<td>2</td>
<td>Field cannot be Not Applicable</td>
</tr>
</tbody>
</table>
Hospital Complications
Section: Complications/PI
WI CORE: Yes
NTDB Variable: Hospital Complications (Q_01)
ImageTrend Field: Complications

Definition:
- Any medical complication that occurred during the patient’s stay at your hospital

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

Additional Information:
- The Null value “Not Applicable” should be used for patients with no complications. This is done by leaving the element blank.
- For any Hospital complication to be valid, there must be a diagnosis noted in the patient medical record that meets the definition in this data dictionary.
- For all hospital complications that follow the CDC definition [e.g. VAP, CAUTI, CLABSI, Osteomyelitis] always use the most recent definition provided by the CDC.
- Check all that apply
- Graft/prosthesis/flap failure was retired in 2016

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
HOSPITAL COMPLICATIONS

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

**KDIGO (Stage 3) Table:**

(SCr) 3 times baseline

OR;

Increase in SCr to ≥ 4mg/dl (≥ 35.3µmol/l)

OR;

Initiation of renal replacement therapy OR, In patients < 18 years, decrease in eGFR to <35 ml/min per 1.73 m²

OR;

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

OR;

Anuria for ≥ 12 hrs.

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

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

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

Timing: Within 1 week of known clinical insult or new or worsening respiratory symptoms.
Chest imaging: Bilateral opacities – not fully explained by effusions, lobar/lung collapse, or nodules.

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

Oxygenation: $200 < \frac{PaO2}{FiO2} \leq 300$
(at a minimum) With PEEP or CPAP $\geq 5$ cmH2Oc
Alcohol Withdrawal Syndrome: (Consistent with the 2016 World Health Organization (WHO) definition of Alcohol Withdrawal Syndrome. Always use the most recent definition provided by the WHO.) Characterized by tremor, sweating, anxiety, agitation, depression, nausea, and malaise. It occurs 6-48 hours after cessation of alcohol consumption, and when uncomplicated, abates after 2-5 days. It may be complicated by grand mal seizures and may progress to delirium (known as delirium tremens). Must have occurred during the patient’s initial stay at your hospital, and documentation of alcohol withdrawal must be in the patient's medical record.

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

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

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

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

AND

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

January 2016 CDC CAUTI Criterion SUTI 1a:

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

OR

Patient must meet 1, 2, and 3 below:
1. Patient had an indwelling urinary catheter in place for >2 calendar days which was removed on the day of, or day before the date of event.
2. Patient has at least one of the following signs or symptoms:
   - Fever (>38°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 >10^5 CFU/ml.

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

Patient must meet 1, 2 and 3 below:

1. Patient is ≤1 year of age
2. Patient has at least one of the following signs or symptoms:
   • fever (>38.0°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 ≥10^5 CFU/ml.

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

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

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

**AND**

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

**January 2016 CDC Criterion LCBI 1:**
Patient has a recognized pathogen identified from one or more blood specimens by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST.))

AND

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

OR

January 2016 CDC Criterion LCBI 2:
Patient has at least one of the following signs or symptoms: fever (>38\(^\circ\)C), chills, or hypotension

AND

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

AND

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

OR

January 2016 CDC Criterion LCBI 3:
Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38\(^\circ\)C), hypothermia (<36\(^\circ\)C), apnea, or bradycardia

AND

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

AND

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

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

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

AND

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

AND

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

AND

patient has at least one of the following signs or symptoms: fever (>38°C); localized pain or tenderness. A culture or non-culture based test that has a negative finding does not meet this criterion.
- c. an abscess or other evidence of infection involving the deep incision that is detected on gross anatomical or histopathologic exam, or imaging test

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

1. Deep Incisional Primary (DIP) – a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB)
2. Deep Incisional Secondary (DIS) – a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site incision for CBGB)
A diagnosis of SSI must be documented in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

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

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

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

---

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

<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
<th>Code</th>
<th>Operative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>AAA</td>
<td>Abdominal aortic aneurysm repair</td>
<td>LAM</td>
<td>Laminectomy</td>
</tr>
<tr>
<td>AMP</td>
<td>Limb amputation</td>
<td>LTP</td>
<td>Liver transplant</td>
</tr>
<tr>
<td>APPY</td>
<td>Appendix surgery</td>
<td>NECK</td>
<td>Neck surgery</td>
</tr>
<tr>
<td>AVSD</td>
<td>Shunt for dialysis</td>
<td>NEPH</td>
<td>Kidney surgery</td>
</tr>
<tr>
<td>BILI</td>
<td>Bile duct, liver or pancreatic surgery</td>
<td>OVRY</td>
<td>Ovarian surgery</td>
</tr>
<tr>
<td>CEA</td>
<td>Carotid endarterectomy</td>
<td>PRST</td>
<td>Prostate surgery</td>
</tr>
<tr>
<td>CHOL</td>
<td>Gallbladder surgery</td>
<td>REC</td>
<td>Rectal surgery</td>
</tr>
<tr>
<td>COLO</td>
<td>Colon surgery</td>
<td>SB</td>
<td>Small bowel surgery</td>
</tr>
<tr>
<td>CSEC</td>
<td>Cesarean section</td>
<td>SPLE</td>
<td>Spleen surgery</td>
</tr>
<tr>
<td>GAST</td>
<td>Gastric surgery</td>
<td>THOR</td>
<td>Thoracic surgery</td>
</tr>
<tr>
<td>HTP</td>
<td>Heart transplant</td>
<td>THUR</td>
<td>Thyroid and/or parathyroid surgery</td>
</tr>
<tr>
<td>HYST</td>
<td>Abdominal hysterectomy</td>
<td>VHYS</td>
<td>Vaginal hysterectomy</td>
</tr>
<tr>
<td>KTP</td>
<td>Kidney transplant</td>
<td>XLAP</td>
<td>Exploratory Laparotomy</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Code</th>
<th>Operative Procedure</th>
</tr>
</thead>
<tbody>
<tr>
<td>BRST</td>
<td>Breast surgery</td>
</tr>
<tr>
<td>CARD</td>
<td>Cardiac surgery</td>
</tr>
<tr>
<td>CBGB</td>
<td>Coronary artery bypass graft with both chest and donor site incisions</td>
</tr>
<tr>
<td>CBGC</td>
<td>Coronary artery bypass graft with chest incision only</td>
</tr>
<tr>
<td>CRAN</td>
<td>Craniotomy</td>
</tr>
<tr>
<td>FUSN</td>
<td>Spinal fusion</td>
</tr>
<tr>
<td>FX</td>
<td>Open reduction of fracture</td>
</tr>
<tr>
<td>HER</td>
<td>Hernorrhaphy</td>
</tr>
<tr>
<td>HPRO</td>
<td>Hip prosthesis</td>
</tr>
<tr>
<td>KPRO</td>
<td>Knee prosthesis</td>
</tr>
<tr>
<td>PACE</td>
<td>Pacemaker surgery</td>
</tr>
<tr>
<td>PVBY</td>
<td>Peripheral vascular bypass surgery</td>
</tr>
<tr>
<td>VSHN</td>
<td>Ventricular shunt</td>
</tr>
</tbody>
</table>
Documentation of ECG changes indicative of acute MI (one or more of the following three):

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

OR

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

OR

Physician diagnosis of myocardial infarction

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

Organ/space surgical site infection: (Consistent with the January 2016 CDC defined SSI. Always use the most recent definition provided by the CDC.) Must meet the following criteria:
Infection occurs within 30 or 90 days after the NHSN operative procedure (where day 1 = the procedure date) according to the list in Table 2

AND

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

AND

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

AND

meets at least one criterion for a specific organ/space infection site listed in Table 3. These criteria are found in the Surveillance Definitions for Specific Types of Infections chapter.
A diagnosis of SSI must be documented in the patient’s medical record, and must have occurred during the patient’s initial stay at your hospital.

**Osteomyelitis** *(Consistent with the January 2016 CDC definition of Bone and Joint infection. Always use the most recent definition provided by the CDC.)* Osteomyelitis must meet at least one of the following criteria:
1. Patient has organisms identified from bone by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).
2. Patient has evidence of osteomyelitis on gross anatomic or histopathologic exam.
3. Patient has at least two of the following localized signs or symptoms: fever (>38.0°C), swelling*, pain or tenderness*, heat*, or drainage* AND at least one of the following:
   a. organisms identified from blood by culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis and treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST) in a patient with imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).
   b. imaging test evidence suggestive of infection (e.g., x-ray, CT scan, MRI, radiolabel scan [gallium, technetium, etc.]), which if equivocal is supported by clinical correlation (i.e., physician documentation of antimicrobial treatment for osteomyelitis).

* With no other recognized cause

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

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

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

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

Severe sepsis: sepsis plus organ dysfunction, hypotension (low blood pressure), or hypoperfusion (insufficient blood flow) to 1 or more organs.
Septic shock: sepsis with persisting arterial hypotension or hypoperfusion despite adequate fluid resuscitation.

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

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

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

**AND:**

- Duration of neurological deficit ≥24 h

**OR:**

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

**AND:**

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

**AND:**

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

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

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

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

**AND**
involves only skin and subcutaneous tissue of the incision

AND

patient has at least one of the following:

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

AND

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

criterion.

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

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

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

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

- the patient's initial stay at your hospital.

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

Unplanned Intubation: Patient requires placement of an endotracheal tube and mechanical or assisted
ventilation because of the onset of respiratory or cardiac failure manifested by severe respiratory distress,
hypoxia, hypercarbia, or respiratory acidosis. In patients who were intubated in the field or Emergency
Department, or those intubated for surgery, unplanned intubation occurs if they require reintubation > 24
hours after extubation. Must have occurred during the patient's initial stay at your hospital.

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

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

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>• New or progressive and persistent infiltrate</td>
<td>• Organism identified from blood</td>
</tr>
<tr>
<td></td>
<td>• Consolidation</td>
<td>• Organism identified from pleural fluid</td>
</tr>
<tr>
<td></td>
<td>• Cavitation</td>
<td>• Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing.)</td>
</tr>
<tr>
<td></td>
<td>• Pneumatoceles, in infants ≥1 year old</td>
<td>• ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram’s stain)</td>
</tr>
<tr>
<td></td>
<td>AND at least two of the following:</td>
<td>• Positive quantitative culture of lung tissue</td>
</tr>
<tr>
<td></td>
<td>• New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td>• Histopathologic exam shows at least one of the following evidences of pneumonia:</td>
</tr>
<tr>
<td></td>
<td>• New onset or worsening cough, or dyspnea, or tachypnea</td>
<td>o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli</td>
</tr>
<tr>
<td></td>
<td>• Rales or bronchial breath sounds</td>
<td>o Evidence of lung parenchyma invasion by fungal hyphae or pseudozymas</td>
</tr>
<tr>
<td></td>
<td>• Worsening gas exchange (e.g., PaO₂/FIO₂ &lt; 240), increased oxygen requirements, or increased ventilator demand</td>
<td></td>
</tr>
</tbody>
</table>
### VAP Algorithm (PNU2 Viral, Legionella, and other Bacterial Pneumonias):

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>At least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
<td>- Fever (&gt;38°C or &gt;100.4°F)</td>
<td>- Virus, Bordetella, Legionella, Chlamydia or Mycoplasma identified from respiratory secretions or tissue by a culture or non-culture based microbiologic testing method which is performed for purposes of clinical diagnosis or treatment (e.g., not Active Surveillance Culture/Testing (ASC/AST)).</td>
</tr>
<tr>
<td>- Consolidation</td>
<td>- Leukopenia (&lt;4000 WBC/mm³) or leukocytosis (&gt;12,000 WBC/mm³)</td>
<td>- Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia)</td>
</tr>
<tr>
<td>- Cavitation</td>
<td>- For adults &gt;70 years old, altered mental status with no other recognized cause</td>
<td>- Fourfold rise in Legionella pneumonia serogroup 1 antibody titer &gt; 1:128 in paired acute and convalescent sera by indirect IFA.</td>
</tr>
<tr>
<td>- Pneumatoceles, in infants &lt;1 year old</td>
<td>AND at least one of the following:</td>
<td>- Detection of L. pneumophila serogroup 1 antigens in urine by RIA or EIA.</td>
</tr>
<tr>
<td></td>
<td>- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- New onset or worsening cough, or dyspnea, or tachypnea</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Rales or bronchial breath sounds</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Worsening gas exchange (e.g., PaO₂/FiO₂&lt;240), increased oxygen requirements, or increased ventilator demand</td>
<td></td>
</tr>
</tbody>
</table>

**NOTE:** In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.
**VAP Algorithm (PNU3 Immunocompromised Patients):**

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS</th>
<th>LABORATORY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Two or more serial chest imaging test results with at least one of the following:</td>
<td>Patient who is immunocompromised has at least one of the following:</td>
<td>At least one of the following:</td>
</tr>
<tr>
<td>- New or progressive and persistent infiltrate</td>
<td>- Fever (≥38°C or &gt;100.4°F)</td>
<td>- Identification of matching Candida spp. from blood and sputum, endotracheal aspirate, BAL or protected specimen brushing.11,12,13</td>
</tr>
<tr>
<td></td>
<td>- Consolidation</td>
<td>- Evidence of fungi from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) from one of the following:</td>
</tr>
<tr>
<td></td>
<td>- Cavitation</td>
<td>- Direct microscopic exam</td>
</tr>
<tr>
<td></td>
<td>- Pneumatoceles, in infants &lt;1 year old</td>
<td>- Positive culture of fungi</td>
</tr>
<tr>
<td></td>
<td><strong>NOTE:</strong> In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest imaging test result is acceptable.</td>
<td>- Non-culture diagnostic laboratory test</td>
</tr>
</tbody>
</table>

Any of the following from: LABORATORY CRITERIA DEFINED UNDER PNU2

- New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements
- New onset or worsening cough, or dyspnea, or tachypnea
- Rales or bronchial breath sounds
- Worsening gas exchange (e.g., O2 desaturations [e.g., PaO2/FiO2 <240][7, increased oxygen requirements, or increased ventilator demand])
- Hemoptysis
- Pleuritic chest pain
**VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant’s ≤1 year old:**

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
</table>
| Two or more serial chest imaging test results with at least one of the following:  
  - New or progressive and persistent infiltrate  
  - Consolidation  
  - Cavitation  
  - Pneumatoceles, in infants ≤1 year old | Worsening gas exchange (e.g., O₂ desaturation [e.g. pulse oximetry <84%], increased oxygen requirements, or increased ventilator demand)  
  AND at least three of the following:  
  - Temperature instability  
  - Leukopenia (<4000 WBC/mm³) or leukocytosis (>15,000 WBC/mm³) and left shift (>10% band forms)  
  - New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
  - Apnea, tachypnea, nasal flaring with retraction of chest wall, or nasal flaring with grunting  
  - Wheezing, rales, or monchi  
  - Cough  
  - Bradycardia (<100 beats/min) or tachycardia (>170 beats/min) |

**NOTE:** In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.

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

<table>
<thead>
<tr>
<th>IMAGING TEST EVIDENCE</th>
<th>SIGNS/SYMPTOMS/LABORATORY</th>
</tr>
</thead>
</table>
| Two or more serial chest imaging test results with at least one of the following:  
  - New or progressive and persistent infiltrate  
  - Consolidation  
  - Cavitation  
  - Pneumatoceles, in infants ≤1 year old | At least three of the following:  
  - Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F)  
  - Leukopenia (<4,000 WBC/mm³) or leukocytosis (>15,000 WBC/mm³)  
  - New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements  
  - New onset or worsening cough, or dyspnea, apnea, or tachypnea  
  - Rales or bronchial breath sounds  
  - Worsening gas exchange (e.g., O₂ desaturation [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) |

**NOTE:** In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive imaging test result is acceptable.

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

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

1. External cause codes for child and adult abuse take priority over all other external cause codes except child and adult abuse.
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.
Wisconsin Core Data Elements
Section: Demographic
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Registry #

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.

Field Values:
• Applicable Data

Additional Information:
• Shows as Facility – yymmdd-CaseXXXXX
• 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.
Section: Demographic

WI CORE: Yes

NTDB Variable: None

ImageTrend 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 discovery of the existing MRN.

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Discharge Summary
4. Admission Form
Section: Demographics  TR1.27
WI CORE: Yes  NTDB Variable: None  DI V5 field: Account #

Definition:
- The facility account number that represents a specific visit. Each visit has a new account number assigned for that visit.

Field Values:
- Relevant value for data element

Additional Information:
- If a patient is seen twice at a facility (even if the same day) this number should be different

Data Source Hierarchy Guide:
1. Triage/Trauma Flow Sheet
2. ED Record
3. Face Sheet
4. Billing Sheet
5. Discharge Summary
Section: Demographics

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Patient’s Last Name

Definition:
- The last name of the patient.

Field Values:
- Relevant value for the data element

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

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form
Section: Demographics

WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Patient’s First Name

Definition:
- The first name of the patient

Field Values:
- Relevant value for the data element

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

Data Source Hierarchy Guide:
1. Face Sheet
2. Billing Sheet
3. Admission Form
Section: Injury
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Injury Type

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

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

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

Data Source Hierarchy Guide:
- NTDB External Cause of Injury Matrix.
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Was patient extricated?

Definition:

- Was the patient extricated?

Field Values:

1. Yes
2. No
3. Unknown
4. Not Applicable

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
Section: Pre-hospital
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Scene/Transport Agency Name

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

Field Values:
- Relevant value for the data element.

Additional information
- Picked from a drop-down menu after selecting agency state.
- If agency cannot be found, select “Out of State Agency” and inform trauma program by emailing DHSTrauma@dhs.wisconsin.gov

Data Source Hierarchy Guide:
1. EMS Run Report
Section: Pre-hospital

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: EMS Run Sheet Present

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.

Field Values:

1. Complete
2. Incomplete
3. Missing
4. Not applicable
5. 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
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
Section: Pre-Hospital

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Pre-hospital Respiratory Assistance

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

Field Values:
- Unassisted Respiratory Rate
- Assisted Respiratory Rate
- Not Applicable
- Not Known/Not Recorded

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

Data Source Hierarchy Guide
- EMS Run Report
Section: Referring Facility

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Transfer In

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

Field Values:
1. Yes
2. No

Additional Information
- If “No” is selected then submit the tab and continue data entry

Data Source Hierarchy Guide:
1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet
3. Referring facility paperwork
Section: Referring Facility

WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Referring Hospital

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

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

Additional Information:
- If “other” is selected then must fill out additional field “if other”

Data Source Hierarchy Guide:
4. EMS run sheet
5. Trauma/Triage/Hospital Flow Sheet
6. Referring facility paperwork
Section: Referring Facility

WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Other Facility

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

Field Values:
- Free text description of the facility that transferred the patient to your facility

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

Data Source Hierarchy Guide:
1. EMS run sheet
2. Trauma/Triage/Hospital Flow Sheet.
Section: Referring Facility

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Referring Facility Arrival Date

Definition:
  • The date the patient arrived at the Referring facility.

Field Values:
  • Relevant data values in MM/DD/YYYY

Additional Information:
  • If date of arrival is not documented, leave blank

Data Source Hierarchy Guide:
  1. Referring facility documentation
  2. Trauma/Transfer/Hospital Flow Sheet
  3. EMS Run Sheet
Section: Referring Facility

WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Time

Definition:
- The time the patient arrived at the referring facility

Field Values:
- Time in 24-hour format HH:MM

Additional Information:
- If time of arrival is not documented, leave blank

Data Source Hierarchy Guide:
1. Referring facility documentation
2. Trauma/Triage/Hospital Flowsheet
Section: Referring Facility
TR33.30
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Discharge Date

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

Field Values:
- Date in MM/DD/YYYY format

Additional Information:
- If date of discharge is not documented, leave blank

Data Source Hierarchy Guide:
1. Referring Facility documentation
2. EMS run sheet
Section: Referring Facility

TR33.31

WI CORE: Yes

NTDB Variable: None

ImageTrend 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, leave blank

Data Source Hierarchy Guide:

1. Referring Facility Documentation
2. EMS Run Sheet
Section: Referring Facility

WI CORE: Yes

NTDB Variable: None

ImageTrend 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
Definition:
   • How did the patient come into your facility?

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

Data Source Hierarchy
   1. Trauma/Triage/Hospital Flow Sheet
   2. Nursing Notes
   3. Access Center Record/Communication Center
   4. EMS Run Sheet.
Section: ED/TTA
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Length of Stay

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

Field Values
- Relevant value for data element

Additional Information
- Auto-calculated
Section: ED/TTA
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Arrived From

Definition:
- Location the patient arrived from.

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

Additional Information
- Patients injured at home should be coded as scene
Section: ED/TTA  
WI CORE: Yes  
NTDB Variable: None  
ImageTrend 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
- Other
- Not Applicable
- Not Known/Not Recorded

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: ED/TTA
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Trauma Team Activation

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

Field Values:
1. Level 1
2. Level 2
3. Level 3
4. Not Activated
5. Not Known/Not Recorded

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

Data Source Hierarchy Guide:
1. Trauma/Triage/Hospital Flow Sheet
2. Nursing Notes
3. Physician Notes
Section: ED/TTA
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Date Trauma Team Activated

Definition:
- The date that the facility specific trauma alert/activation was paged out

Field Values:
- Date (MM/DD/YYYY) the page/alert was sent out

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

Data Source Hierarchy Guide:

1. Trauma/Triage/Hospital Flow Sheet
Section: ED/TTA
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: 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
- Visible if a leveled trauma activation is entered (Level 1, Level 2, Level 3)
- If the patient was not an activation/alert, leave blank

Data Source Hierarchy Guide:

1. Trauma/Triage/Hospital Flow Sheet
Section: ED/TTA

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Response Time

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.
Section: ED/TTA

WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Admitting service

Definition:
- The service that the patient was admitted to

Field Values:

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

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

Data Source Hierarchy Guide:
1. Trauma/Triage/Hospital Flow Sheet.
2. History & Physical.
Section: Initial Assessment

TR18.135

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: RTS Calc

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.
Section: Procedures

TR22.30

WI CORE: Yes

NTDB Variable: None

ImageTrend Field: Procedure Performed

Definition:

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

Field Values:

- Yes
- No
- Not Known/Not Recorded

Additional Information

- If the answer is “No”, leave ICD-10 Procedures, Date Performed, and Time blank.
Section: Diagnosis
WI CORE: Yes
NTDB Variable: None (NTDB calculates ISS)
ImageTrend 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
• Must complete ICD 10 Diagnosis and AIS Code to populate
Section: Diagnosis
WI CORE: Yes
NTDB Variable: None
ImageTrend 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
Section: Diagnosis
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: ISS Region

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

Field Values:
1. Head – TR21.2
2. Face – TR21.5
4. Abdomen – TR21.6
5. Extremity – TR21.4

Additional Information:
- Auto-populated by entering ICD 10 Diagnosis and AIS Code
- Head or Neck Injuries include injury to the brain or cervical spine, skull or cervical spine fractures.
- Facial injuries include those involving the mouth, ears, nose and facial bones.
- Chest injuries include all lesions to internal organs. Chest injuries also include those to the diaphragm, rib cage, and thoracic spine.
- Abdominal or pelvic contents injuries include all lesions to internal organs. Lumbar spine lesions are included in the abdominal or pelvic region.
- Injuries to the extremities or to the pelvic or shoulder girdle including sprains, fractures, dislocations, and amputations, except for the spinal column, skull and rib cage.
- External injuries include lacerations, contusions, abrasions, and burns, independent of their location on the body surface.
Section: Outcome
WI CORE: Yes
NTDB Variable: None
ImageTrend Field: Length of Stay

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

Field Values:
- Relevant value for data element

Additional Information:
- Calculated in minutes, hours, and days.
- This is auto-calculated based on ED and Hospital Admission/Discharge information

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

### DEMOGRAPHICS

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<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
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<td>TR200.14.1</td>
<td>ICD10 AIS Codes</td>
<td>ICD-10 AIS 05 Code</td>
<td>ED-Hospital Abbreviated Injury Scale - AIS Code (TR21.22)</td>
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</tbody>
</table>

### OUTCOME

<table>
<thead>
<tr>
<th>Required</th>
<th>Data Element</th>
<th>Element Name</th>
<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>NTDB</td>
<td>TR26.9</td>
<td>Total ICU Days</td>
<td>ICU Days-Total</td>
<td>Hospital Total ICU Length Of Stay - Days (TR26.9)</td>
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<tr>
<td>NTDB</td>
<td>TR26.58</td>
<td>Total Ventilator Days</td>
<td>Vent days-Total</td>
<td>Hospital Total Ventilator Days (TR26.58)</td>
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<tr>
<td>NTDB</td>
<td>TR25.93</td>
<td>Discharge Order Date</td>
<td>Hospital Discharge Orders Written Date</td>
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<tr>
<td>NTDB</td>
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<td>Discharge Order Time</td>
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<tr>
<td>NTDB</td>
<td>TR25.27</td>
<td>Discharge Disposition</td>
<td>Hospital Discharge Disposition</td>
<td>Hospital Discharge Disposition (TR25.27)</td>
</tr>
<tr>
<td>CORE</td>
<td>TR25.44</td>
<td>Length of Stay</td>
<td>Hospital Length Of Stay</td>
<td>Hospital Length Of Stay (TR25.44)</td>
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<tr>
<td>CORE</td>
<td>TR25.34</td>
<td>Discharge Date</td>
<td>Hospital Discharge Date</td>
<td>Hospital Discharge Date (TR25.34)</td>
</tr>
<tr>
<td>CORE</td>
<td>TR25.48</td>
<td>Discharge Time</td>
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<td>Hospital Discharge Time (TR25.48)</td>
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<tr>
<td>CORE</td>
<td>TR25.92</td>
<td>Discharge Status</td>
<td>Discharge Status (Alive/Dead)</td>
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### FINANCIAL INFORMATION

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<tr>
<td>NTDB</td>
<td>TR2.5</td>
<td>Primary Method of Payment</td>
<td>Financial - Primary Method of Payment</td>
<td>Hospital Charges Primary Method Of Payment (TR2.5)</td>
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### HOSPITAL COMPLICATIONS

<table>
<thead>
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<th>Analytical Report Name</th>
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<tbody>
<tr>
<td>NTDB</td>
<td>TR23.1</td>
<td>Complications</td>
<td>Complication Type</td>
<td>Complication Type During Patient Hospital Stay (TR23.1)</td>
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In addition to the required elements above, the following options are commonly used within reports.

### OTHER COMMON ELEMENTS

<table>
<thead>
<tr>
<th>Element Name</th>
<th>Transactional Report Name</th>
<th>Analytical Report Name</th>
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<tbody>
<tr>
<td>Facility Name</td>
<td>Facility Name</td>
<td>Hospital Name</td>
</tr>
<tr>
<td>Region Name</td>
<td>Region Name</td>
<td>Hospital Region</td>
</tr>
<tr>
<td>Facility Trauma Level (I, II, III, IV)</td>
<td>Designation Name</td>
<td>Hospital Trauma Level</td>
</tr>
<tr>
<td>ED Admission Date</td>
<td>ED/Acute Care Admission Date</td>
<td>ED-Hospital Patient Arrival Date</td>
</tr>
</tbody>
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