

Ohio Trauma Registry 2016

Trauma Acute Care Registry Data Dictionary

Version 2016.0

*This edition is effective for all trauma patients
presenting for treatment on or after January 1, 2016.*



Acknowledgements

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TACR is a component of the Ohio Trauma Registry (OTR) and is maintained by the Ohio Department of Public Safety, 1970 W. Broad St., Columbus, Ohio 43218. For more information about the TACR, OTR and/or the State of Ohio's Trauma System, contact the Ohio Department of Public Safety's EMS Office of Research and Analysis, at (800)233-0785, EMSdata@dps.ohio.gov or visit <http://ems.ohio.gov>.

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OHIO TACR INCLUSION/EXCLUSION CRITERIA – ICD-10

TRAUMA PATIENT DEFINITION

In order to ensure consistent data collection across the State of Ohio and to follow the National Trauma Data Standard, a trauma patient is defined as a patient sustaining a traumatic injury and meeting the patient inclusion criteria described below.

PATIENT INCLUSION CRITERIA

To be included in the Trauma Acute Care Registry (TACR),

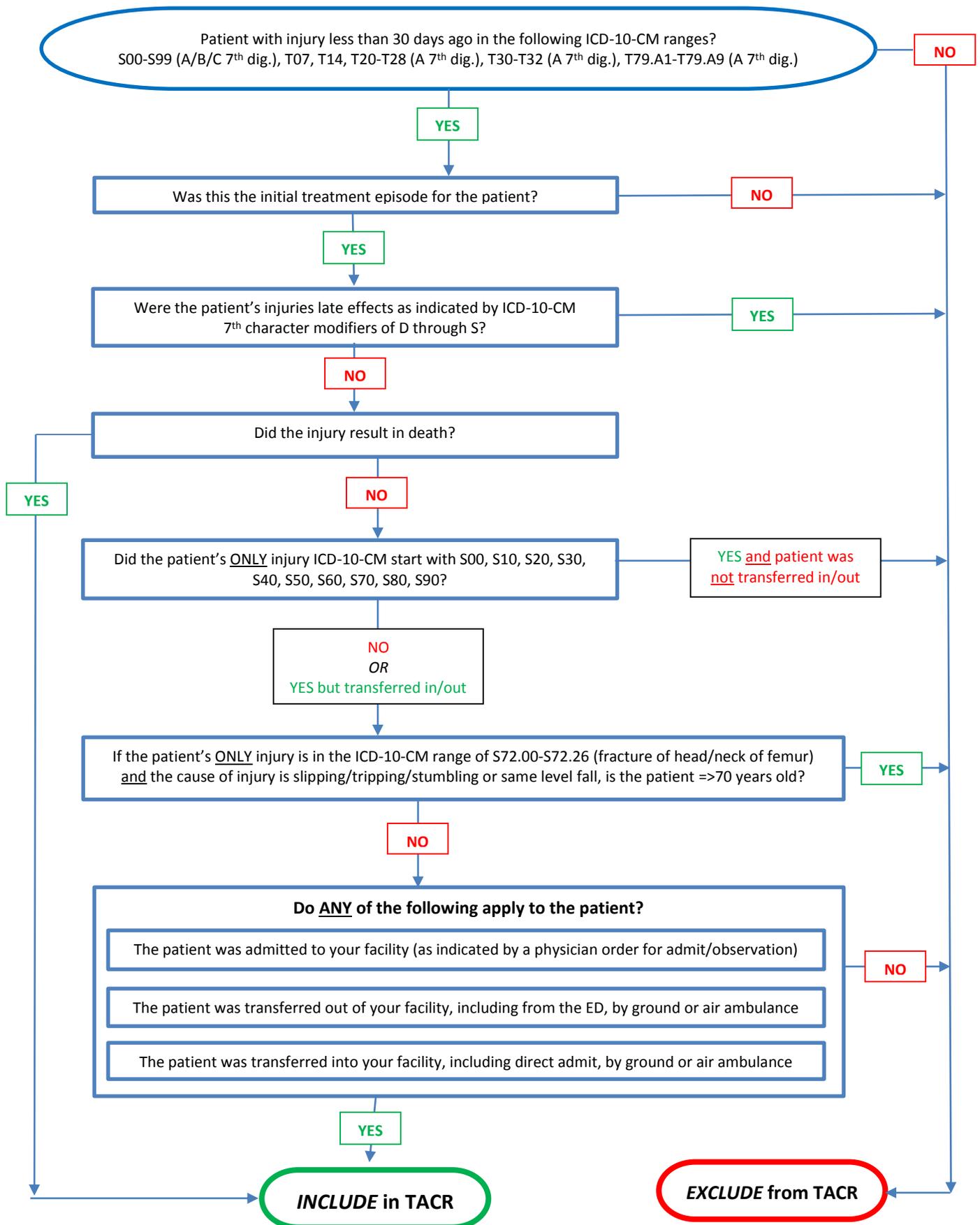
1. The patient must have incurred, no more than 30 days prior to presentation for initial treatment, at least one of the injury diagnostic codes defined in the International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM):
 - **S00-S99 with 7th character modifier of A, B 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 specified body parts – initial encounter);
 - **T30-T32** (Burn by TBSA percentage);
 - **T79.A1-T79.A9 with 7th character modifier of A ONLY** (Traumatic compartment syndrome – initial encounter)
2. The patient **MUST ALSO**
 - On initial presentation for treatment of an injury, be admitted to a hospital or hospital observation unit, as defined by a physician order regardless of the length of stay; **AND/OR**
 - Be transferred via EMS transport (including air ambulance) from one hospital (or free standing emergency department) to another hospital regardless of the patient's length of stay or admission status; **AND/OR**
 - Have an outcome of death resulting from the traumatic injury (independent of hospital admission or hospital transfer status).

PATIENT EXCLUSION CRITERIA

Patients with the following isolated ICD-10-CM codes are **EXCLUDED** from the TACR:

- **S72.00-S72.26**, fracture of head/neck of femur ONLY IF age >70 AND it resulted from slipping, tripping, stumbling or a same level fall (W01.0, W18.30, W18.31, W18.39);
- **S00, S10, S20, S30, S40, S50, S60, S70, S80, S90** (Superficial injuries. Patients with a superficial injury that were transferred in/out for treatment of injuries or died because of injuries would be included in the registry)
- **7th character modifiers of D through S** (Late effects)

Ohio TACR Inclusion/Exclusion Decision Tree – ICD-10



COMMON NULL VALUES

Definition

Common Null Values are terms to be used with TACR Data Elements as described in this document for specifically-defined data fields when an answer cannot be provided.

Field Values

NA= Not Applicable

ND= Not Known/Not Recorded/Not Documented

Additional Information

- Although not written out on the following pages, these Common Null Values are included in the TACR dataset for every allowable data field. To ascertain their allowability by data field, see the “Accepts Null Value” notation on every data field descriptor page.
- *Not Applicable (Field Value NA)*: This null value code applies if, at any time of patient care documentation, the information requested was “Not Applicable” (NA) to the patient, the hospitalization or the patient care event. For example, variables documenting EMS care would be NA if a patient self-transport to the hospital.
- *Not Known/Not Recorded/Not Documented (Field Value ND)*: 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 documents that there was an attempt to obtain information, but it was unknown by all parties or the information was missing at the time of documentation. For example, injury date and time may be documented in the hospital patient care report as “Unknown”. Another example, Not Known/Not Recorded/Not Documented should also be coded when documentation was expected, but none was provided (i.e., no EMS run sheet in the hospital record for patient transported by EMS).
- For any collection of data to be of value and reliably represent what was intended, a strong commitment must be made to ensure the correct documentation of incomplete data. When data elements associated with the TACR are electronically stored in a database or moved from one database to another, the indicated null values should be applied.

References to Other Databases

- Compare with NHTSA V.2.10 – E00
- Compare with NTDS V.1.2.5

HOSPITAL CODE

Definition

Hospital Code is a four-digit (4) hospital code assigned by the Ohio Department of Public Safety.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Stored as a four digit code (xxxx)

Data Source Hierarchy

- Ohio Department of Public Safety Hospital Code List

UNIQUE ADMISSION NUMBER

Definition

Unique Admission Number is a number assigned to the trauma patient at your facility. A patient encounter number or account number can be used.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- Use an identifiable number specific to your facility, e.g. patient encounter or account number

PATIENT'S HOME CITY

Definition

Patient's Home City is the patient's city, township, or village of residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 Emergency Department (ED) Documentation

References to Other Databases

- NHTSA V.2.2 – E06_05
- NTDS 1.2.5

PATIENT'S HOME STATE

Definition

Patient's Home State is the state, territory, or province (or the District of Columbia) of the patient's residence.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_07
- NTDS 1.2.5

PATIENT'S HOME COUNTY

Definition

Patient's Home County is the patient's county (or parish) of residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_06
- NTDS 1.2.5

PATIENT'S HOME ZIP CODE

Definition

Patient's Home Zip Code is the zip code of the patient's primary residence.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Stored as a 5 digit code (XXXXX).

Data Source Hierarchy

- 1 Billing Sheet/Medical Records Coding Summary Sheet
- 2 ED Admission Form
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_08
- NTDS 1.2.5

PATIENT'S HOME COUNTRY

Definition

Patient's Home Country is the country where the patient resides.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character fields representing a country (e.g. U.S.)

Data Source Hierarchy

- 1 Billing Sheet/Medical Records Coding Summary Sheet
- 2 ED Admission Form
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_09
- NTDS 1.2.5

ALTERNATE HOME RESIDENCE

Definition

Alternate Home Residence is documentation of the residential status of a patient who has no home zip code.

Field Values

- 1 Homeless
- 2 Undocumented Resident
- 3 Migrant Worker

Common Null Values

- Accepted

Additional Information

- Only used when Zip 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 Resident* 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

- 1 Billing Sheet/Medical Records Coding Summary Sheet
- 2 ED Admission Form
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NTDS 1.2.5

DATE OF BIRTH

Definition

Date of Birth is the patient's date of birth.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as MMDDYYYY
- If age is known, but the date of birth is not, enter 01/01/YYYY (YYYY appropriate to patient's known age)

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_16
- NTDS 1.25

AGE

Definition

Age is the patient's age (or best approximation) at the time of injury.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate patient age in hours, days, months or years
- Must also complete variable *Age Units* (see next page)
- Only completed when Date of Birth is "Not Recorded/Not Known" or age is less than 24 hours

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_14
- NTDS 1.2.5

AGE UNITS

Definition

Age Units are the units used to document the patient's age (years, months, days, hours).

Field Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate patient age in hours, days, months or years
- Must also complete variable *Age*
- Only completed when Date of Birth is "Not Recorded/Not Known" or age is less than 24 hours

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Triage Form/Trauma Flow Sheet
- 4 EMS Run Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_15
- NTDS 1.2.5

SEX

Definition

The patient's sex.

Field Values

- 1 Male
- 2 Female

Common Null Values

- Not Accepted

Additional Information

- Patients who have undergone a surgical and/or hormonal sex change should be coded according to what sex they state they are. If they are unable to state their sex, they should be coded according to what sex they appear to be.

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_11
- NTDS 1.2.5

RACE

Definition

Race is 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

Common Null Values

- Accepted

Additional Information

- Patient race should be based upon self-report or identified by a family member
- The maximum number of races that may be reported for an individual patient is 2

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 EMS Run Sheet
- 4 Triage Form/Trauma Flow Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_12
- NTDS 1.2.5

ETHNICITY

Definition

Ethnicity is the patient's ethnicity in terms of Hispanic heritage.

Field Values

- 1 Hispanic or Latino
- 2 Not Hispanic or Latino

Common Null Values

- Accepted

Additional Information

- Patient ethnicity should be based upon self-report or identified by a family member
- The maximum number of ethnicities that may be reported for an individual patient is 1

Data Source Hierarchy

- 1 ED Admission Form
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Triage Form/Trauma Flow Sheet
- 4 EMS Run Sheet
- 5 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E06_13
- NTDS 1.2.5

PRIMARY ICD-10 EXTERNAL CAUSE CODE

Definition

Primary E-Code is a designation used to describe the mechanism (or external factor) that caused the injury event.

Field Values

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

Common Null Values

- Accepted

Additional Information

- The Primary E-Code should describe the main reason a patient is admitted to the hospital
- E-codes can be used to auto-generate the trauma type (blunt, penetrating, burn) and intentionality based upon the CDC matrix
- Activity codes should not be reported in this field

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 Billing Sheet/Medical Records Coding Summary Sheet
- 4 ED Documentation

References to Other Databases

NTDS 1.2.5

ADDITIONAL ICD-10 EXTERNAL CAUSE CODE

Definition

Additional E-code is a designation used to describe, for example, a mass casualty event or other external cause of injury.

Field Values

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

Common Null Values

- Accepted

Additional Information

- E-codes can be used to calculate trauma type (blunt, penetrating, burn) and intentionality based upon the CDC matrix
- Activity codes should not be reported in this field

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 Billing Sheet/Medical Records Coding Summary Sheet
- 4 ED Documentation

References to Other Databases

NTDS 1.2.5

ICD-10 PLACE OF OCCURRENCE CODE

Definition

ICD-10 Place of Occurrence code is a Y92.x code used to describe the place, site or location of the injury event.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Some software systems collect the location E-Code has a text value (street, home, etc.) and convert that value into the appropriate location E-Code during the export of data to the TACR and/ or NTDB

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 Billing Sheet/Medical Records Coding Summary Sheet
- 4 ED Documentation

References to Other Databases

- NTDS 1.2.5

WORK-RELATED

Definition

Work-related is whether the injury occurred during paid employment.

Field Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- If work-related, two additional data fields must be completed, *Patient's Occupational Industry* and *Patient's Occupation*

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E07_15
- NTDS 1.2.5

PATIENT'S OCCUPATIONAL INDUSTRY

Definition

Patient's Occupational Industry is the occupational industry associated with the patient's work environment.

Field Values

- | | |
|------------------------------------|------------------------------|
| 1 Finance, Insurance, Real Estate | 8 Construction |
| 2 Manufacturing | 9 Government |
| 3 Retail Trade | 10 Natural Resources, Mining |
| 4 Transportation, Public Utilities | 11 Information Services |
| 5 Agriculture, Forestry, Fishing | 12 Wholesale Trade |
| 6 Professional, Business Services | 13 Leisure, Hospitality |
| 7 Education, Health Services | 14 Other Services |

Common Null Values

- Accepted

Additional Information

- Code as *NA* if injury is not work-related
- If work related, also complete *Patient's Occupation*
- Based upon US Bureau of Labor Statistics Industry Classification

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 EMS Run Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E07_16
- NTDS 1.2.5

PATIENT'S OCCUPATION

Definition

Patient's Occupation is the occupation of the patient.

Field Values

- | | |
|---|---|
| 1 Business, Financial Operations Occupations | 13 Computer, Mathematical Occupations |
| 2 Architecture, Engineering Occupations | 14 Life, Physical, Social Science Occupations |
| 3 Community, Social Services Occupations | 15 Legal Occupations |
| 4 Education, Training, Library Occupations | 16 Arts, Design, Entertainment, Sports, Media |
| 5 Healthcare Practitioners, Technical Occupations | 17 Healthcare Support Occupations |
| 6 Protective Service Occupations | 18 Food Preparation, Serving Related |
| 7 Building, Grounds Cleaning & Maintenance | 19 Personal Care, Service Occupations |
| 8 Sales & Related Occupations | 20 Office, Administrative Support Occupations |
| 9 Farming, Fishing, Forestry Occupations | 21 Construction, Extraction Occupations |
| 10 Installation, Maintenance, Repair Occupations | 22 Production Occupations |
| 11 Transportation, Material Moving Occupations | 23 Military Specific Occupations |
| 12 Management Occupations | |

Common Null Values

- Accepted

Additional Information

- Only completed if injury is work-related, otherwise document "NA"
- If work related, also complete *Patient's Occupational Industry*
- Based upon 1999 US Bureau of Labor Statistics Standard Occupational Classification (SOC)

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 EMS Run Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E07_17
- NTDS 1.2.5

INJURY INCIDENT DATE

Definition

Injury Incident Date is the date that the injury occurred.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Estimates of the date of injury should be based upon report by patient, witness, family or health care provider. Other proxy measures (e.g. 911 call-time) should NOT be used

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E05_01
- NTDS 1.2.5

INJURY INCIDENT TIME

Definition

Injury Incident Time is the time of day that the injury occurred.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- 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-time) should NOT be used

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E05_01
- NTDS 1.2.5

INCIDENT CITY

Definition

Incident City is the city, village or township in which the injury occurred or to which the EMS unit responded for the patient.

Field Values

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

Common Null Values

- Accepted

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E08_12
- NTDS 1.2.5

INCIDENT STATE

Definition

Incident State is the state, territory or province (or best approximation) in which the patient was injured or to which the EMS unit responded for the patient.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E08_14
- NTDS 1.2.5

INCIDENT COUNTY

Definition

Incident County is the county or parish (or best approximation) where the patient was found or to which the EMS unit responded to the patient.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Used to calculate FIPS code

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E08_13
- NTDS 1.2.5

INCIDENT LOCATION ZIP CODE

Definition

Incident Location Zip Code is the zip code of the location where the patient was injured.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Stored as a five digit code (XXXXX)
- May require adherence to HIPAA regulations

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation

References to Other Databases

- NHTSA V.2.2 – E08_15
- NTDS 1.2.5

INCIDENT COUNTRY

Definition

Incident Country is the country (or best approximation) in which the patient was injured or to which the EMS unit responded to the patient.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Values are two character fields representing a country (e.g. US)

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation
- 4 Medical Records

References to Other Databases

- NTDS 1.2.5

PROTECTIVE DEVICES

Definition

Protective Devices is the safety equipment in use or worn by the patient at the time of the injury.

Field Values

- | | |
|--|---|
| 1 None Used | 7 Helmet (e.g., bicycle, skiing, motorcycle) |
| 2 Lap Belt | 8 Airbag Present |
| 3 Personal Floatation Device | 9 Protective Clothing (e.g. padded leather pants) |
| 4 Protective Non-Clothing Gear (e.g. shin guard) | 10 Shoulder Belt |
| 5 Eye Protection | 11 Other |
| 6 Child Restraint (booster seat, child car seat) | |

Common Null Values

- Accepted
- Field cannot be “Not Applicable”

Additional Information

- Check all that apply
- If “Child Restraint” is present, complete variable *Child Specific Restraint*
- If “Airbag” is present, complete variable *Airbag Deployment*
- 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
- If chart indicates *three- point restraint*, choose field values #2 and 10

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation
- 4 Medical Records

References to Other Databases

- NHTSA V.2.2 – E10_08
- NTDS 1.2.5

CHILD SPECIFIC RESTRAINT

Definition

Child Specific Restraint indicates protective child restraint devices used by the pediatric patient at the time of injury.

Field Values

- 1 Child Car Seat
- 2 Infant Car Seat
- 3 Child Booster Seat

Common Null Values

- Accepted

Additional Information

- Evidence of the use of child restraint may be reported or observed
- Only completed when *Protective Devices* include "Child Restraint"

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation
- 4 Medical Records

References to Other Databases

- NTDS 1.2.5

AIRBAG DEPLOYMENT

Definition

Airbag Deployment indicates whether an airbag deployed during a motor vehicle crash.

Field Values

- 1 Airbag Not Deployed
- 2 Airbag Deployed Front
- 3 Airbag Deployed Side
- 4 Airbag Deployed Other (knee, airbelt, curtain, etc)

Common Null Values

- Accepted

Additional Information

- ***Airbag Deployed Front* should be used for patients with airbag deployment documented in the medical record when the site of the airbag is not further specified.**
- Check all that apply
- Evidence of the use of airbag deployment may be reported or observed
- Only completed when *Protective Devices* include "Airbag"

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 Triage Form/Trauma Flow Sheet
- 3 ED Documentation
- 4 Medical Records

References to Other Databases

- NHTSA V.2.2 – E10_09
- NTDS 1.2.5

TRANSPORT MODE FOR ARRIVAL AT YOUR HOSPITAL

Definition

Transport Mode for Arrival at Your Hospital is the manner of transport delivering the patient to your hospital.

Field Values

- 1 Ground Ambulance
- 2 Helicopter Ambulance
- 3 Fixed-wing Ambulance
- 4 Private or Public Vehicle or Walk-in
- 5 Police Transport
- 6 Other Transport Mode

Common Null Values

- Accepted

Data Source Hierarchy

- EMS Run Sheet
- ED Record

References to Other Databases

- NTDS 1.2.5

TRANSPORT AGENCY

Definition

Transport Agency is the EMS agency or air ambulance that delivered the patient to your hospital.

Field Values

- Relevant value for data element (ODPS-assigned EMS Agency ID)

Common Null Values

- Accepted

Additional Information

- “Non-applicable” (NA) is used to indicate that a patient arrived via “Private or Public Vehicle or Walk-in,” “Police Transport,” or “Other Transport Mode”

Data Source Hierarchy

- 1 EMS Run Sheet
- 2 ED Record

References to Other Databases

-

OTHER TRANSPORT MODES

Definition

Other Transport Modes documents all other types of transport used during patient care prior to the patient arriving at your hospital, except the transport mode delivering the patient to your hospital. An example is an ambulance transporting the patient to the helicopter landing zone.

Field Values

- 1 Ground Ambulance
- 2 Helicopter Ambulance
- 3 Fixed-wing Ambulance
- 4 Private or Public Vehicle or Walk-in
- 5 Police Transport
- 6 Other Transport Mode

Common Null Values

- Accepted

Additional Information

- For patients with an unspecified mode of transport, select 6, *Other*
- “Non-applicable” (NA) is used to indicate that a patient had a single mode of transport and therefore this field does not apply to the patient

Data Source Hierarchy

- 3 EMS Run Sheet
- 4 ED Record

References to Other Databases

- NTDS 1.2.5

EMS DISPATCH DATE TO SCENE OR TRANSFERRING FACILITY

Definition

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

- 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.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Total EMS Time* (which is the elapsed time from EMS dispatch to hospital arrival)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_04
- NTDS 1.2.5

EMS DISPATCH TIME TO SCENE OR TRANSFERRING FACILITY

Definition

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

- 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.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Total EMS Time* (which is the elapsed time from EMS dispatch to hospital arrival)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_04
- NTDS 1.2.5

EMS UNIT ARRIVAL DATE AT SCENE OR TRANSFERRING FACILITY

Definition

The date the unit *transporting to your hospital* arrived on the scene/transferring facility (the time the vehicle stopped moving).

- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility arrived at the transferring facility (arrival is defined at date/time when the vehicle stopped moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene arrived at the scene (arrival is defined at date/time when the vehicle stopped moving).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated fields, *Total EMS Response Time* (which is the elapsed time from EMS dispatch to scene arrival) & *Total EMS Scene Time* (which is the elapsed time from EMS scene arrival to scene departure)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_06
- NTDS 1.2.5

EMS UNIT ARRIVAL TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

The time the unit *transporting to your hospital* arrived on the scene (the time the vehicle stopped moving).

- 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).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated fields, *Total EMS Response Time* (which is the elapsed time from EMS dispatch to scene arrival) & *Total EMS Scene Time* (which is the elapsed time from EMS scene arrival to scene departure)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_06
- NTDS 1.2.5

EMS UNIT DEPARTURE DATE FROM SCENE OR TRANSFERRING FACILITY

Definition

The date the unit *transporting to your hospital* left the scene (the time the vehicle started moving).

- For inter facility transfer patients, this is the date on which the unit transporting the patient to your facility from the transferring facility departed from the transferring facility (departure is defined at date/time when the vehicle started moving).
- For patients transported from the scene of injury to your hospital, this is the date on which the unit transporting the patient to your facility from the scene departed from the scene (arrival is defined at date/time when the vehicle started moving).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Total EMS Scene Time* (which is the elapsed time from EMS scene arrival to scene departure)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_09
- NTDS 1.2.5

EMS UNIT DEPARTURE TIME FROM SCENE OR TRANSFERRING FACILITY

Definition

The time the unit *transporting to your hospital* left the scene (the time the vehicle started moving).

- 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 (arrival is defined at date/time when the vehicle started moving).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field *Total EMS Scene Time* (which is the elapsed time from EMS scene arrival to scene departure)

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E05_09
- NTDS 1.2.5

INITIAL FIELD SYSTOLIC BLOOD PRESSURE

Definition

Initial Field *Systolic Blood Pressure* is the first recorded systolic blood pressure measured at the scene of injury.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Revised Trauma Score---EMS* (adult & pediatric)
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_04
- NTDS 1.2.5

INITIAL FIELD PULSE RATE

Definition

Initial Field Pulse Rate is the first recorded pulse measured at the scene of injury (palpated or auscultated), expressed as a number per minute.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_07
- NTDS 1.2.5

INITIAL FIELD RESPIRATORY RATE

Definition

Initial Field Respiratory Rate is the first recorded respiratory rate measured at the scene of injury (expressed as a number per minute).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Revised Trauma Score---EMS* (adult & pediatric)
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_11
- NTDS 1.2.5

INITIAL FIELD OXYGEN SATURATION

Definition

Initial Field Oxygen Saturation is the first recorded oxygen saturation measured at the scene of injury (expressed as a percentage).

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_09
- NTDS 1.2.5

INITIAL FIELD GCS - EYE

Definition

Initial Field GCS Eye Opening is the first recorded Glasgow Coma Score eye assessment done 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

Common Null Values

- Accepted

Additional Information

- Used to calculate *Overall GCS – EMS Score*
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_15
- NTDS 1.2.5

INITIAL FIELD GCS - VERBAL

Definition

Initial Field GCS Verbal Response is the first recorded Glasgow Coma Score verbal assessment done at the scene of injury.

Field Values

- Pediatric(<= 2 years of age)
 - 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

Common Null Values

- Accepted

Additional Information

- Used to calculate *Overall GCS – EMS Score*
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_16
- NTDS 1.2.5

INITIAL FIELD GCS - MOTOR

Definition

Initial Field GCS Motor Response is the first recorded Glasgow Coma Score motor assessment done at the scene of injury.

Field Values

- Pediatric (<= 2 years of age)
 - 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

Common Null Values

- Accepted

Additional Information

- Used to calculate Overall GCS – EMS Score
- If patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS score recorded, but written documentation closely (or directly) relates to verbiage describing a specific level of functioning within the GCS scale, the appropriate numeric score may be listed. E.g. the chart indicates: "patient withdraws from a painful stimulus," a Motor GCS of 4 may be recorded, IF there is no other contradicting documentation.

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_17
- NTDS 1.2.5

INITIAL FIELD GCS - TOTAL

Definition

Initial Field Scene GCS Total Score is the first recorded total Glasgow Coma Score done at the scene of injury.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate an additional calculated field, *Revised Trauma Score---EMS* (adult & pediatric)
- If the patient is transferred to your facility with no EMS run sheet from the scene of injury, record as *Not Known/Not Recorded/Not Documented*
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_19
- NTDS 1.2.5

INITIAL FIELD GCS QUALIFIER

Definition

Initial Field GCS Qualifier documents circumstances related to the patient when or near the time that the *INITIAL Field Scene GCS Total Score* was obtained.

Field Values

- 1 Patient is chemically sedated or paralyzed
- 2 Obstruction to the patient's eye(s) prevents accurate eye assessment
- 3 Patient is intubated
- 4 GCS is valid meaning that the patient is not sedated, not intubated and without eye obstruction

Common Null Values

- Accepted

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.)
- Select *NA* if the patient was not transported to your hospital by EMS

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- Not an NTDS Field

SCENE INTERVENTIONS

Definition

Scene Interventions indicates whether a critical procedure was performed by EMS at the scene or en route to your hospital, and if so, the procedure that was performed.

Field Values

- 1 CPR
- 2 Needle Thoracostomy or Chest Tube
- 3 Nasal Endotracheal Tube
- 4 Oral Endotracheal Tube
- 5 Surgical Airway (i.e. surgical, needle or percutaneous cricothyrotomy, tracheostomy)
- 6 Other Non-Surgical Airway (Supraglottic Airway (e.g., Laryngeal Mask Airway, King, Combitube))

Common Null Values

- Accepted

Additional Information

- Select *NA* if the patient was not treated at the scene by EMS

Data Source Hierarchy

- 1 EMS Run Sheet

References to Other Databases

- Not an NTDS Field

PREHOSPITAL CARDIAC ARREST

Definition

Prehospital Cardiac Arrest is indication of whether patient experienced cardiac arrest prior to ED/Hospital arrival.

Field Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- 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 of the reporting hospital, prior to admission at the center in which the registry is maintained. Pre-hospital cardiac arrest could occur at a transferring institution.
- Any component of basic and/or advanced cardiac life support must have been initiated by a health care provider.

Data Source Hierarchy

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

References to Other Databases

NTDS 1.2.5

INTER-FACILITY TRANSFER

Definition

Inter-facility Transfer is whether the patient was transferred to your facility from another hospital.

Field Values

- 1 Yes
- 2 No

Common Null Values

- Accepted

Additional Information

- A patient transferred from a private doctor's office, stand-alone ambulatory surgery center, and urgent care clinic or delivered to your hospital by a non-EMS transport is NOT considered an inter-facility transfer.
- Outlying facilities (i.e. hospitals and free-standing emergency departments) that provide emergency care services to assess and/or stabilize a patient are considered to be acute care facilities.

Data Source Hierarchy

- 1 EMS Run Sheet

References to Other Databases

- NTDS 1.2.5

TRANSFERRING HOSPITAL CODE

Definition

Transferring Hospital Code documents the Ohio Department of Public Safety (ODPS) assigned-number for the acute care facility which transferred a trauma patient to your hospital.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Data Source Hierarchy

- 1 ED Record
- 2 History & Physical Documentation

References to Other Databases

- Not a NTDS Field

ED/HOSPITAL ARRIVAL DATE

Definition

ED/Hospital Arrival Date is the date that the patient arrived at your ED/hospital.

Field Values

- Relevant value for data entry

Common Null Values

- Accepted

Additional Information

- If the patient was brought to the ED, enter the date patient arrived at ED
- If the patient was directly admitted to the hospital, enter date patient was admitted to the hospital
- 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 Form/Trauma Flow Sheet
- 2 ED Record
- 3 Billing Sheet/Medical Records Coding Summary Sheet
- 4 Hospital Discharge Summary

References to Other Databases

- NTDS 1.2.5

ED/HOSPITAL ARRIVAL TIME

Definition

ED/Hospital Arrival Time is the time of day that the patient arrived to your ED/hospital.

Field Values

- Relevant value for data entry

Common Null Values

- Accepted

Additional Information

- If the patient was brought to your hospital ED, enter the time patient arrived at the ED.
- If the patient was a directly admit to your hospital and bypassed the ED, enter that time that the patient was admitted to your hospital.
- 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 Form/Trauma Flow Sheet
- 2 ED Record
- 3 Billing Sheet/Medical Records Coding Summary Sheet
- 4 Hospital Discharge Summary

References to Other Databases

- NTDS 1.2.5

TRAUMA ACTIVATION LEVEL

Definition

Trauma Activation Level is the highest level of trauma activation called for the patient when at your hospital.

Field Values

- 1 Highest Level of Activation
- 2 Other Level of Activation
- 3 No Trauma Activation

Common Null Values

- Not Accepted

Additional Information

- Select 3 if your facility does not have a Trauma Service

Data Source Hierarchy

- 1 Trauma Flow Sheet
- 2 ED Record

References to Other Databases

- Not an NTDS Field

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Definition

ED/Hospital Initial Systolic Blood Pressure is the patient's first recorded systolic blood pressure within 30 minutes or less of ED/hospital arrival.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Use to auto-generated an additional calculated field, *Revised Trauma Score---ED* (adult & pediatric)
- Please note that first recorded/ hospital vitals do not need to be from the same assessment

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL PULSE RATE

Definition

ED/Hospital Initial Pulse Rate is the patient's first recorded pulse rate within 30 minutes or less of ED/hospital arrival (palpated or auscultated), expressed as a number per minute.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL RESPIRATORY RATE

Definition

ED/Hospital Initial Respiratory Rate is the patient's first recorded respiratory rate within 30 minutes or less of ED/hospital arrival.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If available, complete additional field *Initial ED/Hospital Respiratory Assistance*
- Used to auto-generate an additional calculated field *Revised Trauma Score---ED* (adult & pediatric)

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL RESPIRATORY ASSISTANCE

Definition

ED/Hospital Initial Respiratory Assistance documents whether the patient was receiving respiratory assistance within 30 minutes or less of ED/hospital arrival.

Field Values

- 1 Unassisted Respiratory Rate
- 2 Assisted Respiratory Rate

Common Null Values

- Accepted

Additional Information

- Only completed if a value is provided for *ED/Hospital Initial Respiratory Rate*
- Respiratory Assistance is defined as mechanical and/or external support of respiration

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL OXYGEN SATURATION

Definition

ED/Hospital Initial Oxygen Saturation is the patient's first recorded oxygen saturation within 30 minutes or less of ED/hospital arrival, expressed as a percentage.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If available, complete additional field *ED/Hospital Initial Supplemental Oxygen*

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL SUPPLEMENTAL OXYGEN

Definition

ED/Hospital Supplemental Oxygen Administration during Initial Oxygen Saturation Measurement is whether supplemental oxygen was provided to the patient during the assessment of *ED/Hospital Initial Oxygen Saturation Level* within 30 minutes or less of ED/hospital arrival.

Field Values

- 1 No Supplemental Oxygen
- 2 Supplemental Oxygen

Common Null Values

- Accepted

Additional Information

- Only completed if a value is provided for *ED/Hospital Initial Oxygen Saturation*

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL TEMPERATURE

Definition

ED/Hospital Initial Temperature is the patient's first recorded temperature within 30 minutes or less of ED/hospital arrival, documented in degrees Fahrenheit.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL GCS - EYE

Definition

ED/Hospital Initial GCS Eye Opening is the patient's first recorded Glasgow Coma Score (GCS) eye assessment documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

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

Common Null Values

- Accepted

Additional Information

- Necessary 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.

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL GCS - VERBAL

Definition

ED/Hospital Initial GCS Verbal Response is the patient's first recorded Glasgow Coma Score verbal assessment documented within 30 minutes or less of ED/hospital arrival.

Field Values

- Pediatric(<= 2 years of age)
 - 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

Common Null Values

- Accepted

Additional Information

- Necessary 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.

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL GCS - MOTOR

Definition

ED/Hospital Initial GCS Motor Response is the patient's first recorded Glasgow Coma Score motor assessment documented within 30 minutes or less of ED/hospital arrival.

Field Values

- Pediatric(<= 2 years of age)
 - 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

Common Null Values

- Accepted

Additional Information

- Necessary 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.

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL GCS - TOTAL

Definition

ED/Hospital Initial GCS Total Score is the patient's first recorded Glasgow Coma Score documented within 30 minutes or less of ED/hospital arrival in your ED/hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Utilize **only** if total score is available without individual component scores
- Used to auto-generate an additional calculated field, *Revised Trauma Score---ED (adult & pediatric)*
- If a patient does not have a numeric GCS recorded, but there is documentation related to their level of consciousness such as "AAOx3," "awake alert and oriented," or "patient with normal mental status," interpret this as GCS of 15 IF there is no other contradicting documentation.

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Unit Record (if a direct admission)

References to Other Databases

- NTDS 1.2.5

INITIAL ED/HOSPITAL GCS ASSESSMENT QUALIFIERS

Definition

ED/Hospital Initial GCS Qualifiers are factors that potentially affected the patient's first Glasgow Coma Score assessment within 30 minutes or less of ED/hospital arrival.

Field Values

- 1 Patient Chemically Sedated
- 2 Obstruction to the Patient's Eye
- 3 Patient Intubated
- 4 Valid GCS: Patient not sedated, not intubated and without eye obstruction

Common Null Values

- Accepted

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.

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 EMS Run Sheet
- 4 Nursing Unit Vitals (if a direct admission)

References to Other Databases

- NTDS 1.2.5

HEIGHT

Definition

Height is the patient's height in centimeters.

Field Values

- Height in centimeters

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Admission Record

References to Other Databases

- NTDS 1.2.5

WEIGHT

Definition

Weight is the patient's weight in kilograms.

Field Values

- Weight in kilograms

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Triage Form/Trauma Flow Sheet
- 2 ED Record
- 3 Nursing Admission Record
- 4

References to Other Databases

- NTDS 1.2.5

ED DISCHARGE WRITTEN DATE

Definition

ED Discharge Date is the date that the order was written for the patient to be discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient is directly admitted to the hospital, code as *NA*

Data Source Hierarchy

- 1 Hospital Discharge Summary
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Physicians' Progress Notes

References to Other Databases

- NTDS 1.2.5

ED DISCHARGE WRITTEN TIME

Definition

ED Discharge Time is the time that the order was written for the patient to be discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- If the patient is directly admitted to the hospital, code as *NA*

Data Source Hierarchy

- 1 Hospital Record
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Physicians' Progress Notes

References to Other Databases

- NTDS 1.2.5

ED DISCHARGE DATE

Definition

ED Discharge Date is the date that the patient was discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate additional calculated field, *Total ED Time* (elapsed time from ED admit to ED discharge)
- If the patient is directly admitted to the hospital, code as *NA*

Data Source Hierarchy

- 4 Hospital Discharge Summary
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Physicians' Progress Notes

References to Other Databases

- NTDS 1.2.5

ED DISCHARGE TIME

Definition

ED Discharge Time is the time that the patient was discharged from your ED.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to auto-generate additional calculated field, *Total ED Time* (which is the elapsed time from ED arrival to ED discharge)
- If the patient is directly admitted to the hospital, code as *NA*

Data Source Hierarchy

- 4 Hospital Record
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Physicians' Progress Notes

References to Other Databases

- NTDS 1.2.5

ED DISCHARGE DISPOSITION

Definition

ED Discharge Disposition is a general location of where the patient goes at the time of discharge from your ED.

Field Values

- | | |
|---|------------------------------------|
| 1 Floor bed (general admission, non-specialty unit bed) | 7 Operating Room |
| 2 Observation unit | 8 Intensive Care Unit (ICU) |
| 3 Telemetry/step-down unit (less acuity than ICU) | 9 Home without services |
| 4 Home with services | 10 Left against medical advice |
| 5 Deceased/Expired | 11 Transferred to another hospital |
| 6 Other (jail, institutional care, mental health, etc.) | |

Common Null Values

- Accepted

Additional Information

- If reported as “Died” complete variable *Signs of Life*
- If the patient is directly admitted to the hospital, code as *NA*

Data Source Hierarchy

- 1 Hospital Discharge Summary
- 2 Nursing Progress Notes
- 3 Social Worker Notes

References to Other Databases

- NTDS 1.2.5

ED TRANSFER TO HOSPITAL

Definition

ED Transfer to Hospital is a subsequent hospital destination of the patient upon discharge from your ED.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Data Source Hierarchy

1. ED Record
2. History & Physical Documentation

References to Other Databases

SIGNS OF LIFE

Definition

Signs of Life are whether the patient arrived for treatment in the ED/ Hospital with signs of life.

Field Values

- 1 Arrived with no signs of life
- 2 Arrived with signs of life

Common Null Values

- Accepted

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 Form/Trauma Flow Sheet
- 2 Physician's Progress Notes
- 3 ED Documentation

References to Other Databases

- NTDS 1.2.5

ALCOHOL USE INDICATOR

Definition

Use of alcohol by patient.

Field Values

- 1 No (not tested)
- 2 No (confirmed by test)
- 3 Yes (confirmed by test [trace levels])
- 4 Yes (confirmed by test [beyond legal limit])

Common Null Values

- Accepted

Additional Information

- Blood alcohol concentration (BAC) may be documented at any facility (or setting) treating this patient event
- “Beyond legal limit” is defined as a blood alcohol concentration above the legal limit for the State of Ohio
 - Adult Legal Limit is < 0.08 mcg/dl
 - Pediatric (\leq 21 years of age) Legal Limit is <0.02 mcg/dl
- “Trace levels” is defined as any alcohol level below the legal limit, but not zero.
- If alcohol use is suspected, but not confirmed by test, record null value “Not Known/Not Recorded.”

Data Source Hierarchy

- 1 Lab Results
- 2 ED Physician Notes

References to Other Databases

- NTDS 1.2.5

ALCOHOL LEVEL RANGE

Definition

Alcohol Level Range is the level of the patient's Initial blood alcohol level (BAL) drawn at your hospital when the BAL is positive.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This field is answered only if *the patient is positive for alcohol use*.
- *Document the patients BAL in whole numbers. Example: 102.*
- *Document NA if patient did not have a blood alcohol level tested.*
- Examples:
 - $0.104 > 104.0$, which converts to "104". Move the decimal 3 places to the right. The zero gets dropped.
 - $0.354 > 354.0 > 354$. Again, move the decimal 3 places to the right. The zero gets dropped.
 - $180 > 180.0 > 0.18$. The decimal is moved 3 places to the left, when you convert a whole number reading to a decimal reading.

Data Source Hierarchy

- 1 Lab Results
- 2 ED Physician Notes

References to Other Databases

DRUG USE INDICATOR

Definition

Use of drugs by patient.

Field Values

1. No (not tested)
2. No (confirmed by test)
3. Yes (confirmed by test [prescription drug])
4. Yes (confirmed by test [illegal use drug])

Common Null Values

- Accepted

Additional Information

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

Data Source Hierarchy

- 1 Lab Results
- 2 ED Physician Notes

References to Other Databases

- NTDS 1.2.5

ICD-10 HOSPITAL PROCEDURES

Definition

Hospital Procedures are all operative or essential procedures conducted on the patient during his/her stay at your hospital.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Operative and/or essential procedures are defined as procedures performed in the Operating Room, Emergency Department, and/or Intensive Care Unit that were essential to the diagnoses, stabilization, or treatment of the patient's specific injuries or their complications at your hospital.
- Include only procedures performed at your hospital.
- At a minimum, the procedures listed in Appendix B should be captured for TACR. The hospital may choose to capture additional procedures for internal use. Procedures included on in the Procedures List that are designated 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.

Data Source Hierarchy

- 1 Operative Reports
- 2 ED and ICU Records
- 3 Trauma Flow Sheet
- 4 Anesthesia Record
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Hospital Discharge Summary

References to Other Databases

- NTDS 1.2.5

PROCEDURE EPISODE

Definition

Procedure Episode documents the frequency of operative visits. Each trip to the operating room should be identified in sequential order (regardless of number of procedures completed at that time).

Field Values

- 1 First Operative Episode
- 2 Second Operative Episode
- 3 Third Operative Episode
- 4 Fourth Operative Episode
- 5 Fifth Operative Episode
- 6 Sixth Operative Episode
- 7 Seventh Operative Episode
- 8 Eighth Operative Episode
- 9 Ninth Operative Episode
- 10 Tenth or More Operative Episode

Common Null Values

- Accepted

Additional Information

- Include only those operative procedures performed at your hospital
- This field is linked to the *Hospital Procedures* Field
- Leave field blank if procedure was not performed in the Operating Room
- All of the procedures done in the first OR visit would be Episode 1, all in visit 2 would be Episode 2, and so forth.

Data Source Hierarchy

- 1 Operative Reports

HOSPITAL PROCEDURE START DATE

Definition

The date operative and essential procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- This field is linked to the *Hospital Procedures* Field

Data Source Hierarchy

- 1 Operative Reports
- 2 Anesthesia Record
- 3 OR Nurses' Notes
- 4 Emergency Department Record
- 5 EMS Run Report

References to Other Databases

- NTDS 1.2.5

HOSPITAL PROCEDURE START TIME

Definition

The time operative and essential procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Procedure start time is defined as the time that the incision was made or that the essential procedure started
- This field is linked to the *Hospital Procedures* Field

Data Source Hierarchy

- 1 Operative Reports
- 2 Anesthesia Record
- 3 OR Nurses' Notes
- 4 Emergency Department Record
- 5 EMS Run Report

References to Other Databases

- NTDS 1.2.5

CO-MORBID CONDITIONS

Definition

Co-morbid Conditions are pre-existing health factors present in the patient prior to arrival at your ED/hospital.

Field Values

0	No Known Co-morbid Conditions	18	History of PVD
1	Other Co-morbid Conditions Not Listed Here	19	Hypertension Requiring Medication
2	Alcohol Use Disorder	21	Prematurity
4	Bleeding Disorder	23	Chronic Obstructive Pulmonary Disease (COPD)
5	Currently receiving Chemotherapy for Cancer	24	Steroid Use
6	Congenital Anomalies	25	Cirrhosis
7	Congestive Heart Failure	26	Dementia
8	Current Smoker	27	Major Psychiatric Illness
9	Chronic Renal Failure	28	Drug use disorder
10	Cerebrovascular accident (CVA)	30	Attention deficit disorder/attention deficit hyperactivity disorder (ADD/ADHD)
11	Diabetes Mellitus	50	Osteoporosis
12	Disseminated Cancer	51	Hearing Impaired
13	Advanced Directive Limiting Care	52	Vision Impairment
15	Functionally Dependent Health Status	53	Language Barrier
16	History of Angina Within Past 1 Month		
17	History of Myocardial Infarction		

Common Null Values

- Accepted

Additional Information

- Field Value #0, *No Known Co-morbid Conditions* is used for patients with no known co-morbid conditions as coded by the hospitals or defined within the NTDS Data Dictionary.
- Field value #1, *Other Co-morbid Conditions Not Otherwise Listed Here*, is used if that patient has a pre-existing condition that is not included in this list.
- Field value #13, *Advanced Directive Limiting Care*, is selected here ONLY if the patient had a Do Not Resuscitate (DNR) PRIOR TO the patient's arrival in your ED/hospital. To document patient DNR orders issued AFTER arrival to your ED/hospital, see next page.

Data Source Hierarchy

- 1 History and Physical
- 2 Discharge Sheet
- 3 Billing Sheet

References to Other Databases

- NTDS 1.2.5

DNR STATUS

Definition

DNR Status documents the presence of a physician's order to withhold select resuscitative efforts from the patient, and whether the order was issued prior to or during the patient's stay at your ED/hospital.

Field Values

- 0 Not a DNR patient (patient is to receive all resuscitative efforts if needed)
- 1 DNR status ordered prior to patient's arrival at your hospital
- 2 DNR status ordered after patient's arrival to your hospital

Common Null Values

- Accepted

Additional Information

- This field is completed for each patient
- DNR status is typically ordered for a patient who does not wish to be resuscitated in the event of a cardiac arrest (no palpable pulse) or respiratory arrest (no spontaneous respirations or the presence of labored breathing) near the end of life.
- A DNR status includes both *DNR-CC* (comfort care) and *DNR-CCA* (comfort care arrest) orders.
- DNR may also be referred to as Allow Natural Death (AND)

Data Source Hierarchy

- 1 Do Not Resuscitate Document
- 2 History and Physical
- 3 Discharge Sheet
- 4 Billing Sheet

References to Other Databases

- NTDS 1.2.5

ICD-10 INJURY DIAGNOSES

Definition

Injury Diagnoses are the patient's diagnoses for all injuries identified at your ED/hospital for this injury event. Diagnoses must be confirmed by a physician at your facility.

Field Values

- Injury diagnoses are defined by ICD-10-CM codes; refer to inclusion criteria

Common Null Values

- Accepted

Additional Information

- Can be utilized to generate Abbreviated Injury Score and Injury Severity Score
- The maximum number of diagnoses that may be reported for an individual patient is 50

Data Source Hierarchy

- 1 Autopsy Report
- 2 Operative Report
- 3 Discharge Summary
- 4 Trauma Flow Sheet
- 5 Radiology Results
- 6 Billing Sheet/Medical Records Coding Summary Sheet
- 7 ED and ICU Records

References to Other Databases

- NTDS 1.2.5

AIS PRE-DOT CODE

Definition

AIS Pre-dot Code is a component of the Abbreviated Injury Scale (AIS) code that reflects the patient's injuries diagnosed at your ED/hospital.

Field Values

- The pre-dot code is the 6 digits preceding the decimal point in an associated AIS code

Common Null Values

- Accepted

Additional Information

- Can be utilized to generate Abbreviated Injury Score and Injury Severity Score

Data Source Hierarchy

- AIS Dictionary

References to Other Databases

- NTDS 1.2.5

AIS SEVERITY

Definition

AIS Severity is the Abbreviated Injury Scale (AIS) severity codes that reflect the patient's injuries diagnosed at your ED/hospital.

Field Values

- 1 Minor Injury
- 2 Moderate Injury
- 3 Serious Injury
- 4 Severe Injury
- 5 Critical Injury
- 6 Maximum Injury, Virtually Non-survivable
- 7 Not Possible to Assign an AIS

Common Null Values

- Accepted

Additional Information

- Field value #7, *Not Possible to Assign an AIS*, is chosen if the severity of an injury is not known

Data Source Hierarchy

- AIS Dictionary

References to Other Databases

- NTDS 1.2.5

AIS VERSION

Definition

AIS version is the software version used to calculate Abbreviated Injury Scale (AIS) severity codes for the patient's current injury event.

Field Values

1 AIS 05

Common Null Values

- Accepted

Data Source Hierarchy

- AIS Dictionary

References to Other Databases

- NTDS 1.2.5

INJURY SEVERITY SCORE

Definition

Injury Severity Score (ISS) is a nationally-accepted scoring system that reflects the patient's injuries for this injury event.

Field Values

- Relevant ISS value for the constellation of injuries

Common Null Values

- Accepted

Data Source Hierarchy

- AIS Dictionary

References to Other Databases

- NTDS 1.2.5

TOTAL ICU LENGTH OF STAY

Definition

Total ICU Length of Stay documents the total number of days that the patient spent in any intensive care unit (ICU) (including all episodes) while in your hospital.

Field Values

- Relevant numeric value

Common Null Values

- Accepted

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.
- If the patient had no ICU days according to the above definition, code as 'Not applicable.'
- See Appendix E for examples of ICU LOS calculations

Data Source Hierarchy

- 1 ICU Nursing Flow Sheet
- 2 Calculate Based on Admission Form and Discharge Sheet
- 3 Nursing Progress Notes

References to Other Databases

- NTDS 1.2.5

TOTAL VENTILATOR DAYS

Definition

Total Ventilator Days documents the total number of days that the patient spent on mechanical ventilation (excluding time in the OR) while in your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

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.
- If the patient was not on the ventilator according to the above definition, code as 'Not applicable.'
- See Appendix E for examples of Total Ventilator Days calculations

Data Source Hierarchy

- 1 ICU Respiratory Therapy Flowsheet
- 2 ICU Nursing Flow Sheet
- 3 Physician's Daily Progress Notes
- 4 Calculate Based on Admission Form and Discharge Sheet

References to Other Databases

- NTDS 1.2.5

HOSPITAL DISCHARGE ORDER WRITTEN DATE

Definition

Hospital Discharge Date is the date that the order was written for the patient to be discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Hospital Record
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Physician Discharge Summary

References to Other Databases

- NTDS 1.2.5

HOSPITAL DISCHARGE ORDER WRITTEN TIME

Definition

Hospital Discharge Time is the time of day that the order was written for the patient to be discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Hospital Record
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Physician Discharge Summary

References to Other Databases

- NTDS 1.2.5

HOSPITAL DISCHARGE DATE

Definition

Hospital Discharge Date is the date that the patient was discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate *Total Length of Hospital Stay* (which is the elapsed time from ED/Hospital arrival to Hospital Discharge)

Data Source Hierarchy

- 4 Hospital Record
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Physician Discharge Summary

References to Other Databases

- NTDS 1.2.5

HOSPITAL DISCHARGE TIME

Definition

Hospital Discharge Time is the time of day that the patient was discharged from your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Used to calculate field *Total Length of Hospital Stay* (which is the elapsed time from ED/Hospital Arrival to Hospital Discharge)

Data Source Hierarchy

- 4 Hospital Record
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Physician Discharge Summary

References to Other Databases

- NTDS 1.2.5

HOSPITAL DISCHARGE DISPOSITION

Definition

Hospital Discharge Disposition documents in general terms where the patient went after discharge from your hospital.

Field Values

- 1 Discharged/Transferred to another hospital for ongoing acute inpatient care
- 2 Discharged to an intermediate care facility (ICF)/long term care facility (LTCF)
- 3 Discharged/Transferred to home under the care of an organized home health service
- 4 Left against medical advice (AMA) or discontinued care
- 5 Died
- 6 Discharged home or self-care (routine discharge)
- 7 Discharged to a skilled nursing facility (SNF)
- 8 Discharged to hospice care
- 9 [Value 9 not used]
- 10 Discharged to court/law enforcement/jail
- 11 Discharged to another type of inpatient rehabilitation facility (IRF)
- 12 Discharged to a long term acute care hospital (LTACH)
- 13 Discharged/transferred to psychiatric hospital/psychiatric unit
- 14 Discharged/transferred to other type of institution not listed here

Common Null Values

- Accepted

Additional Information

- In field values #3 and #6, "Home" refers to the patient's current place of residence (e.g., home, prison, etc.)
- Field values based upon UB-04 disposition coding
- Disposition to any other non-medical facility should be coded as 6
- Disposition to any other medical facility should be coded as 9
- Refer to the glossary for definitions of facility types

Data Source Hierarchy

- 1 Hospital Discharge Summary Sheet
- 2 Nurses Notes
- 3 Case Manager/Social Services Notes

References to Other Databases

- NTDS 1.2.5

INPATIENT TRANSFER TO HOSPITAL

Definition

Inpatient Transfer to Hospital documents a subsequent hospital destination for the patient after inpatient admission at your hospital. This includes transfers to inpatient rehabilitation facilities.

Field Values

- Four-digit hospital code assigned by the Ohio Department of Public Safety.

Common Null Values

- Accepted

Data Source Hierarchy

- 1 Discharge Summary
- 2 Progress Notes
- 3 Billing/Registration Sheet

References to Other Databases

- Not a NTDS Field

LENGTH OF STAY

Definition

Length of Stay documents the total number of days that the patient occupied a bed while in your hospital.

Field Values

- Relevant value for data element

Common Null Values

- Not Accepted

Additional Information

- This field is calculated from data in the “Hospital Arrival Date” and “Discharge Date” fields.
- Recorded in full day increments with any partial calendar day counted as a full calendar day.

Data Source Hierarchy

- 1 Registration Form
- 2 Discharge Form

References to Other Databases

DISCHARGE STATUS

Definition

Discharge Status is whether the patient left your hospital alive or dead.

Field Values

- 1 Alive
- 2 Dead

Common Null Values

- Not Accepted

Data Source Hierarchy

- 1 Discharge Summary
- 2 Progress Notes
- 3 Billing Sheet

References to Other Databases

-

DATE OF DEATH

Definition

Date of Death is the date that the patient was pronounced dead or time of declaration of brain death.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Only complete field when *Discharge Status* is completed as *Dead*
- This may differ from the date of discharge
- *Date of Death* must be \leq *Hospital Discharge Date*

Data Source Hierarchy

- 1 Hospital Record
- 2 Billing Sheet/Medical Records Coding Summary Sheet
- 3 Physician Discharge Summary

References to Other Databases

TIME OF DEATH

Definition

Time of Death is the time of day that the patient was pronounced dead or time of declaration of brain death.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Only complete field when *Discharge Status* is completed as *Dead*
- This may differ from the time of discharge
- *Time of Death* must be \leq *Hospital Discharge Time*

Data Source Hierarchy

- 4 Hospital Record
- 5 Billing Sheet/Medical Records Coding Summary Sheet
- 6 Physician Discharge Summary

References to Other Databases

PRIMARY METHOD OF PAYMENT

Data Format is single-choice.

Definition

Primary Method of Payment is the patient's foremost source of payment for care while in your hospital.

Field Values

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

Common Null Values

- Accepted

Additional Information

- Examples of "Other Government Payer Source": Veterans Affairs (VA), Champus, Tri Care, Champ VA.
- Charity or HCAP should be coded under "Not Billed"

Data Source Hierarchy

- 1 Billing Sheet/Medical Records Coding Summary Sheet
- 2 Hospital Admission Form

References to Other Databases

- NTDS 1.2.5

AUTOPSY PERFORMED

Data Format is single-choice.

Definition

Autopsy Performed documents whether an internal organ exam was performed on the patient by a trained pathologist.

Field Values

- 1 Yes, an autopsy was performed
- 2 No, an autopsy was not performed

Common Null Values

- Accepted

Additional Information

- Select *NA* if the patient is alive

Additional Information

- If only an external or visual-type exam was done and no internal organs were surgically explored, field value #2, *No, an autopsy was not performed*, should be selected.

Data Source Hierarchy

- 1 Autopsy Report
- 2 Discharge Summary

References to Other Databases

-

HOSPITAL COMPLICATIONS

Data Format is multiple-choice.

Definition

Hospital Complications document any medical complication that occurred during the patient's stay at your hospital.

Field Values

0	No Complications	21	Pulmonary Embolism
1	Complications occurred that are otherwise not on this list	22	Stroke/ CVA
4	Acute kidney injury	23	Superficial surgical site infection
5	Acute lung injury/ Acute respiratory distress syndrome (ARDS)	25	Unplanned intubation
8	Cardiac arrest with CPR	29	Osteomyelitis
11	Decubitus ulcer	30	Unplanned return to the OR
12	Deep surgical site infection	31	Unplanned return to the ICU
13	Drug or alcohol withdrawal syndrome	32	Severe Sepsis
14	Deep Vein Thrombosis (DVT) / thrombophlebitis	33	Catheter-associated urinary tract infection (CAUTI)
15	Extremity compartment syndrome	34	Central line-associated bloodstream infection (CLABSI)
18	Myocardial infarction	35	Ventilator-associated pneumonia (VAP)
19	Organ/ space surgical site infection		

Common Null Values

- Accepted

Additional Information

- The Field Value #1, *Complications occurred that are otherwise not on this list*, is chosen if that patient had a complication but it is not included in the list here. The list here mirrors the NTDS list of tracked patient complications.
- The field value #0, *No Complications*, should be used for patients with no medical complications as a result of this injury episode.

Data Source Hierarchy

- 1 Discharge Summary
- 2 History and Physical
- 3 Billing Sheet

References to Other Databases

- NTDS 1.2.5

APPENDIX A - Discharge Disposition

Field Value	Variable	Definition
2	Intermediate Care Facility (ICF)	A nursing home providing long-term care less than a skilled level, usually custodial care only.
7	Skilled Nursing Facility (SNF)	A nursing home or unit which provides skilled nursing or rehabilitation care, less than the level of an inpatient rehabilitation facility.
8	Hospice	A special way of caring for persons who are terminally ill. Hospice services can be provided in the home or at a nursing facility.
9	Inpatient Rehabilitation Facility (IRF)	A hospital or part of a hospital which provides intensive (3 hours per day) of rehabilitation therapies to persons with disability from recent injury or illness.
10	Long Term Acute Care Hospital (LTACH)	A special hospital or part of a hospital that provides treatment for patients who stay, on average, more than 25 days for extended acute care. Most patients are transferred from an intensive or critical care unit.

Appendix B - Procedure List For *Hospital Procedures* Data Field

DIAGNOSTIC & THERAPEUTIC IMAGING

Computed tomographic studies*
Diagnostic ultrasound (includes FAST)
Doppler ultrasound of extremities*
Angiography
Angioembolization
Echocardiography
Cystogram
Inferior vena cava (IVC) filter
Urethrogram

CARDIOVASCULAR

Central venous catheterization*
Pulmonary artery catheterization*
Cardiac output monitoring*
Open cardiac massage
Cardiopulmonary Resuscitation (CPR)

CENTRAL NERVOUS SYSTEM

Insertion of ICP monitor
Ventriculostomy
Cerebral oxygen monitoring

GASTROINTESTINAL

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

GENITOURINARY

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

MUSCULOSKELETAL

Soft tissue/bony debridement*
Closed reduction fractures
Skeletal (and halo) traction*
Fasciotomy

RESPIRATORY

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

TRANSFUSION

The following blood products should be captured over first 24 hours after hospital arrival:
Transfusion of red cells *
Transfusion of platelets *
Transfusion of plasma *

OTHER

Hyperbaric oxygen
Decompression chamber
Total Parenteral Nutrition (TPN)

***May be performed multiple times during hospitalization**

APPENDIX C - Co-Morbid Conditions

Field Value	Variable	Definition																										
2	Alcohol Use Disorder	(Consistent with APA DSM 5): Diagnosis of alcohol use disorder documented in the patient medical record.																										
4	Bleeding disorder	<p>Any condition that places the patient at risk for bleeding in which there is a problem with the body's blood clotting process (e.g., vitamin K deficiency, hemophilia, thrombocytopenia, chronic anticoagulation therapy with Coumadin, Plavix, or similar medications.) Do not include patients on chronic aspirin therapy. The following is a list of medications that impact the patient's risk for bleeding. Please utilize the associated time frames for discontinuation of medication prior to determine your answer to this variable.</p> <table border="1"> <thead> <tr> <th>Medication</th> <th>Time Frame</th> </tr> </thead> <tbody> <tr> <td>Coumadin (warfarin)</td> <td>5 days</td> </tr> <tr> <td>Heparin (IV only)</td> <td>4 hours</td> </tr> <tr> <td>Plavix (clopidogrel)</td> <td>10 days</td> </tr> <tr> <td>Ticlid (ticlopidine)</td> <td>14 days</td> </tr> <tr> <td>Lovenox (enoxaparin)</td> <td>12 hours</td> </tr> <tr> <td>Reopro (abciximab)</td> <td>9 days</td> </tr> <tr> <td>Integrilin (eptifibatide)</td> <td>2 days</td> </tr> <tr> <td>Agrylin (anagrelide)</td> <td>3 days</td> </tr> <tr> <td>Fragmin (dalteparin)</td> <td>24 hours</td> </tr> <tr> <td>Aggrastat (triofiban)</td> <td>4 hours</td> </tr> <tr> <td>Pradaxa (dabigatran etexilate)</td> <td>2 days</td> </tr> <tr> <td>Xarelto (rivaroxaban)</td> <td>2 days</td> </tr> </tbody> </table>	Medication	Time Frame	Coumadin (warfarin)	5 days	Heparin (IV only)	4 hours	Plavix (clopidogrel)	10 days	Ticlid (ticlopidine)	14 days	Lovenox (enoxaparin)	12 hours	Reopro (abciximab)	9 days	Integrilin (eptifibatide)	2 days	Agrylin (anagrelide)	3 days	Fragmin (dalteparin)	24 hours	Aggrastat (triofiban)	4 hours	Pradaxa (dabigatran etexilate)	2 days	Xarelto (rivaroxaban)	2 days
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5	Currently receiving Chemotherapy for Cancer	A patient who is currently receiving any chemotherapy treatment for cancer prior to admission. Chemotherapy may include, but is not restricted to, oral and parenteral treatment with chemotherapeutic agents for malignancies such as colon, breast, lung, head and neck, and gastrointestinal solid tumors as well as lymphatic and hematopoietic malignancies such as lymphoma, leukemia, and multiple myeloma. Do not include if treatment consists solely of hormonal therapy.																										
6	Congenital Anomaly	Defined as documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic congenital anomaly.																										
7	Congestive Heart Failure (CHF)	<p>Defined as the inability of the heart to pump a sufficient quantity of blood to meet the metabolic needs of the body or can do so only at an increased ventricular filling pressure. To be included, this condition must be noted in the medical record as CHF, congestive heart failure, or pulmonary edema with onset or increasing symptoms within 30 days prior to injury.</p> <p>Common manifestations are:</p> <ol style="list-style-type: none"> 1. Abnormal limitation in exercise tolerance due to dyspnea or fatigue 2. Orthopnea (dyspnea on lying supine) 																										

		<ul style="list-style-type: none"> 3. Paroxysmal nocturnal dyspnea (awakening from sleep with dyspnea) 4. Increased jugular venous pressure 5. Pulmonary rales on physical examination 6. Cardiomegaly 7. Pulmonary vascular engorgement
8	Current Smoker	A patient who reports smoking cigarettes every day or some days. Excludes patients who smoke cigars or pipes or use smokeless tobacco (chewing tobacco or snuff).
9	Chronic Renal Failure	Acute or chronic renal failure prior to injury that was requiring periodic peritoneal dialysis, hemodialysis, hemofiltration, or hemodiafiltration. (Excludes transplant patients)
10	CVA/residual neurological deficit	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).
11	Diabetes Mellitus	Diabetes mellitus prior to injury that required exogenous parenteral insulin or an oral hypoglycemic agent. Do not include a patient if diabetes is controlled by diet alone.
12	Disseminated Cancer	<p>Patients who have cancer that:</p> <ul style="list-style-type: none"> 1. Has spread to one site or more sites in addition to the primary site AND 2. In whom the presence of multiple metastases indicates the cancer is widespread, fulminant, or near terminal. Other terms describing disseminated cancer include “diffuse,” “widely metastatic,” “widespread,” or “carcinomatosis.” Common sites of metastases include major organs (e.g., brain, lung, liver, meninges, abdomen, peritoneum, pleura, and bone). <p>Report Acute Lymphocytic Leukemia (ALL), Acute Myelogenous Leukemia (AML), and Stage IV Lymphoma under this variable. Do NOT report Chronic Lymphocytic Leukemia (CLL), Chronic Myelogenous Leukemia (CML), Stages I through III Lymphoma, or Multiple Myeloma as disseminated cancer.</p>
13	Advanced Directive Limiting Care	The patient had a Do Not Resuscitate (DNR) document or similar advance directive recorded prior to injury.
15	Functionally dependent health status	<p>Pre-injury functional status may be represented by the ability of the patient to complete activities of daily living (ADL) including: bathing, feeding, dressing, toileting, and walking. This item is marked YES if the patient, prior to injury, was partially dependent or completely dependent upon equipment, devices or another person to complete some or all activities of daily living.</p> <p>Formal definitions of dependency are listed below:</p> <ul style="list-style-type: none"> 1. Partially dependent: The patient requires the use of equipment or devices coupled with assistance from another person for some activities of daily living. Any patient coming from a nursing home setting who is not

		<p>totally dependent would fall into this category, as would any patient who requires kidney dialysis or home ventilator support that requires chronic oxygen therapy yet maintains some independent functions.</p> <p>2. Totally dependent: The patient cannot perform any activities of daily living for himself/herself. This would include a patient who is totally dependent upon nursing care, or a dependent nursing home patient. All patients with psychiatric illnesses should be evaluated for their ability to function with or without assistance with ADLs just as the non-psychiatric patient.</p>
16	History of angina within past 1 month	Pain or discomfort between the diaphragm and the mandible resulting from myocardial ischemia. Typically angina is a dull, diffuse (fist sized or larger) substernal chest discomfort precipitated by exertion or emotion and relieved by rest or nitroglycerine. Radiation often occurs to the arms and shoulders and occasionally to the neck, jaw (mandible, not maxilla), or interscapular region. For patients on anti-anginal medications, enter yes only if the patient has had angina within one month prior to admission.
17	History of Myocardial Infarction (MI)	The history of a non-Q wave, or a Q wave infarction in the six months prior to injury as diagnosed in the patient's medical record.
18	History of Peripheral Vascular Disease (PVD)	(History of peripheral vascular disease): Any type of operative (open) or interventional radiology angioplasty or revascularization procedure for atherosclerotic PVD (e.g., aorta-femoral, femoral-femoral, femoral-popliteal, balloon angioplasty, stenting, etc.). Patients who have had amputation for trauma or resection/repair of abdominal aortic aneurysms, including Endovascular Repair of Abdominal Aortic Aneurysm (EVAR), would not be included.
19	Hypertension requiring medication	History of a persistent elevation of systolic blood pressure >140 mm Hg and a diastolic blood pressure >90 mm Hg requiring an antihypertensive treatment (e.g., diuretics, beta blockers, <i>angiotensin-converting enzyme (ACE)</i> inhibitors, calcium channel blockers). History of hypertension prior to injury must be documented in the patient's chart.
21	Prematurity	Defined as documentation of premature birth, a history of bronchopulmonary dysplasia, or ventilator support for greater than 7 days after birth.—Premature birth is defined as infants delivered before 37 weeks from the first day of the last menstrual period.
23	Respiratory Disease	<p>Defined as severe chronic lung disease, chronic asthma, cystic fibrosis, or <i>chronic obstructive pulmonary disease (COPD)</i> such as <i>emphysema</i> and/or <i>chronic bronchitis</i> resulting in any one or more of the following:</p> <ol style="list-style-type: none"> 1. Functional disability from COPD (e.g., dyspnea, inability to perform <i>activities of daily living [ADLs]</i>) 2. Hospitalization in the past for treatment of COPD 3. Requires chronic bronchodilator therapy with oral or inhaled agents 4. A <i>Forced Expiratory Volume in 1 second (FEV1)</i> of <75% of predicted on pulmonary function testing <p>Do not include patients whose only pulmonary disease is <i>acute</i> asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.</p>
24	Steroid use	Patients that required the regular administration of oral or parenteral corticosteroid medications (e.g., prednisone, dexamethasone) in the 30 days prior to injury for a chronic medical condition (e.g., COPD, asthma, rheumatologic disease, rheumatoid arthritis, inflammatory bowel disease). Do not include topical corticosteroids applied to the skin or corticosteroids administered by inhalation or rectally.

25	Cirrhosis	Documentation in the medical record of cirrhosis, which might also be referred to as end stage liver disease. If there is documentation of prior or present esophageal or gastric varices, portal hypertension, previous hepatic encephalopathy, or ascites with notation of liver disease, then cirrhosis should be considered present. Cirrhosis should also be considered present if documented by diagnostic imaging studies or a laparotomy/laparoscopy.
26	Dementia	With particular attention to senile or vascular dementia (e.g. Alzheimer's).
27	Major Psychiatric Illness	Defined as documentation of the presence of pre-injury major depressive disorder, bipolar disorder, schizophrenia, anxiety / panic disorder, borderline or antisocial personality disorder, and / or adjustment disorder / post-traumatic stress disorder.
28	Drug Abuse or Dependence	With particular attention to opioid, sedative, amphetamine, cocaine, diazepam, alprazolam, or lorazepam dependence (excludes ADD / ADHD or chronic pain with medication use as-prescribed).
30	Attention deficit disorder/Attention deficit hyperactivity disorder (ADD/ADHD)	History of a disorder involving inattention, hyperactivity or impulsivity requiring medication for treatment.
50	Osteoporosis	Thinning of bone tissue and loss of bone density over time; most common in post-menopausal women.
51	Hearing Impaired	Impairment of the sense of hearing.
52	Vision Impairment	Vision impairments result from conditions that range from the presence of some usable vision, low vision, to the absence of any vision, total blindness. Low vision is a term that describes a person with a vision impairment that cannot be improved by correction but has some usable vision remaining.
53	Language Barrier	Barrier to communication resulting from speaking different languages

Appendix D – Hospital Complications

	Variable	Definition
4	Acute Kidney Injury	<p>A patient who did not require chronic renal replacement therapy prior to injury, who has worsening renal dysfunction after injury requiring renal replacement therapy. 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.</p> <p>GFR criteria: Increase creatinine x3 or GFR decrease > 75%</p> <p>Urine output criteria: UO < 0.3ml/kg/h x 24 hr or Anuria x 12 hrs</p>
5	Acute Lung Injury/ Acute Respiratory Distress Syndrome (ARDS)	<p>ALI/ARDS occurs in conjunction with catastrophic medical conditions, such as pneumonia, shock, sepsis (or severe infection throughout the body, sometimes also referred to as systemic infection, and may include or also be called a blood or blood-borne infection), and trauma. It is a form of sudden and often severe lung failure that is usually characterized by a PaO₂ / FiO₂ ratio of < 300 mmHg, bilateral fluffy infiltrates seen on a frontal chest radiograph, and an absence of clearly demonstrable volume overload (as signified by pulmonary wedge pressure < 18 mmHg, if measured, or other similar surrogates such as echocardiography which do not demonstrate analogous findings).</p>
8	Cardiac Arrest with CPR	<p>The sudden abrupt loss of cardiac function that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support. Excludes patients that arrive at the hospital in full arrest.</p>
11	Decubitus Ulcer	<p>Defined as any partial or full thickness loss of dermis resulting from pressure exerted by the patient’s weight against a surface. Deeper tissues may or may not be involved. Equivalent to NPUAP Stages II – IV and NPUAP “unstageable” ulcers.</p> <p>EXCLUDES intact skin with nonblanching redness (NPUAP Stage I), which is considered reversible tissue injury.</p>
12	Deep Surgical Site Infection	<p>Defined as a deep incisional SSI must meet one of the following criteria:</p> <ol style="list-style-type: none"> 1. Infection occurs within 30 days after the operative procedure if no implant is left in place or within one year if implant is in place and the infection appears to be related to the operative procedure and involves deep soft tissues (e.g., fascial and muscle layers) of the incision <p>AND patient has at least one of the following:</p> <ol style="list-style-type: none"> 1. purulent drainage from the deep incision but not from the organ/space component of the surgical site of the following: 2. a deep incision spontaneously dehisces or is deliberately opened by a surgeon and is culture-positive or not cultured when the patient has at least one of the following signs or symptoms: fever (>38°C), or localized pain or tenderness. A culture-negative finding does not meet this criterion. 3. an abscess or other evidence of infection involving the deep incision is found on direct examination, during reoperation, or by histopathologic or radiologic examination 4. diagnosis of a deep incisional SSI by a surgeon or attending physician. <p>NOTE: There are two specific types of deep incisional SSIs:</p> <ol style="list-style-type: none"> 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)

		<p>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 [leg] incision for CBGB)</p> <p>REPORTING INSTRUCTIONS:</p> <ul style="list-style-type: none"> • Classify infection that involves both superficial and deep incision sites as deep incisional SSI.
13	Drug or Alcohol Withdrawal Syndrome	<p>Defined as a set of symptoms that may occur when a person who has been habitually drinking too much alcohol or habitually using certain drugs (e.g. narcotics, benzodiazepine) experiences physical symptoms upon suddenly stopping consumption. Symptoms may include: activation syndrome (i.e., tremulousness, agitation, rapid heart beat and high blood pressure), seizures, hallucinations or delirium tremens.</p>
14	Deep Vein Thrombosis (DVT)/ Thrombophlebitis	<ul style="list-style-type: none"> • The formation, development, or existence of a blood clot or thrombus within the vascular system, which may be coupled with inflammation. This diagnosis may be confirmed by a venogram, ultrasound, or CT. The patient must be treated with anticoagulation therapy and/or placement of a vena cava filter or clipping of the vena cava.
15	Extremity Compartment Syndrome	<p>Defined as a condition not present at admission in which there is documentation of tense muscular compartments of an extremity through clinical assessment or direct measurement of intracompartmental pressure) requiring fasciotomy. Compartment syndromes usually involve the leg but can also occur in the forearm, arm, thigh, and shoulder. Record as a complication if it is originally missed, leading to late recognition, a need for late intervention, and has threatened limb viability.</p>
18	Myocardial Infarction	<p>A new acute myocardial infarction occurring during hospitalization (within 30 days of injury).</p>
19	Organ/ Space Surgical Site Infection	<p>Defined as an infection that occurs within 30 days after an operation and infection involves any part of the anatomy (e.g., organs or spaces) other than the incision, which was opened or manipulated during a procedure; and at least one of the following, including:</p> <ol style="list-style-type: none"> 1. Purulent drainage from a drain that is placed through a stab wound or puncture into the organ/space; 2. Organisms isolated from an aseptically obtained culture of fluid or tissue in the organ/space; 3. An abscess or other evidence of infection involving the organ/space that is found on direct examination, during reoperation, or by histopathologic or radiologic examination; or 4. Diagnosis of an organ/space SSI by a surgeon or attending physician.
21	Pulmonary Embolism	<ul style="list-style-type: none"> • Defined as 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.

22	Stroke/ CVA	<p>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:</p> <ol style="list-style-type: none"> 1. Change in level of consciousness, 2. Hemiplegia, 3. Hemiparesis, 4. Numbness or sensory loss affecting one side of the body, 5. Dysphasia or aphasia, 6. Hemianopia 7. Amaurosis fugax, 8. Or other neurological signs or symptoms consistent with stroke <p>AND</p> <ul style="list-style-type: none"> • 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 <p>AND</p> <ul style="list-style-type: none"> • No other readily identifiable nonstroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified <p>AND</p> <ul style="list-style-type: none"> • Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, and angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission). <p>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.</p>
23	Superficial Surgical Site Infection	<p>Defined as an infection that occurs within 30 days after an operation and infection involves only skin or subcutaneous tissue of the incision and at least one of the following:</p> <ol style="list-style-type: none"> 1. Purulent drainage, with or without laboratory confirmation, from the superficial incision. 2. Organisms isolated from an aseptically obtained culture of fluid or tissue from the superficial incision. 3. At least one of the following signs or symptoms of infection: pain or tenderness, localized swelling, redness, or heat and superficial incision is deliberately opened by the surgeon, unless incision is culture-negative. 4. Diagnosis of superficial incisional surgical site infection by the surgeon or attending physician. <p>Do not report the following conditions as superficial surgical site infection:</p> <ol style="list-style-type: none"> 1. Stitch abscess (minimal inflammation and discharge confined to the points of suture penetration). 2. Infected burn wound. 3. Incisional SSI that extends into the fascial and muscle layers (see deep surgical site infection).

25	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.
29	Osteomyelitis	Defined as meeting at least one of the following criteria: <ol style="list-style-type: none"> 1. Organisms cultured from bone. 2. Evidence of osteomyelitis on direct examination of the bone during a surgical operation or histopathologic examination. 3. At least two of the following signs or symptoms with no other recognized cause: fever (38° C), localized swelling, tenderness, heat, or drainage at suspected site of bone infection and at least one of the following: <ol style="list-style-type: none"> a. Organisms cultured from blood b. Positive blood antigen test (e.g., H. influenzae, S. pneumoniae) c. Radiographic evidence of infection, e.g., abnormal findings on x-ray, CT scan, magnetic resonance imaging (MRI), radiolabel scan (gallium, technetium, etc.).
30	Unplanned Return to the OR	Unplanned return to the operating room after initial operation management for a similar or related previous procedure.
31	Unplanned Return to the ICU	Unplanned return to the intensive care unit after initial ICU discharge. Does not apply if ICU care is required for postoperative care of a planned surgical procedure.
32	Severe Sepsis	Defined as an obvious source of infection with bacteremia and two or more of the following: <ol style="list-style-type: none"> 1. Temp > 38 degrees C or < 36 degrees C 2. White Blood Cell count > 12,000/mm³, or >20% immature (Source of Infection) 3. Hypotension – (Severe Sepsis) 4. Evidence of hypoperfusion: (Severe Sepsis) <ol style="list-style-type: none"> A. Anion gap or lactic acidosis or B. Oliguria, or C. Altered mental status
33	Catheter-associated Urinary Tract Infection	(Consistent with the January 2015 CDC defined CAUTI): A UTI where an indwelling urinary catheter was in place for >2 calendar days on the date of event, with day of device placement being Day 1, AND An indwelling urinary catheter was in place on the date of event or the day before. If an indwelling urinary catheter was in place for >2 calendar days and then removed, the date of event for the UTI must be the day of discontinuation or the next day for the UTI to be catheter-associated. CAUTI Criterion SUTI 1a: Patient must meet 1, 2, and 3 below: <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • Fever (>38°C) • Suprapubic tenderness with no other recognized cause • Costovertebral angle pain or tenderness with no other recognized cause

		<p>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.</p> <p>OR</p> <p>Patient must meet 1, 2, and 3 below:</p> <ol style="list-style-type: none"> 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: <ul style="list-style-type: none"> • fever ($>38^{\circ}\text{C}$) • 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. <p>CAUTI Criterion SUTI 2:</p> <p>Patient must meet 1, 2 and 3 below:</p> <ol style="list-style-type: none"> 1. Patient is ≤ 1 year of age 2. Patient has at least one of the following signs or symptoms: <ul style="list-style-type: none"> • fever ($>38.0^{\circ}\text{C}$) • hypothermia ($<36.0^{\circ}\text{C}$) • apnea with no other recognized cause • bradycardia with no other recognized cause • lethargy with no other recognized cause • vomiting with no other recognized cause • suprapubic tenderness with no other recognized cause 3. Patient has a urine culture with no more than two species of organisms, at least one of which is bacteria of $\geq 10^5$ CFU/ml.
34	Central line-associated bloodstream infection	<p>(Consistent with the January 2014 CDC Defined CLABSI): 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,</p> <p>AND</p> <p>A CL or UC was in place on the date of event or the day before. If a CL or UC was in place for >2 calendar days and then removed, the LCBI criteria must be fully met on the day of discontinuation or the next day. If the patient is admitted or transferred into a facility with a central line in place (e.g., tunneled or implanted central line), and that is the patient's only central line, day of first access as an inpatient is considered Day 1. "Access" is defined as line placement, infusion or withdrawal through the line.</p> <p>January 2014 CDC Criterion LCBI 1:</p> <p>Patient has a recognized pathogen cultured from one or more blood cultures</p> <p>AND</p> <p>Organism cultured from blood is not related to an infection at another site</p> <p>OR</p>

		<p>January 2014 CDC Criterion LCBI 2: Patient has at least one of the following signs or symptoms: fever (>38°C), chills, or hypotension AND positive laboratory results are not related to an infection at another site AND the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., and Micrococcus spp.) is cultured from two or more blood cultures drawn on separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements</p> <p>OR</p> <p>January 2014 CDC Criterion LCBI 3: Patient ≤ 1 year of age has at least one of the following signs or symptoms: fever (>38° C core), hypothermia (<36°C core), apnea, or bradycardia AND positive laboratory results are not related to an infection at another site AND the same common commensal (i.e., diphtheroids [Corynebacterium spp. not C. diphtheriae], Bacillus spp. [not B. anthracis], Propionibacterium spp., coagulase-negative staphylococci [including S. epidermidis], viridans group streptococci, Aerococcus spp., Micrococcus spp.) is cultured from two or more blood cultures drawn on the same or consecutive days and separate occasions. Criterion elements must occur within a timeframe that does not exceed a gap of 1 calendar day between two adjacent elements.</p>
35	Ventilator-associated Pneumonia	<p>(Consistent with the January 2015 CDC Defined VAP): A pneumonia where the patient is on mechanical ventilation for >2 calendar days on the date of event, with day of ventilator placement being Day 1, AND The ventilator was in place on the date of event or the day before. If the patient is admitted or transferred into a facility on a ventilator, the day of admission is considered Day 1.</p> <p>(See next page for algorithms)</p>

VAP Algorithm (PNU2 Bacterial or Filamentous Fungal Pathogens):

<p>RADIOLOGY Two or more serial chest radiographs with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatocoles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable.</p>	<p>SIGNS/SYMPTOMS At least one of the following:</p> <ul style="list-style-type: none"> • Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • 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 sypnea, or tachypnea • Rales or bronchial breath sounds • Worsening gas exchange (e.g., O₂ desaturations (e.g., PaO₂/FiO₂≤240), increased oxygen requirements, or increased ventilator demand) 	<p>LABORATORY At least one of the following:</p> <ul style="list-style-type: none"> • Positive growth in blood culture not related to another source of infection • Positive growth in culture of pleural fluid • Positive quantitative culture from minimally-contaminated LRT specimen (e.g., BAL or protected specimen brushing) • ≥5% BAL-obtained cells contain intracellular bacteria on direct microscopic exam (e.g., Gram's stain) • Positive quantitative culture of lung tissue • Histopathologic exam shows at least one of the following evidences of pneumonia: <ul style="list-style-type: none"> o Abscess formation or foci of consolidation with intense PMN accumulation in bronchioles and alveoli o Evidence of lung parenchyma invasion by fungal hyphae or pseudohyphae
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(See next page for algorithms)

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

<p>RADIOLOGY Two or more serial chest radiographs with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatoceles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic</p>	<p>SIGNS/SYMPTOMS At least one of the following:</p> <ul style="list-style-type: none"> • Fever (>38°C or >100.4°F) • Leukopenia (<4000 WBC/mm³) or leukocytosis (≥12,000 WBC/mm³) • For adults ≥70 years old, altered mental status with no other recognized cause <p>AND at least two of the following:</p> <ul style="list-style-type: none"> • New onset of purulent sputum, or change in character of sputum, or increased respiratory secretions, or increased suctioning requirements • New onset or worsening cough, 	<p>LABORATORY At least one of the following:</p> <ul style="list-style-type: none"> • Positive culture of virus, Legionella or Chlamydia from respiratory secretions • Positive non culture diagnostic laboratory test of respiratory secretions or tissue for virus, Bordetella, Chlamydia, Mycoplasma, Legionella (e.g., EIA< FAMA< shell vial assay, PCR, micro-IF) • Fourfold rise in paired sera (IgG) for pathogen (e.g., influenza viruses, Chlamydia) • Fourfold rise in L. pneumophila serogroup 1 antibody titer to ≥1:128 in paired acute and convalescent sera by indirect IFA. • Detection of Legionella pneumophila serogroup 1 antigens in urine by RIA or EIA
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VAP Algorithm ALTERNATE CRITERIA (PNU1), for infant's ≤1 year old:

<p>RADIOLOGY Two or more serial chest radiographs with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate 	<p>SIGNS/SYMPTOMS Worsening gas exchange (e.g., O₂ desaturation [e.g. pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand) AND at least three of the following:</p> <ul style="list-style-type: none"> • Temperature instability
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<ul style="list-style-type: none"> • Consolidation • Cavitation • Pneumatocoles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable.</p>	<ul style="list-style-type: none"> • 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 rhonchi • Cough • Bradycardia (<100 beats/min) or tachycardia (>170 beats/min)
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VAP Algorithm ALTERNATE CRITERIA (PNU1), for children >1 year old or ≤12 years old:

RADIOLOGY	SIGNS/SYMPTOMS/LABORATORY
<p>Two or more serial chest radiographs with at least one of the following:</p> <ul style="list-style-type: none"> • New or progressive and persistent infiltrate • Consolidation • Cavitation • Pneumatocoles, in infants ≤1 year old <p>NOTE: In patients without underlying pulmonary or cardiac disease (e.g., respiratory distress syndrome, bronchopulmonary dysplasia, pulmonary edema, or chronic obstructive pulmonary disease), one definitive chest radiograph is acceptable</p>	<p>At least three of the following:</p> <ul style="list-style-type: none"> • Fever (>38.0°C or >100.4°F) or hypothermia (<36.0°C or <96.8°F) • Leukopenia (<4000 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 desaturations [e.g., pulse oximetry <94%], increased oxygen requirements, or increased ventilator demand)

APPENDIX E - Calculating ICU Length of Stay and Ventilator Days

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

APPENDIX F - Glossary of Abbreviations

ACE	Angiotensin Converting Enzyme
ACS	Abdominal compartment syndrome; American College of Surgeons
ADL	Activities of daily living
AIS	Abbreviated Injury Scale
ARDS	Acute respiratory distress syndrome
ARF	Acute Renal Failure
BMI	Body mass index
BP	Blood pressure
CDC	Centers for Disease Control and Prevention
CHF	Congestive heart failure
CPAP/BIPAP	Continuous positive airway pressure/variable bi-level positive airway pressure
CT	Computerized topography
CVA	Cerebral vascular accident
DNR	Do not resuscitate
DNR-CC	Do not resuscitate; comfort care only
DNR-CCA	Do not resuscitate; comfort care arrest
DVT	Deep vein thrombosis
EOA	Esophageal Obturator Airway
ED	Emergency department
EMS	Emergency medical services
FAST	Focused assessment with sonography for trauma
FIPS	Federal Information Processing Standard codes
GCS	Glasgow Coma Score
ICD-10-CM	International Classification of Diseases, Tenth Revision, Clinical Modification
IgG	Immunoglobulin G
ISS	Injury Severity Score
LMA	Laryngeal Mask Airway
MI	Myocardial infarction
MRI	Magnetic resonance imaging
NHTSA	National Highway Traffic Safety Administration
NTDS	National Trauma Data Standard
OPO	Organ Procurement Organization
OR	Operating Room
OTR	Ohio Trauma Registry
PT	Prothrombin time
PTT	Partial thromboplastin time
PVD	Peripheral vascular disease
SaO ₂	Saturation of oxygen in arterial blood
TACR	Trauma Acute Care Registry
UB-04	Uniform Billing Form-04
XSD	XML (Extensible Markup Language) Schema definition

CHANGE LOG

November 12, 2015

- Corrected typo in the ICD-10 inclusion criteria decision tree.
- Aligned Co-Morbid Condition field values with NTDS 2016 field values.
- Aligned Hospital Complications field values with NTDS 2016 field values.
- Updated Table of Contents to reflect all changes.
- Renamed document OTR TACR Data Dictionary 2016.1

September 16, 2015 (From TACR Data Dictionary 2015.2)

- Removed ICD-9 to ICD-10 transition language
- Removed ICD-9-based inclusion/exclusion criteria
- Removed ICD-9-based inclusion/exclusion decision tree
- Removed 'Primary ICD-9 External Cause Code'
- Removed 'Additional ICD-9 External Cause Code'
- Removed 'ICD-9 Location E-Code'
- Removed 'ICD-9 Hospital Procedures'
- Removed 'ICD-9 Injury Diagnoses'
- Removed 'ISS Body Region'
- Aligned Alternate Home Residence field values with NTDS 2016 field values
- Aligned Age Units field values with NTDS 2016 field values
- Aligned AIS Version field values with NTDS 2016 field values
- Added 'ED Discharge Order Written Date' field
- Added 'ED Discharge Order Written Time' field
- Added 'Hospital Discharge Order Written Date' field
- Added 'Hospital Discharge Order Written Time' field.
- Updated Table of Contents to reflect all changes
- Renamed document OTR TACR Data Dictionary 2016.0

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