Ohio Trauma Registry

2014

Trauma Acute Care Registry

Data Dictionary

Version 2014.0

This edition is effective for all trauma patients presenting for treatment on or after January 1, 2014.

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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 Tim Erskine, Ohio Department of Public Safety, at phone numbers (614)387-1951 or (800)233-0785, or visit TErskine@dps.state.oh.us or http://ems.ohio.gov.

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TRAUMA ACUTE CARE REGISTRY INCLUSION/EXCLUSION CRITERIA

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, Ninth Revision, Clinical Modification (ICD-9-CM) in the range of 800 – 959.9, 987.9, 991.0-991.6, 992.0-992.9, 994.0, 994.1, 994.7, 994.8, 995.50-995.59.

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**

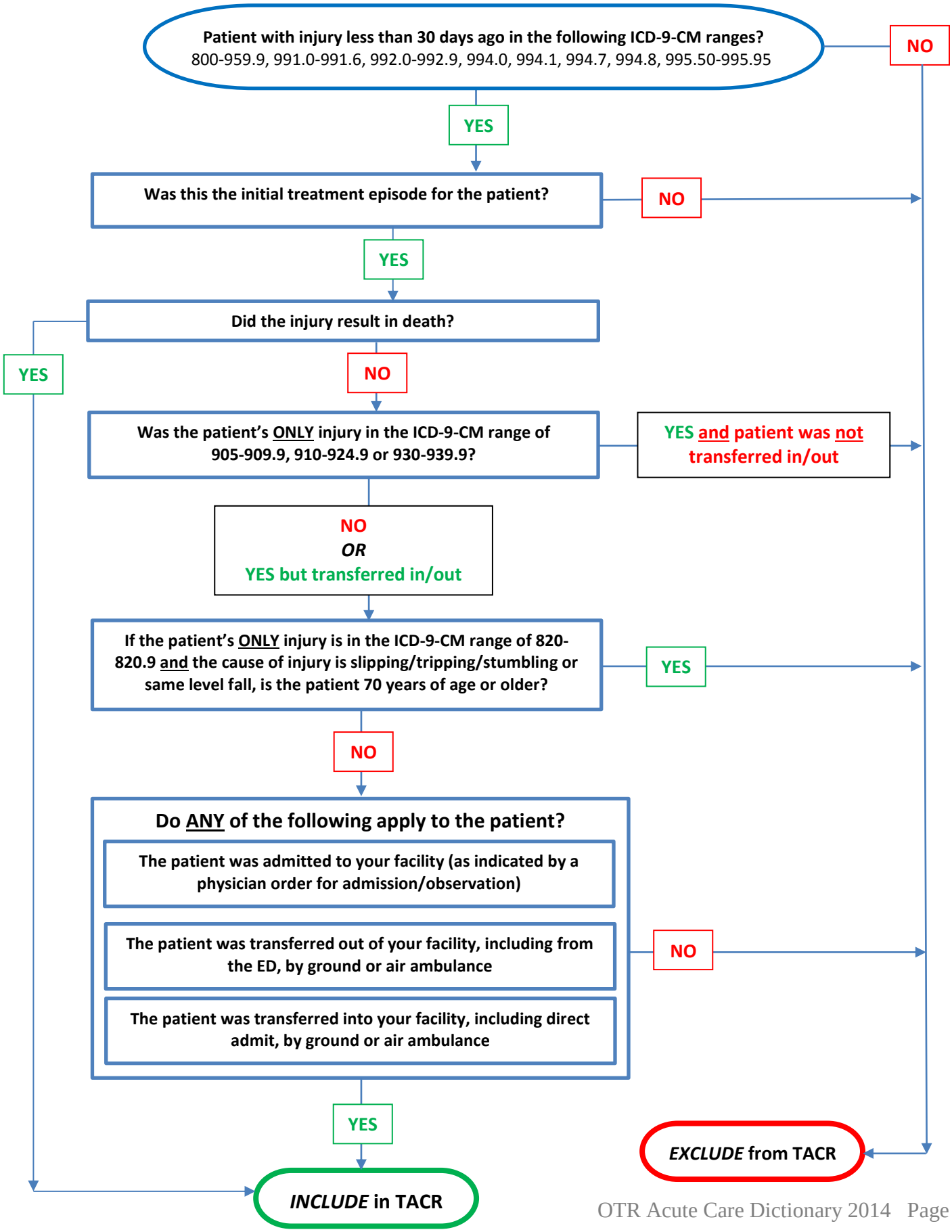
    - Have an outcome of death resulting from the traumatic injury (independent of hospital admission or hospital transfer status).

PATIENT EXCLUSION CRITERIA

Patients with the following isolated ICD-9-CM codes are **EXCLUDED** from the TACR:

- **820.0-820.9**, fracture of neck of femur *ONLY IF age >70 AND it resulted from slipping, tripping, stumbling or a same level fall (E885.9, E888.8, E888.9);*
- **905-909.9**, late effects of injury;
- **9910-924.9,** superficial injuries, including blisters, contusions, abrasions and insect bites (but exclude 910-924.9 if that is the ONLY injury identified and the patient was admitted to the hospital. Patients with an isolated contusions or abrasions that were transferred in/out or died would be included in the registry, Where "contusion and abrasion codes" means 910-924.9.); **AND/OR**
- **930-939.9**, foreign bodies.

Ohio TACR Inclusion/Exclusion Decision Tree



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-transports 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 be 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

Data Format is numeric.

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

- State of Ohio Hospital

UNIQUE ADMISSION NUMBER

Data Format is numeric.

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

Data Source Hierarchy

1 Hospital's trauma registry tracking number

PATIENT'S HOME CITY

Data Format is single-choice.

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

Data Format is single-choice.

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

Data Format is single-choice.

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

Data Format is numeric text.

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).
- May require adherence to HIPAA regulations.

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

Data Format is single-choice.

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

Data Format is single-choice.

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
4 Foreign Visitor

Common Null Values

- Accepted

Additional Information

- *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
- *Foreign Visitor* is defined as any person visiting a country other than his/her usual place of residence for any reason.

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

Data Format is a date.

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

Data Format is numeric.

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

Data Format is single-choice.

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

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

Data Format is single-choice.

Definition

Sex is the patient's current gender.

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 gender they state they are. If they are unable to state their gender, 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

Data Format is multiple-choice.

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

Data Format is single-choice.

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 E-CODE

Data Format is numeric.

Definition

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

Field Values

- Relevant ICD-9-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
- ICD-9-CM Codes were retained over ICD-10 due to CMS's continued use of ICD-9
- The E-code series beginning with 849 are NOT entered in this field
- External cause status (E000) and Activity (E001-E030) E-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 E-CODE

Data Format is numeric.

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-9-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
- ICD-9-CM codes were retained over ICD-10 due to CMS's continued use of ICD-9
- The E-code series beginning with 849 are NOT entered in this field
- External cause status (E000) and Activity (E001-E030) E-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

LOCATION E-CODE

Data Format is numeric.

Definition

Location E-code is an E-code used to describe the place, site or location of the injury event (E849.x).

Field Values

0 Home
1 Farm
2 Mine/Quarry
3 Industrial Place/Premises
4 Recreation/Sport
5 Street/Highway
6 Public Building
7 Residential Institution
8 Other Specified Place
9 Unspecified Place

Common Null Values

- Accepted

Additional Information

- ICD-9-CM Codes were retained over ICD-10 due to CMS's continued use of ICD-9.
- Some software systems collect the location E-Code has a text value (street, home, ect.) and convert that value into the appropriate location E-Code during the export of data to the TACR, 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

Data Format is single-choice.

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

Data Format is single-choice.

Definition

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

Field Values

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

Data Format is single-choice.

Definition

Patient's Occupation is the patient's occupation.

Field Values

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

Data Format is a 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

- Collected as MMDDYYYY
- 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

Data Format is numeric.

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

- Document as military time
- Estimates of time of injury should be based upon report by patient, witness, family, or health care provider. Other proxy measures (e.g. 911 call-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

Data Format is single-choice.

Definition

Incident City is the city or nearest 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

Additional Information

- Used to calculate FIPS code
- If incident location resides outside of formal city boundaries, report nearest city/town

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

Data Format is single-choice.

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

Data Format is single-choice.

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

Data Format is numeric.

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

Data Format is single-choice.

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

Data Format is multiple-choice.

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
2 Lap Belt
3 Personal Floatation Device
4 Protective Non-Clothing Gear (e.g. shin guard)
5 Eye Protection
6 Child Restraint (booster seat, child car seat)
7 Helmet (e.g., bicycle, skiing, motorcycle)
8 Airbag Present
9 Protective Clothing (e.g. padded leather pants)
10 Shoulder Belt
11 Other

Common Null Values

- Accepted

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

Data Format is single-choice.

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

Data Format is multiple-choice.

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

Data Format is single-choice.

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

Data Format is single choice.

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

Data Format is multiple-choice.

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

Data Format is a date.

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

- Collected as MMDDYYYY
- 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

Data Format is numeric.

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

- Document as military time
- 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

Data Format is date.

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

- Collected as MMDDYYYY
- 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

Data Format is numeric.

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

- Document as military time
- 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

Data Format is a date.

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

- Collected as MMDDYYYY
- 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

Data Format is numeric.

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

- Document as military time
- Used to auto-generate an additional calculated field *Total EMS Scene Tim*e (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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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*

Data Source Hierarchy

- EMS Run Sheet

References to Other Databases

- NHTSA V.2.2 – E14_19
- NTDS 1.2.5

INITAIL FIELD GCS QUALIFIER

Data Format is multiple-choice.

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

Data Format is multiple-choice.

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

INTER-FACILITY TRANSFER

Data Format is single-choice.

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

Data Format is single-choice.

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

Data Format is a 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
- Collected as MMDDYYYY
- 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

Data Format is numeric.

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.
- Document as military time
- Used to auto-generate two additional calculated fields: Total EMS Time: (elapsed time from EMS dispatch to hospital arrival) and Total Length of Hospital Stay (elapsed time from ED/Hospital Arrival to ED/Hospital Discharge).

Data Source Hierarchy

1. Triage 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

Data Format is single-choice.

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 Alert Activation

Common Null Values

- Accepted

Additional Information

- Select *NA* if your facility does not have a trauma team

Data Source Hierarchy

1 Trauma Flow Sheet
2 ED Record

References to Other Databases

- Not an NTDS Field

INITIAL ED/HOSPITAL SYSTOLIC BLOOD PRESSURE

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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 addition 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

Data Format is single-choice.

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

Data Format is numeric.

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

Data Format is single-choice.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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

Data Format is numeric.

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)*

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

Data Format is multiple-choice.

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

Data Format is numeric.

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

Data Format is numeric.

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 DATE

Data Format is a 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

- Collected as MMDDYYYY
- 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

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 TIME

Data Format is numeric.

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

- Document as military time
- 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

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 DISPOSITION

Data Format is single-choice.

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

Common Null Values

- Accepted

Additional Information

- Based upon UB-04 disposition coding
- 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

Data Format is single-choice.

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

- Not a NTDS Field

SIGNS OF LIFE

Data Format is single-choice.

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

Data Format is single-choice.

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 States of Ohio, Kentucky and Indiana
  - Adult Legal Limit is < 0.08 mcg/dl
  - Pediatric (≤ 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

Data Format is single-choice.

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

- Not a NTDS Field

DRUG USE INDICATOR

Data Format is single-choice.

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

HOSPITAL PROCEDURES

Data Format is multiple-choice.

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-9-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 on the following page 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 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 *
In addition to coding the individual blood products listed above assign the 99.01 ICD-9 procedure code on patients that receive > 10 units of blood products over first 24 hours following hospital arrival *

OTHER
Hyperbaric oxygen
Decompression chamber
Total Parenteral Nutrition (TPN)

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

PROCEDURE EPISODE

Data Format is multiple-choice.

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

Data Format is a date.

Definition

The date operative and essential procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Collected as MMDDYYYY
- 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

Data Format is numeric.

Definition

The time operative and essential procedures were performed.

Field Values

- Relevant value for data element

Common Null Values

- Accepted

Additional Information

- Document as military time
- 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

Data Format is multiple-choice.

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
1 Other Co-morbid Conditions Not Otherwise Listed Here
2 Alcoholism
3 Ascites within 30 days
4 Bleeding Disorder
5 Currently receiving Chemotherapy for Cancer
6 Congenital Anomalies
7 Congestive Heart Failure
8 Current Smoker
9 Chronic Renal Failure
10 CVA/Residual Neurological Deficit
11 Diabetes Mellitus
12 Disseminated Cancer
13 Advanced Directive Limiting Care
14 Esophageal Varices
15 Functionally Dependent Health Status
16 History of Angina Within Past 1 Month
17 History of Myocardial Infarction
18 History of PVD
19 Hypertension Requiring Medication
21 Prematurity
22 Obesity
23 Respiratory Disease
24 Steroid Use
25 Cirrhosis
26 Dementia
27 Major Psychiatric Illness
28 Drug Abuse or Dependence
29 Pre- Hospital Cardiac Arrest with CPR
50 Osteoporosis
51 Hearing Impaired
52 Vision Impairment
53 Language Barrier

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

Data Format is single-choice.

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

INJURY DIAGNOSES

Data Format is multiple-choice.

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-9-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~~

ISS BODY REGION

Data Format is multiple-choice.

Definition

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

Field Values

1 Head or Neck
2 Face
3 Chest
4 Abdominal or Pelvic Contents
5 Extremities or Pelvic Girdle
6 External

Common Null Values

- Accepted

Additional Information

- Field value #1, *Head or Neck,* includes injury to the brain, skull, cervical spine and/or cervical spine fractures
- Field value #2, *Face,* includes those areas involving the mouth, ears, nose and/or facial bones
- Field value #3, *Chest,* includes all lesions to internal organs within the chest, diaphragm, rib cage and/or thoracic spine
- Field value #4, *Abdominal or Pelvic Contents*, includes all lesions to internal organs within the abdomen and lumbar spine
- Field value #5, *Extremities or Pelvic Girdle,* includes sprains, dislocations, fractures and amputations ***except for the spinal column, skull and rib cage***
- Field value #6, *External, includes* injuries such as lacerations, contusions, abrasions and burns independent of their location on the body surface

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

Data Format is multiple-choice.

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 using ICD-9-CM injury codes found

References to Other Databases

- NTDS 1.2.5

AIS SEVERITY

Data Format is multiple-choice.

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 using ICD-9-CM injury codes found

References to Other Databases

- NTDS 1.2.5

AIS VERSION

Data Format is single-choice.

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 using ICD-9-CM injury codes

References to Other Databases

- NTDS 1.2.5

INJURY SEVERITY SCORE

Data Format is single-choice.

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 using ICD-9-CM injury codes

References to Other Databases

- NTDS 1.2.5

TOTAL ICU LENGTH OF STAY

Data Format is numeric.

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.'

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	

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
	01/03/11	18:00	01/03/11	20:00	3 days (patient was in ICU on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

Data Source Hierarchy

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

Data Format is numeric.

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.'

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

Example #	Start Date	Start Time	Stop Date	Stop Time	LOS
	01/02/11	18:00	01/02/11	20:00	2 days (patient was in on Vent on 2 separate calendar days)
J.	01/01/11	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	3 days (patient was on Vent on 3 separate calendar days)
K.	Unknown	Unknown	01/02/11	16:00	
	01/03/11	18:00	01/03/11	20:00	Unknown (can't compute total)

Data Source Hierarchy

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 DATE

Data Format is a 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

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

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 TIME

Data Format is numeric.

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

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

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 DISPOSITION

Data Format is single-choice.

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 with no home services
7 Discharged to a skilled nursing facility (SNF)
8 Discharged to hospice care
9 Discharged to another type of inpatient rehabilitation facility (IRF)
10 Discharged to a long term acute care hospital (LTACH)

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

Data Format is single-choice.

Definition

Inpatient Transfer to Hospital documents a subsequent hospital destination for the patient after inpatient admission at your hospital.

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

Data Format is numeric.

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

Data Format is single-choice.

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

Data Format is numeric.

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

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

- Not a NTDS Field

TIME OF DEATH

Data Format is numeric.

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

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

- Not a NTDS Field

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
5 No Fault Automobile Insurance
6 Medicare
7 Other Government Payer Source
8 Workers Compensation
9 Blue Cross/Blue Shield
10 Other

Common Null Values

- Accepted

Additional Information

- No fault insurance is any type of insurance contract under which insureds are indemnified for losses by their own insurance company, regardless of fault in the incident generating losses.
- A "No Fault" is to be determined by which state the accident occurred in.
- Ohio is NOT a "No Fault Insurance" state.
- "No Fault Insurance" states include: Kentucky, Michigan, Pennsylvania, Florida, Hawaii, Kansas, Massachusetts, New Jersey, New York, North Dakota, Utah and Minnesota.
- If the accident occurred in one of the above states, please choose "No Fault Insurance" as the primary payer.
- 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
1 Complications occurred that are otherwise not on this list
4 Acute kidney injury
5 Acute lung injury/ Acute respiratory distress syndrome (ARDS)
8 Cardiac arrest with CPR
11 Decubitus ulcer
12 Deep surgical site infection
13 Drug or alcohol withdrawal syndrome
14 Deep Vein Thrombosis (DVT) / thrombophlebitis
15 Extremity compartment syndrome
16 Graft/ prosthesis/ flap failure
18 Myocardial infarction
19 Organ/ space surgical site infection
20 Pneumonia
21 Pulmonary Embolism
22 Stroke/ CVA
23 Superficial surgical site infection
25 Unplanned intubation
27 Urinary tract infection
28 Catheter- related blood stream infection
29 Osteomyelitis
30 Unplanned return to the OR
31 Unplanned return to the ICU
32 Severe Sepsis

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

GLOSSARY OF TERMS

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.

CO-MORBID CONDITIONS

<table>
<tr><th>Field Value</th><th>Variable</th><th>Definition</th><th>ICD-9 Code Range</th></tr>
<tr><td>2</td><td>Alcoholism</td><td>Evidence of chronic use, such as withdrawal episodes. Exclude isolated elevated blood alcohol level in absence of history of abuse. Example, the patient admits to drinking > 2oz. hard liquor or > 12oz. cans of beer or > two 6oz. glasses of wine per day in the two weeks prior to admission.</td><td>291.0 -291.3, 291.81, 291.9, 303.90-303.93, V11.3.3</td></tr>
<tr><td>3</td><td>Ascites</td><td>The presence of fluid accumulation (other than blood) in the peritoneal cavity noted on physical examination, abdominal ultrasound, or abdominal CT/MRI. (Within 30 days)</td><td>789.5 (pre 2008), 789.59</td></tr>
<tr><td>4</td><td>Bleeding disorder</td><td>Any condition that places the patient at risk for excessive bleeding due to a deficiency of blood clotting elements (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.
<table>
<tr><th>Medication</th><th>Time Frame</th></tr>
<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>
</table></td><td>269.0, 286.0, 286.1, 286.4, 287.1, 287.3 (pre-2006), 287.5, 287.9</td></tr>
<tr><td>5</td><td>Currently receiving Chemotherapy for Cancer</td><td>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 no include if treatment consists solely of hormonal therapy.</td><td>V58.1 (pre 2006), V58.11</td></tr>
<tr><td>6</td><td>Congenital Anomaly</td><td>Defined as documentation of a cardiac, pulmonary, body wall, CNS/spinal, GI, renal, orthopedic, or metabolic congenital anomaly.</td><td>740.0 – 759.9, 758.3 (pre 2005), 752.8 (pre 2004)</td></tr>
<tr><td>7</td><td>Congestive Heart Failure (CHF)</td><td>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.</td><td>398.91, 402.01, 402.11, 402.91, 404.11, 404.13, 404.13, 404.91, 404.93, 425.0-425.9, 428.0</td></tr>
</table>

		Common manifestations are: 1. Abnormal limitation in exercise tolerance due to dyspnea or fatigue 2. Orthopnea (dyspnea on lying supine) 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)	V45.1
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).	430-438.9, 436
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.	205.00-250.33, 250.40-250.73
12	Disseminated Cancer	Patients who have cancer that: 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). 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.	196.0-199.1
13	Advanced Directive Limiting Care	The patient had a Do Not Resuscitate (DNR) document or similar advance directive recorded prior to injury.	
14	Esophageal Varices	Esophageal varices are engorged collateral veins in the esophagus which bypass a scarred liver to carry portal blood to the superior vena cava. A sustained increase in portal pressure results in esophageal varices which are most frequently demonstrated by direct visualization at esophagoscopy.	456.0-456.20
15	Functionally dependent health status	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.	

		Formal definitions of dependency are listed below: 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 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. 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.	
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.	413.0-413.9
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.	*410.00, 410.01, 410.10, 410.11, 410.20, 410.21, 410.30, 410.31, 410.40, 410.41, 410.50, 410.51, 410.60, 410.61, 410.70, 410.71, 410.80, 410.81, 410.90, 410.91*
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.	*440.20-440.29, 440.30-440.32 and 443.9*
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, *angiotensin-converting enzyme (*ACE*)* inhibitors, calcium channel blockers). History of hypertension prior to injury must be documented in the patient's chart.	*.0, 401.1, 401.9, 642.00-642.04 642.20-642.24 642.30-642.34, 402.0-402.91; 403.00-403.91; 404.00-404.93; 405.01-405.99;*,
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.	343.0 - 343.9, 765.00-765.19, 770.

22	Obesity	**Defined as a Body Mass Index of 30 or greater.**	278.00-278.01

BMI (kg/m^2)	19	20	21	22	23	24	25	26	27	28	29
Height (in.)	**Weight (lbs.)**										
58	91	96	100	105	110	115	119	124	129	134	138
59	94	99	104	109	114	119	124	128	133	138	143
60	97	102	107	112	118	123	128	133	138	143	148
61	100	106	111	116	122	127	132	137	143	148	153
62	104	109	115	120	126	131	136	142	147	153	158
63	107	113	118	124	130	135	141	146	152	158	163
64	110	116	122	128	134	140	145	151	157	163	169
65	114	120	126	132	138	144	150	156	162	168	174
66	118	124	130	136	142	148	155	161	167	173	179
67	121	127	134	140	146	153	159	166	172	178	185
68	125	131	138	144	151	158	164	171	177	184	190
69	128	135	142	149	155	162	169	176	182	189	196
70	132	139	146	153	160	167	174	181	188	195	202
71	136	143	150	157	165	172	179	186	193	200	208
72	140	147	154	162	169	177	184	191	199	206	213
73	144	151	159	166	174	182	189	197	204	212	219
74	148	155	163	171	179	186	194	202	210	218	225
75	152	160	168	176	184	192	200	208	216	224	232
76	156	164	172	180	189	197	205	213	221	230	238

23	Respiratory Disease	Defined as severe chronic lung disease, chronic asthma, cystic fibrosis, or *chronic obstructive pulmonary disease (COPD) such as emphysema and/or chronic bronchitis* resulting in any one or more of the following: 1. Functional disability from COPD (e.g., dyspnea, inability to perform *activities of daily living [ADLs]*) 2. Hospitalization in the past for treatment of COPD 3. Requires chronic bronchodilator therapy with oral or inhaled agents 4. *A Forced Expiratory Volume in 1 second (FEV1)* of <75% of predicted on pulmonary function testing Do not include patients whose only pulmonary disease is *acute* asthma. Do not include patients with diffuse interstitial fibrosis or sarcoidosis.	011.00-011.66, 011.8-011.99, 012.0-012.9, 277.02, 491.0-491.9, 492.0-492.8, 493.00-493.92, 494.0-494.1, 495.0-495.9, 496, 518.2, 518.83-518.89
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.	*V58.65*
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.	*571.2, 571.5, 571.6, 571.8, 571.9, 572.2, 572.3, 572.4, 572.8*

26	Dementia	With particular attention to senile or vascular dementia (e.g. Alzheimer's).	*290.0-290.43, 294.0-294.11, 331.0-331.2, 331.82-331.89, 332.0-332.1, 333.0, 333.4,*
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.	*295.00-297.9, 300.0-300.09, 301.0-301.7, 301.83, 309.81, 311, V11.0-V11.2, V11.4-V11.8*
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).	*304.00-304.8, 305.2-305.9*
29	Pre-Hospital Cardiac Arrest with CPR	A sudden, abrupt loss of cardiac function which occurs outside of the hospital, prior to admission at the center in which the registry is maintained, that results in loss of consciousness requiring the initiation of any component of basic and/or advanced cardiac life support by a health care provider.	
50	Osteoporosis	Thinning of bone tissue and loss of bone density over time; most common in post-menopausal women.	733.0 – 733.01
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	

Complications

	Variable	Definition	ICD-9 Code Range
4	Acute Kidney Injury	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. GFR criteria: Increase creatinine x3 or GFR decrease > 75% Urine output criteria: UO < 0.3ml/kg/h x 24 hr or Anuria x 12 hrs	584.5-584.9; 588.0-588.9 585.1, 585.89, 585.9, 593.9, 958.5
5	Acute Lung Injury/ Acute Respiratory Distress Syndrome (ARDS)	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).	*518.5, 518.82*
8	Cardiac Arrest with CPR	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.	*427.5 in conjunction with 99.60-99.69, 427.5 with 37.91; V12.53*
11	Decubitus Ulcer	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. EXCLUDES intact skin with nonblanching redness (NPUAP Stage I), which is considered reversible tissue injury.	*707.00 through 707.09 with one code from 707.22-707.25 to indicate the stage using the highest stage documented*
12	Deep Surgical Site Infection	Defined as a deep incisional SSI must meet one of the following criteria: 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 AND patient has at least one of the following: 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. NOTE: There are two specific types of deep incisional SSIs:	*674.30, 674.32, 674.34, 996.60-996.63; 996.66-996.69, 998.59*

		1. Deep Incisional Primary (DIP)- a deep incisional SSI that is identified in a primary incision in a patient that has had an operation with one or more incisions (e.g., C-section incision or chest incision for CBGB) 2. Deep Incisional Secondary (DIS)-a deep incisional SSI that is identified in the secondary incision in a patient that has had an operation with more than one incision (e.g., donor site [leg] incision for CBGB) REPORTING INSTRUCTIONS: • Classify infection that involves both superficial and deep incision sites as deep incisional SSI.	
13	Drug or Alcohol Withdrawal Syndrome	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.	*291.0, 291.3, 291.81, 292.0*
14	Deep Vein Thrombosis (DVT)/ Thrombophlebitis	• 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.	*451.0, 451.11, 451.19, 451.2, 451.81- 451.84, 451.89, 451.9, 453.40, 459.10-459.19, 997.2, 999.2*
15	Extremity Compartment Syndrome	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.	*729.71, 729.72, 998.89, 958.91, 958.92, 958.90*
16	Graft/ Prosthesis/ Flap Failure	Mechanical failure of an extracardiac vascular graft or prosthesis including myocutaneous flaps and skin grafts requiring return to the operating room or a balloon angioplasty.	*996.00, 996.1, 996.52, 996.55, 996.61, 996.62, 996.72*
18	Myocardial Infarction	A new acute myocardial infarction occurring during hospitalization (within 30 days of injury).	*414.8, 412*

19	Organ/ Space Surgical Site Infection	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: 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.	*998.59*
20	Pneumonia	Patients with evidence of pneumonia that develops during the hospitalization. Patients with pneumonia must meet at least one of the following two criteria: Criterion 1. Rales or dullness to percussion on physical examination of chest AND any of the following: a. New onset of purulent sputum or change in character of sputum b. Organism isolated from blood culture c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy Criterion 2. Chest radiographic examination shows new or progressive infiltrate, consolidation, cavitation, or pleural effusion AND any of the following: a. New onset of purulent sputum or change in character of sputum b. Organism isolated from the blood c. Isolation of pathogen from specimen obtained by transtracheal aspirate, bronchial brushing, or biopsy d. Isolation of virus or detection of viral antigen in respiratory secretions e. Diagnostic single antibody titer (IgM) or fourfold increase in paired serum samples (IgG) for pathogen f. Histopathologic evidence of pneumonia	*480.0-480.9, 481, 482.0-482.3, 482.30-483.39, 482.40-482.49, 482.81-48.89, 482.9, 483.0-483.8, 484.1-484.8, 485, 486, 997.31*
21	Pulmonary Embolism	• 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.	*415.11; 415.12; 415.19; 416.2*

22	Stroke/ CVA	A focal or global neurological deficit of rapid onset and NOT present on admission. The patient must have at least one of the following symptoms: 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 AND • Duration of neurological deficit ≥24 h • OR duration of deficit <24 h, if neuroimaging (MR, CT, or cerebral angiography) documents a new hemorrhage or infarct consistent with stroke, or therapeutic intervention(s) were performed for stroke, or the neurological deficit results in death AND • No other readily identifiable nonstroke cause, e.g., progression of existing traumatic brain injury, seizure, tumor, metabolic or pharmacologic etiologies, is identified AND • Diagnosis is confirmed by neurology or neurosurgical specialist or neuroimaging procedure (MR, CT, and angiography) or lumbar puncture (CSF demonstrating intracranial hemorrhage that was not present on admission). Although the neurologic deficit must not present on admission, risk factors predisposing to stroke (e.g., blunt cerebrovascular injury, dysrhythmia) may be present on admission.	*434.01, 434.11, 434.91, 433.01-433.91, 997.02*
23	Superficial Surgical Site Infection	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: 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. Do not report the following conditions as superficial surgical site infection: 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).	*998.59*

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.	
27	Urinary Tract Infection	Defined as an infection anywhere along the urinary tract with clinical evidence of infection, which includes at least one of the following symptoms with no other recognized cause: 1. Fever≥38 C 2. WBC> 100,000 or < 3000 per cubic millimeter 3. Urgency 4. Frequency 5. Dysuria 6. Suprapubic tenderness AND positive urine culture (≥100,000 microorganisms per cm^3 of urine with no more than two species of microorganisms) OR at least <u>two</u> of the following signs or symptoms with no other recognized cause: 1. Fever≥38 C 2. WBC> 100,000 or < 3000 per cubic millimeter 3. Urgency 4. Frequency 5. Dysuria 6. Suprapubic tenderness AND at least <u>one</u> of the following: 1. Positive dipstick for leukocyte esterase and/or nitrate 2. Pyuria (urine specimen with >10 WBC/mm^3 or >3 WBC/high power field of unspun urine) 3. Organisms seen on Gram stain of unspun urine 4. At least two urine cultures with repeated isolation of the same uropathogen (gram-negative bacteria or S. saprophyticus) with $\geq 10^2$ colonies/ml in nonvoided specimens 5. $\leq 10^5$ colonies/ml of a single uropathogen (gram-negative bacteria or S. saprophyticus) in a patient being treated with an effective antimicrobial agent for a urinary tract infection 6. Physician diagnosis of a urinary tract infection 7. Physician institutes appropriate therapy for a urinary tract infection Excludes asymptomatic bacteriuria and “other” UTIs that are more like deep space infections of the urinary tract.	*595.0-595.9 or 599.0*
28	Catheter- related Blood Stream Infection	Defined as organism cultured from the bloodstream that is not related to an infection at another site but is attributed to a central venous catheter. Patients must have evidence of infection including at least one of: Criterion 1: Patient has a recognized pathogen cultured from one or more blood cultures and organism cultured	*993.1, 790.7, 038.0, 038.1, 038.10, 038.11, 038.19, 038.3, 038.4-038.43, 038.49, 038.8, 038.9,*

		from blood is not related to an infection at another site. Criterion 2: Patient has at least one of the following signs or symptoms: Fever>38 C Chills WBC> 100,000 or < 3000 per cubic millimeter Hypotension (SBP<90) or >25% drop in systolic blood pressure Signs and symptoms and positive laboratory results are not related to an infection at another site AND Common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., 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 separate occasions. Criterion 3: 1. Patient < 1 year of age has at least one of the following signs or symptoms: a. Fever (>38°C core) b. Hypothermia (<36°C core), c. Apnea, or bradycardia d. Signs and symptoms and positive laboratory results are not related to an infection at another site and common skin contaminant (i.e., diphtheroids [Corynebacterium spp.], Bacillus [not B. anthracis] spp., 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 separate occasions. Erythema at the entry site of the central line or positive cultures on the tip of the line in the absence of positive blood cultures is not considered a CRBSI	
29	Osteomyelitis	Defined as meeting at least one of the following criteria: 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: 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.).	*730.00-730.29*
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: 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) A. Anion gap or lactic acidosis or B. Oliguria, or C. Altered mental status	*785.52, 995.92*

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-9-CM	International Classification of Diseases, Ninth Revision, Clinical Modification
IgG	Immunoglobulin G
ISS	Injury Severity Score
LMA	Laryngeal Mask Airway
MI	Myocardial infarction
MRI	Magnetic resonance imaging
MMDDYYYY	Date designation that represents the month in two digits followed by the day of the month in two digits, followed by the year in four digits
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
SaO2	Saturation of oxygen in arterial blood
TACR	Trauma Acute Care Registry
UB-04	Uniform Billing Form-04
TACR	XML (Extensible Markup Language) Schema definition
xs-string	XML schema defining the acceptable layout (commas, spaces, carriage returns, etc.)
YYYY	Year designation that is represented in four digits, e.g. 2010

CHANGE LOG

January 2, 2013:

- Inadvertant ommission of isolated hip fractures in >70 due to same level falls from Exclusion Criteria corrected.
- Change Log added and included in Table of Contents.
- File renamed as version 2013.1.

June 2013:

- Removed “Date Exported” data element.
- Added “Transport Agency” data element.
- Updated table of Contents to reflect above changes.
- Amended “Drug Use Indicator” field values to align with NTDS values.
- Removed references to “Appendix 1-A” for hospital codes.
- Removed XML/XSD-related tables from data element entries.
- File renamed as version 2013.2.

July 2013:

- Added Common Null Value to data element entries (previously in the XML/XSD-related tables).
- File renamed as version 2013.3.

September 2013:

- Eliminated reference to “Tristate region” from inclusion criteria.
- Made minor syntax changes to inclusion criteria to increase clarity.
- Replaced Inclusion/Exclusion Decision Tree with more accurate version.
- Eliminated maximum age from Height and Weight data elements.
- Eliminated the following data elements:
    - Scene EMS Run Report Present
    - Inter-Facility EMS Run Report Present
    - Admitting Specialty
    - Procedure Location
    - Billed Hospital Charges
    - Organs/Tissues Requested
- The following data elements were combined into a single, multi-choice data element called “Scene Interventions”:
    - Initial Field Intubation
    - Initial Field CPR
    - Initial Field Needle Chest Decompression or Thoracostomy
- Added “Date of Death” data element.
- Updated Table of Contents to reflect changes above.
- File renamed as version 2014.0.

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